Submitter : Mr. Andrew Klapperich **Date:** 08/07/2007

Organization : Froedtert Memorial Luthren Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

I am a sonographer at a teaching hospital in Miwaukee. We complete very thorough exams here, based on diagnosis. Some studies need just 2D echo, others need 2D plus color and/or spectral Doppler. Without color alone, many significant pathological findings may not be detected. If this was your mother, would you want her to not be dignosed correctly?
Thank you.
Andrew Klapperich MS RDCS
Froedtert Hospital
Milwaukee, WI 53226
414-805-5905

Submitter : Dr. Thomas von Dohlen **Date:** 08/07/2007

Organization : The Heart Center, Inc.

Category : Physician

Issue Areas/Comments

Coding– Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Mr. Kuhn:

As a provider of cardiovascular services to Medicare beneficiaries in West Virginia, I am involved in performance and interpretation of echocardiograms on a daily basis. I am writing to object to the proposed "bundling" of Medicare payment for Doppler color flow imaging (CPT Code 93325) into echocardiography "basic" services.

The contention that Doppler color flow imaging is "intrinsic to the performance" of all echocardiographic procedures may seem, on face value, to true those who view it as a function of "pushing a few buttons" on an echo machine during the acquisition of a study, but this view barely scratches the surface of the true skills and expertise that are involved in gathering, measuring, and quantitating the necessary information and to then synthesize it into a coherent, diagnostic plan for the care and management of each patient with cardiovascular disease.

Those who perform Doppler color flow studies at the levels prescribed by current training and expertise qualifications know that proper acquisistion of images requires making proper adjustments to instrument settings during the gathering of information and that, in certain circumstances, the actual measurement of color flow data and image profiles is needed to determine the quantitative significance of cardiac valve disease, shunt lesions, and other complex lesions.

The training and time required for a sonographer to properly acquire Doppler color flow images is not insignificant and contributes a significant portion of daily work (and overhead, not to mention that color flow imaging adds to the cost of equipment used for imaging) and are not included in the RVU's for "base cost" of any other echocardiographic procedure. Therefore, "bundling" eliminates reimbursement for a valuable and time/equipment/overhead consuming procedure that has been acknowledged as an important component of arriving at a correct diagnosis from which appropriate therapy can be delivered to the patient.

For these reasons, and because there are numerous CPT codes for which color flow imaging is not routines performed, based upon data that has been submitted to you by the ACC and ASE, I strongly urge you not to finalize the "bundling" of color flow Doppler imaging into other echocardiographic procedures. I would also suggest that you work closely with the ACC and ASE to more clearly define the true resources and work that go into the delivery of high quality studies for your beneficiaries with the fairest accounting of the work and overhead that are involved.

Sincerely,

Thomas W. von Dohlen, MD, MBA

Submitter : Dr. Robert DeCresce **Date:** 08/07/2007

Organization : CAP Member

Category : Physician

Issue Areas/Comments

CAP Issues

CAP Issues

August 6, 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 Chicago, Illinois as part of a 16 member independent group practicing at 4 locations. I am based at Rush University Medical Center which is a major tertiary care hospital with multiple residency programs. My current position is Chairman of Pathology.

I appreciate that CMS has undertaken this important initiative to end self-referral abuses in the billing and payment for pathology services. I am personally 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. These arrangements have been made solely to capture revenue from ancillary activities. 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. My own experience with a urology group starting such a laboratory confirmed to me that financial advantage is the driving force behind these ventures. Furthermore, the scale and location of many facilities is at variance with the in-office exception.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. While there might be some merit to these arguments in the theoretical senses but, unfortunately, the driving force in all cases is money. I strongly believe 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. I believe that these practices may encourage over utilization which in itself can impact quality.

Robert P. DeCresce, M.D.
Harriet B. Borland Professor and Chair of Pathology
Rush University Medical Center
Chicago, Illinois
(affiliation for identification purposes only)

Submitter : Dr. Diane Heasley **Date:** 08/07/2007

Organization : Unipath

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 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 [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

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

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services 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,

Diane D. Heasley, D.O.

Submitter : **Dr. Charles Anderson** **Date: 08/07/2007**

Organization : **Dr. Charles Anderson**

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. Christopher Abadi** **Date: 08/07/2007**

Organization : **Newport Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing with regards to bundling the codes for 'doppler and color' for Echocardiography. These codes should remain separate as they are a separate part of the exam that requires additional sonographer time and interpretation time. They are not performed on all echo's and should not be bundled.

