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

Organization : **U.C.A.A.**

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 Ageney 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.

Stephen Sisko M.D.

#3244

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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 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,

Dennis B. Cooke, MD, FACC

AJB:jk

Submitter : Stephen Aufderheide, MD **Date:** 08/07/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

August 1, 2007
This letter is to say thank you that CMS has recognized the under valuation of anesthesia services, and that the Agency is taking steps to address this complicated issue. I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

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

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

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

Thank you for your consideration.

Steve Aufderheide, MD
Northwest Anesthesia Physicians, P.C.

Submitter : **Deborah Barnes, MD** **Date: 08/07/2007**

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

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 19, 2007
I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.
This letter is to thank CMS for recognizing the gross under valuation of anesthesia services, and the Agency's steps taken to address this complicated issue.

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

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

This serves as a major step forward in correcting the long-standing under valuation of anesthesia services.
To ensure that our senior patients will continue to have access to expert anesthesiology medical care, it is vital that CMS follow through with the proposal in the Federal Register, by fully and immediately implementing the anesthesia conversion factor increase, as recommended by the RUC.

Thank you for your consideration of this very important matter.

Deborah W. Barnes, MD
Northwest Anesthesia Physicians, P.C.

Submitter : Mr. Bryan Kniola **Date:** 08/07/2007

Organization : Mr. Bryan Kniola

Category : Health Care Professional or Association

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am a cardiovascular sonographer. Credentialed in cardiac sonography (RDCS), vascular sonography (RVT) and radiologic technology (RT) working in the field for over 20 years. I presently am a full time cardiovascular sonographer working in a hospital setting. I am a member of the American society of Echocardiography and Society of Vascular Ultrasound. In regard to combining the three seperate cpt codes into one, I do not use color flow Doppler with all echo procedures. Adding color flow doppler requires an increase in exam time as well as physician interpretation time. So please take this into consideration.
thankyou.
Bryan Kniola

Submitter : Dr. A.C. Brownell **Date:** 08/07/2007

Organization : Dr. A.C. Brownell

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I emplore you to strongly consider the RUC recommendation to increase the values for anesthesia units. As physicians, we provide care for patients when they are most vulnerable. The value of our vigilance to patient health and safety should be recognized and reflected in reimbursement.

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

Organization : **Sanger Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please refrain from bundling color Doppler echocardiographic services. This is a time consuming, MD and technician service, which is NOT part of every echo and should therefore be treated as such. Thanks. Jim Bower MD

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

Organization : **Silver Cross Hospital**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 7, 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 Joliet, Illinois as part of a group of three pathologists at Silver Cross Hospital.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in this 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,
Alvin M. Ring, M.D.

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

CMS-1385-P-5252-Attach-1.DOC

#5252

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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.

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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,

Amna T. Ahmed, MD

ATA:jk

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

Organization : **SDA**

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. 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

CMS-1385-P-5254-Attach-1.DOC

#5254

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Ronald D. Jenkins, MD

August 7, 2007

Dear Mr. Kuhn:

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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.

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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,

William R. Bennett, MD, FACC

WRB:jk

Submitter : Dr. Eteri Byazrova **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-5255-Attach-1.DOC

#5255

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Robert L. Holman, MD; Ronald D. Jenkins, MD

August 7, 2007

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Sincerely,

Eteri S. Byazrova, MD

ESB:jk

Submitter : Dr. John Everett **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-5256-Attach-1.DOC

#5256

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Amna T. Ahmed, MD; John P. Everett, MD; Marek Janout, MD; Keith A. Kadel, MD; Eric D. Stucky, MD

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Suwong Wongsuwan, MD

COEUR D'ALENE
700 Ironwood Drive, Suite 350
Coeur d'Alene, ID 83814
208-676-9913 ⁂ Fax 208-666-0885
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,

John E. Everett, MD

JPE:jk

Submitter : **Walter Bernard, MD** **Date: 08/07/2007**

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

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 27, 2007

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

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

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

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

Thank you for your consideration of this serious matter.