All of the continued cuts being made is going to result in a shortage of physicians in the long run and result in suboptimal future medical care. We as physcians and hospitals are trying to make a living, deliver good care and remain viable which is becoming more and more difficult with the ongoing cuts. Continued cuts will only continue to hurt the filed of medicine

Thank You

Submitter : **Dr. Charles Anderson** **Date: 08/07/2007**

Organization : **Dr. Charles Anderson**

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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To ensure that our patients have aecess 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. Scott Hope **Date:** 08/07/2007

Organization : Dr. Scott Hope

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please correct the undervaluation of anesthesia services for our elderly. These are some of the sickest patients that we care for. Care for these patients suffers as a result of this underfunding. Thank you.

Submitter : Dr. **Date:** 08/07/2007

Organization : Dr.

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

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

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services 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,

Concerned Doctor

Submitter : **Dr. Jerome Klafta** **Date: 08/07/2007**

Organization : **University of Chicago**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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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. Rohit Talwar** **Date: 08/07/2007**

Organization : **Dr. Rohit Talwar**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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 a pediatric cardiologist, this is of particular concern to me because:

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.

3. I am concerned 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.

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,
Rohit Talwar MD, FACC, FAAP

Submitter : Mr. Chris Kendall **Date:** 08/07/2007

Organization : Mr. Chris Kendall

Category : Other Health Care Professional

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

CODING ADDITIONAL CODES FROM 5-YEAR REVIEW
72 Federal Citation 38122

Dear Mr Kuhn,
As a cardiac sonographer who provides cardiac ultrasound(echocardiography) services to Medicare patients and others at Mayo Clinic Arizona, I am writing to object to CMS 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(CFD) 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 echo (which evaluates cardiac structure and anatomy), CFD is used for evaluating blood flow and hemodynamics of the heart, such as valvular regurgitation, cardiac shunts, and blood flow direction in cardiac blood vessels. In particular, CFD is a critical and seperate component of the echo procedure, in that sonographers and physicians utilize CFD independant of 2-dimensional echo to evaluate and select patients for surgieal intervention with cardiac valve regurgitation. In addition CFD is vital to the diagnosis of intra-cardiac chamber shunts/blood flow in pediatric congenital diseases and fetal echocardiography. CMS proposal to BUNDLE (and therby eliminate payment for) CFD completely ignores the practice expenses and echocardiographers time/work in performance and interpretation of color flow imaging. Say for example a sonographer does not perform CFD, this will reduce time to complete exam and information about cardiac blood flow will not be gained. To use CFD in an exam requires increased cardiac sonographer skill level, increased exam time and unique cardiac ultrasound machine components and instrumentation. The sonographer, equipement time and overhead required for the performance of CFD are not included in the relative value units for any other echocardiography BASE procedure. By allowing this CMS proposal to be approved would eliminate 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 CFD is INTRINSIC to the provision of ALL echocardiography proccdures.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,

Chris Kendall, BS, RDCS
Mayo Clinic Arizona

Submitter : Dr. robert koch **Date:** 08/07/2007

Organization : Lake Heart Specialists

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Sir or Madam,
Addition technician AND physician time, knowledge, effort, thought, and liability is necessary to evaluate COLOR FLOW DOPPLER within an echocardiographic procedure. Without CFD, an echo report is far less evaluative, less definitive, and less valuable. Do not remove CFD reminbursement from the echodoppler code list. Standard 2-d only echodoppler exams are performed without CFD in order to evaluate anatomical issues of the heart only. CFD evaluates physiological flow-related issues of the heart. CFD is a separate and valuable portion of the entire echodoppler approach toward cardiac imaging and evaluation.

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

Submitter : **Dr. Zachary Zanowiak** **Date: 08/07/2007**

Organization : **Dr. Zachary Zanowiak**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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. Mihai Podgoreanu** **Date: 08/07/2007**

Organization : **Duke University Medical Center**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

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

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantifying the severity of these lesions. In particular, color Doppler information is critical to the decision-making process in patients with heart valve disease undergoing valve surgery. It also allows us echocardiographers in the operating room to guide our surgical colleagues on the indication for valve surgery and immediately evaluate results of surgery. Each of these assessments is crucial to the short and long term outcome of our patients. 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 inereases the physician time and equipment time that are required for a study; in fact, the physician 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 physician 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,

Mihai V. Podgoreanu, MD, FASE
Perioperative Echocardiography Service
Duke University Medical Center

Submitter : **Ms. Joan Main** **Date: 08/07/2007**

Organization : **Mayo Clinic**

Category : **Other Technician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

As a cardiac sonographer who provides echocardiography services to Medicare patients and others in Arizona 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,

Joan C. Main, RDCS, MBA, FASE

Cardiac Sonographer, Mayo Clinic

Submitter : **Mr. Kirk Deininger** **Date: 08/07/2007**

Organization : **Reliant Healthcare Solutions, Inc.**

Category : **Other Health Care Provider**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

My comments refer to the proposed payment reductions for Home INR Monitoring services included in the 2008 Proposed Rule (CMS-1385-P). As a direct result of the significant reductions proposed for codes G-0248 and G-0249, my company has recently been forced to permanently discontinue its business of providing Home INR Monitoring products and related services. This is unfortunate because we were one of only four providers capable of providing these services on a national basis. Furthermore, we were one of only two providers who made it a policy of providing training in person, rather than the more efficient (but inferior) telephone or video training methods used by other providers. The result of our departure will be reduced access to the highest quality care.

I would like to take this opportunity to register my thoughts about the consequences of the proposed payment cuts on this 'lifesaving' service.

1. G0249 Equipment Costs - It is apparent that the payment reductions proposed by CMS did not take into account the detailed analysis submitted to CMS last year which showed that the true costs associated with providing these services are double the proposed Fully Implemented PE RVUs. Unfortunately the nominal correction proposed by CMS in ? II.B.2. (i.e. increase in equipment time to 1440 minutes) does not even account for the true cost and risk associated with providing INR equipment dedicated for use by a single patient. Over the course of a year the INR equipment can only used by one individual a maximum of 52 times (as per the National Coverage Decision CMS-190.11). Since G-0249 services are billed in units of 4 tests, the maximum number of minutes that can be absorbed is 18,720 minutes (1444 x 52/4). The result is the RVUs related to equipment costs are understated by at least 300%. Furthermore, it does not begin to account for the risk of underutilization (i.e. patients who test less than 52/year) or discontinuation (i.e. individuals who stop testing before the equipment is fully amortized).

2. Equipment Payment Methodology I have always believed that the INR monitor should be considered and paid for as durable medical equipment because it matches CMS DME definition. If this can not be done, the next best thing would be to allocate 100% of the equipment cost to the G0248 code. This code is a once in a lifetime benefit and therefore CMS would avoid paying for the equipment indefinitely.

3. Training Methods CMS should restrict payments for G-0248 services for trainings conducted in person by a qualified trainer. I am aware of only one other national provider that makes this their policy. Please do not force companies to resort to inferior training methods as a result of the significant payment cuts that are being now proposed.

Although my company will no longer provide these services, I would urge CMS to carefully consider these recommendations in order to ensure that other legitimate providers are not forced out of the market.

Sincerely,

Kirk Deininger
CEO Reliant Healthcare Solutions, Inc.

Submitter : Mrs. Johna Resnik **Date:** 08/07/2007

Organization : UPMC Downtown

Category : Health Care Professional or Association

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Against the bundling of the color flow Doppler into all other echo base codes without any additional charges:
1. Color Doppler requires a seperate skill to perform. One must know how to "tweek" the 2D images and gain to obtain optimal color flow. It's not just a simple as touching the color knob.
2. It is an extra step in the interpretation of echocardiograms. A physician must be trained on the levels (trace,mild,moderate,severe) of regurgitation accoring to color.
3. There are some echo procedures that do not warrant the use of color flow: echo guided drainage of pericardial effusion as well as limited echoes for pericardial effusion and ER echoes to determine wall motion for emergent cath are some examples.
4. It generally adds more time to the procedure, interpretation, and transcription.

Submitter : Anita Cramer **Date:** 08/07/2007

Organization : The Everett Clinic

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

I am a cardiac sonographer who provides echocardiography services to Medicare patients and other patients in Washington state. I am writing to objeet 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 Jan. 2008 on the grounds that color Doppler as become "intrinsic to the performance" of all echocardiograms. Color Doppler is critical in quantifying the severety of valvular incompetence and intracardiac shunting and many other cardiac conditions. As a sonographer, using color Doppler increases the accuracy of a study, but it also increases the time that is spent performing the test and therefore should not be "bundled" in the "base" procedure. Please refrain from finalizing this proposal to "bundle: color flow Doppler charges into other echocardiography procedures. Thank you for your consideration of this very important issue to our field.

Anita Cramer

Submitter : **Dr. Ernest Wu** **Date: 08/07/2007**

Organization : **Dr. Ernest Wu**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Naples, FL as part of 10 member pathology group covering two hospitals and an outpatient laboratory.