Walt Bernard, MD
Northwest Anesthesia Physicians, P.C.

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

Organization : **Massachusetts General Hospital**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Dear Mr. Kuhn:

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

It is true that color Doppler, in conjunction with two-dimensional echocardiography, has become an integral part of echocardiography, as it is important for the accurate diagnosis of numerous cardiac conditions. Color flow Doppler is used for identifying and quantifying the severity of many cardiac abnormalities, such as valvular regurgitation or intracardiac shunting. The information obtained with color Doppler is critical to the therapeutic decision making process in patients heart valve disease and appropriate selection of patients to undergo valve surgery. However, CMS s proposal to bundle , and thereby eliminate payment for, color flow Doppler completely ignores the practice expenses, resources required, and physician work involved in performance and interpretation of these studies.

While color flow Doppler can be performed concurrently or in concert with the two-dimensional imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time, equipment time, and physician time that are required for a study. In point of fact, color flow Doppler s role in the evaluation of valve disease and other conditions has become more complex, thereby, increasing the physician and sonographer time required for the performance and interpretation of these studies. 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, CMS would simply eliminate Medicare payment for a service that, as CMS itself acknowledges, is important for accurate diagnosis of cardiac conditions and that is not reimbursed under any other CPT code.

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,
Jonathan J. Passcri, MD
Cardiac Ultrasound Laboratory
Massachusetts General Hospital

GENERAL

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Sincerely yours,

Jonathan J. Passeri, MD
Cardiac Ultrasound Laboratory
Massachusetts General Hospital

Submitter : Dr. Angelo Ferraro **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-5259-Attach-1.DOC

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August 7, 2007

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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,

Ronald M. Fritz, DO, FACC

RMF:jk

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

Organization : **Cardiology Consultants**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

I oppose the proposed changes for coding related to Echocardiography that would bundle the color Doppler portion. This part is not necessarily routine for a study, and does take extra time in performing as well as interpreting the study. Addiotionally, further cut-backs in re-imbursement for this, as well as other services or procedures, is only going to make care less available and less reliable for all patients, especially the medicare population. I encourage you to re-consider these changes and the impact that will happen outside of the economics of the matter.

Thank you for your consideration.

Submitter : **Janet Hays** **Date: 08/07/2007**

Organization : **Janet Hays**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

As a practicing cardiologist with subspecialty training in echocardiography, I must protest the plan to bundle color flow doppler imaging into a general echo exam. Color flow doppler imaging gives very specific information that is not always needed (hence, not all studies require it), but when needed, must be done very thoroughly. Increasingly, decisions on complex heart valve problems and congenital defects are made primarily with color flow doppler, and in these cases extra technician and physician time is needed to obtain and interpret the specific measurements made. In those cases, I would not consider sending a patient for heart surgery without it. The only other way to try to get that information would be with a catheterization, a much more expensive and risky procedure for the patient. Heart disease is a very common condition, and it would be real disservice for many Americans to deny access to this very safe and necessary component of imaging. Thank you.

Submitter : Dr. Ronald Fritz **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-5262-Attach-1.DOC

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Robert L. Holman, MD
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August 7, 2007

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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,

Ronald M. Fritz, DO, FACC

RMF:jk

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

Organization : Dr. Nancy Sweeney

Category : Physician

Issue Areas/Comments

Impact

Impact

Dear Committee Members,
I would like to support whatever increases can be made to the anesthesia reimbursement fee schedule. I joined a practice in Montana in 1991. I was the only "pediatric anesthesiologist" as I have completed residencies in both fields along with fellowships in both. Anyway, as the Medicare reimbursement fee went down, so were the anesthesiologists that wanted to take care of Medicare patients. And within about 4 years, everyone that had previously avoided pediatric patients wanted to take care of them because at least Medicaid in Montana paid better than Medicare. Many providers do not want to take care of Medicare patients. Mine is only one example of many more that are out there.
I strongly urge the committee to look at this, as patients want the best care and deserve the best care but when fewer physicians want to take care of these people(often much sicker than those who are not on Medicare), more and more people will experience problems with obtaining quality care.
Give the elderly a choice in the matter. Let them buy better insurance if they can and it is out there.
Thanks,
Dr. Nancy Jo Sweeney
Ambulatory and Pediatric Anesthesiologist