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,

Ernest Wu, M.D.

Submitter : **Dr. David McPherson** **Date: 08/07/2007**

Organization : **U Texas Health Science Center at Houston**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CODING - ADDITIONAL CODES FROM 5 YEAR REVIEW
There is substantial physician and sonographer time required to perform a full color flow Doppler exam.
If this service is to be bundled with other echo codes, it requires the recognition of the additional time committment that is required to perform the color flow portion of the study.
Presently, the proposed bundling does not recognize this additional time committment.

Submitter : **Dr. Joseph Abate** **Date: 08/07/2007**

Organization : **Heart Clinics Northwest**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

See Attachment

[redacted]
#5235

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. Amna Ahmed** **Date: 08/07/2007**

Organization : **Heart Clinics Northwest**

Category : **Physician**

Issue Areas/Comments

Coding– Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

See Attachment

#5236

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

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

Submitter : Mr. William Courtney **Date:** 08/07/2007

Organization : Advanced Medical Imaging, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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

Dear Mr. Kuhn:

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

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

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

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an 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. [Include additional examples from your practice of CPT codes that are rarely billed with color flow Doppler.]

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

Sincerely yours,

William E. Courtney, RDCS
Advanced Medical Imaging, Inc.

Submitter : Dr. Paul Kalish **Date:** 08/07/2007

Organization : North Shore Long Island Jewish Health System

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 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 senior staff pathologist with the North Shore Long Island Jewish Health System, Chairman of the Department of Pathology at Glen Cove Hospital in Glen Cove, New York, Assistant Director of the central NSLIJ Health System Laboratory, and a member of the College of American Pathologists.

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. In fact, I have been solicited to join such practice models, and I have consistently refused because I believe this type of arrangement to be antithetical to good and efficient medical care.

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. I know that pathologists who work in such environments must tailor their diagnoses to the interests of the group that hired them and not to the interests of the patient or the payer of the bills. An independent pathology practitioner is essential to effective diagnosis and efficient and proper use of medical services.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. This is clearly not true, since many of the pathologists in such arrangements work alone without the benefit of consulting colleagues. Quality monitoring is often completely absent, whereas it is mandatory for regulated pathology practices in hospitals and accredited laboratories. 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 E. Kalish, MD, Fellow CAP

Submitter : **Dr. William Bennett** **Date: 08/07/2007**

Organization : **Heart Clinics Northwest**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

See Attachment

#2239

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

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

Submitter : **Dr. Andrew Boulet** **Date: 08/07/2007**

Organization : **Heart Clinics Northwest**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

See Attachment

CMS-1385-P-5240-Attach-1.DOC

#5240

Heart Clinics NORTHWEST

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American College of Cardiology

www.heartclinicsnw.com

ICANL
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Accredited Nuclear Cardiology Laboratory

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Joseph A. Abate, MD; Dennis B. Cooke, MD; Ronald M. Fritz, DO; Carl L. Hanson, MD; Ronald D. Jenkins, MD; James Pataky, MD; Wolfgang J.T. Spyra, MD

SANDPOINT
606 N 3rd Avenue, Suite 203
Sandpoint, ID 83864
208-263-2505 ⁂ Fax 208-263-2908
Robert L. Holman, MD; Ronald D. Jenkins, MD

August 7, 2007

Dear Mr. Kuhn:

As a cardiologist who provides echocardiography services to Medicare patients and others in Spokane, WA, 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,

Andrew J. Boulet, MD, FACC

AJB:jk

Submitter : Mr. Tracy Huth **Date:** 08/07/2007

Organization : DIS Inc.

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

I am a Registered Cardiac Sonographer with over 20 years experience. I do not perform color doppler on all procedures. The use of color doppler adds to both the sonographer's and physician's time per study.

Submitter : Dr. Joseph Abate **Date:** 08/07/2007

Organization : Heart Clinics Northwest

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

See Attachment

CMS-1385-P-5242-Attach-1.DOC

Heart Clinics NORTHWEST

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www.heartclinicsnw.com

ICANL Nuclear Cardiology Accredited Nuclear Cardiology Laboratory

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SANDPOINT
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Sandpoint, ID 83864
208-263-2505 ⁂ Fax 208-263-2908
Robert L. Holman, MD; Ronald D. Jenkins, MD

5242

August 7, 2007

Dear Mr. Kuhn:

As a cardiologist who provides echocardiography services to Medicare patients and others in Coeur d'Alene, Idaho, 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,

Joseph A. Abate, MD, FACC

AJB:jk