Submitter : LAURA BLANDIN **Date:** 08/07/2007

Organization : SOUTH DENVER ANESTHESIOLOGISTS PC

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.

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August 7, 2007

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Sincerely,

R. Dean Hill, MD, FACC
President, Heart Clinics Northwest

RDH:jk

Submitter : **Dr. Robert Holman** **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-5267-Attach-1.DOC

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Sandpoint, ID 83864
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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 Sandpoint, ID, 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,

Robert L. Holman, MD, FACC

RLH:jk

Submitter : Mark Baskerville, MD **Date:** 08/07/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 27, 2007

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

As an anesthesiologist practicing in Oregon, I provide care to a high proportion of our state's Medicare recipients. I pride myself in being able to give excellent health care to all payers within our system. But, because of tightening economic constraints, I recognize that many of my fellow physicians may leave the state of Oregon to practice elsewhere -- namely due to the dwindling Medicare reimbursement. I hope that I am not forced to make that decision too.

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

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

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

Please help me to continue practicing quality anesthesia care in the state of Oregon. Thank you for your consideration of this serious matter.

Mark J. Baskerville, MD
Northwest Anesthesia Physicians, P.C.

Submitter : Dr. Michael Hostetler **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-5269-Attach-1.DOC

#5269

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August 7, 2007

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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,

Michael D. Hostetler, MD, FACC

MDH:jk

Submitter : Dr. Marek Janout **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-5270-Attach-1.DOC

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Robert L. Holman, MD
Ronald D. Jenkins, MD

August 7, 2007

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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,

Marek Janout, MD

MJ:jk

Submitter : Rob Carricaburu **Date:** 08/07/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

August 3, 2007

This letter is to say thank you to CMS for recognizing the under valuation of anesthesia services, and to request the Agency take steps to address this complicated issue. This letter is to give my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant under valuation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services still stands at $16.19 per unit. In an effort to rectify this untenable situation, the RUC recommended CMS increase the anesthesia conversion factor, to offset the calculated 32% work under valuation.

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

Thank you for considering this important matter.

John Gregg Melton, MD
Northwest Anesthesia Physicians, P.C.

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

Organization : **HEART CARE CENTER OF NW HOUSTON**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

CODING-ADDITIONAL CODES FROM 5 YEAR REVIEW
FEDERAL REGISTER CITATION IS 72 FEDERAL REGISTER 38122(JULY 12, 2007)

Kamran Sherwani, Md
HEART CARE CENTER OF NW HOUSTON
11840 FM 1960 West
Houston, Texas 77065

Re: CMS1412-PN; PRACTICE EXPENSE

Dear Dr. MeClellan:

As an active cardiologist in private practice, I would like to comment on the Proposed Notice published by CMS in the Federal Register of June 29, 2006 which sets forth proposed changes to the relative value units used to establish payment for services to Medicare patients under the Physician Fee Schedule.

My concerns are in regards to the impact of payment reductions for the most common combination of echocardiography procedures performed in the office setting: transthoracic echocardiograms with spectral and color flow Doppler (CPT codes 93307, 93320, and 93325).

We recently completed our application for echo lab accreditation in line with recent federal government attempts to improve quality and standardize echocardiographic studies. Our practice agrees strongly with the regulations that accompany accreditation. However, I am concerned that payment reductions of this magnitude will have an adverse effect on patient care by reducing the quality of these crucial echocardiographic studies at the very time we are trying to rapidly advance quality and consistency.

In our practice, we use echocardiography daily in the diagnosis of a broad range of adult cardiac disease, including but not limited to congestive heart failure, valve disorders, coronary artery disease, and congenital heart defects seen in the adult population. Even though color flow doppler is not used in every study, it is an invaluable tool in the assessment of valvular regurgitation by locating the origin and direction of the regurgitant jets prior to the performance of PW or CW doppler. Jet width and spectral strength is essential for assessing the severity of some valvular disorders. The performance of this portion of the examination must be done by a skilled sonographer who has had extensive and expensive training. These sonographers are in increasingly short supply due to the push for registration or certification and the need for lab accreditation. This portion of the examination is a separate process which should not be lumped in with other procedures since it offers information not readily measured by other echocardiographic techniques. The interpretation of color flow and spectral doppler also requires additional physician time and training.

I understand that the American Society of Echocardiography(ASE) is conducting a complete technical analysis of the Proposed Notice and will be submitting comprehensive comments. I support and strongly urge you to consider making the changes suggested by ASE in the Final Rule. It would be very detrimental to the practice of cardiology for us to take two steps forward in improving quality and standardization of testing and then to take three steps back.

Sincerely yours,

Kamran Sherwani, MD
Heart Care Center of NW Houston
11840 FM 1960 West, Houston, Texas 77095 (281-955-7863)

Submitter : **Dr. Ronald Jenkins** **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-5273-Attach-1.DOC

#5273

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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 Sandpoint, ID, 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.

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Sincerely,

Ronald D. Jenkins, MD

RDJ:jk

Submitter : **Domenico Castaldo, MD** **Date: 08/07/2007**

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

Category : **Physician**

Issue Areas/Comments

Coding– Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

August 7, 2007

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To ensure our senior patients have access to expert anesthesiology medical care, it is important 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.

Domenico Castaldo, MD
Northwest Anesthesia Physicians, PC

Submitter : Dr. Keith Kadel **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-5275-Attach-1.DOC

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August 7, 2007

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Sincerely,

Keith A. Kadel, MD

KAK:jk

Submitter : David Donielson, MD **Date:** 08/07/2007

Organization : Northwest Anesthesia Physicians, P.C.

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

July 31, 2007

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

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

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

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

Thank you for your consideration of this serious matter.

David Donielson, MD
Northwest Anesthesia Physicians, P.C.

Submitter : Dr. Kevin Kavanaugh **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-5277-Attach-1.DOC

#5277

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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,

Kevin M. Kavanaugh, MD, FACC

KMK:jk

Submitter : Dr. Timothy Lessmeier **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-5278-Attach-1.DOC

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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,

Timothy J. Lessmeier, MD, FACC

TJL:jk

Submitter : Dr. Eric Orme **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-5279-Attach-1.DOC

#5274

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August 7, 2007

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Sincerely,

Eric C. Orme, MD, FACC

ECO:jk

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

Organization : **The Cardiovascular Group, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in Fairfax, VA, 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.

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Sincerely yours,

Gautam Ramakrishna, MD

The Cardiovascular Group, PC
Fairfax, VA

Submitter : Dr. James Pataky **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-5281-Attach-1.DOC

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Robert L. Holman, MD
Ronald D. Jenkins, MD

August 7, 2007

Dear Mr. Kuhn:

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Sincerely,

James Pataky, MD

JP:jk

Submitter : Dr. Michael Ring **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-5282-Attach-1.DOC

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August 7, 2007

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Sincerely,

Michael E. Ring, MD, FACC

MER:jk

Submitter : Dr. Wolfgang Spyra **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-5283-Attach-1.DOC

#5283

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606 N 3rd Avenue, Suite 203
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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 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,

Wolfgang J. Spyra, MD, FACC

WJS:jk

Submitter : Dr. William Stifter **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-5284-Attach-1.DOC

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ICANL
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