Submitter : **Dr. Gary Shanks** **Date: 08/11/2007**

Organization : **Dr. Gary Shanks**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Mcdicaid 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. This is especially true in rural states, such as Iowa.

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.

Gary Shanks, MD, JD.
Bettendorf, IA. 52722

Submitter : **Dr. Richard Friedberg** **Date: 08/11/2007**

Organization : **Baystate Health, Springfield, MA**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

11 August 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 Springfield, Massachusetts, where I am Chairman of the Department of Pathology and Medical Director of Baystate Reference Laboratories. I am also Professor and Deputy Chairman of Pathology at Tufts School of Medicine in Boston, MA. My department has 22 subspecialty-focused pathologists providing the majority of the diagnostic pathology services in Western Massachusetts.

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,

Richard C Friedberg MD,PhD
Chairman, Dept of Pathology
Baystate Health
Springfield, Massachusetts

CMS-1385-P-5613

Submitter : Mr. Rodney Moffett **Date:** 08/11/2007

Organization : Arizona Association of Nurse Anesthetists

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

Rodney Moffett CRNA, MS
11739 W Patrick Ln
Sun City, AZ 85373

Submitter : **Mrs. Katharine Smith** **Date: 08/11/2007**

Organization : **AZANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I am writing to encourage you to agree to the reimbursement increase for Certified Registered Nurse Anesthetists. Thank you so much for your supporte.

Submitter : Mrs. Beth Wood **Date:** 08/11/2007

Organization : Mrs. Beth Wood

Category : Occupational Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I recently declined a position w/in a physician practice in part because of the uncertainty of this pending legislation so it does need to be reviewed & clarified. In ideal, having a physician & therapist close relationship w/ proximity should improve teamwork & quality of care. In reality, I have seen it often leading to misconduct because there is money to be made. I have known of 2 such practices & both have had patients (pts) tell me of questionable behaviors. I know of a therapist being told by a local physician gp they would put him out of business if he didn't join their new in-house clinic. Currently a local orthopedic surgeon has insisted his pts go to the clinic that he orchestrated coming to town & appears to have an investment in. Pts have reported that he has become angry when they say they want to go elsewhere for therapy. He has even threatened to refuse to follow up w/ them on occasion if they go to another clinic. I am a certified hand therapist (CHT) & some of my patients were previously seen by an athletic trainer under a PT's supervision & have complained about the quality of care they had received thru this physician driven practice. This physician tends to defer his low /non-paying or difficult to manage pts elsewhere & does not promote this clinic to them. Pts tell me they were recommended to go elsewhere. His behaviors appear unethical because the end result is not in the best interest of the pt as they are not made aware of free choice in a provider. I have had a hand surgeon insist that an elderly pt attend 3 times a wk in his therapy clinic only, despite her explaining that she can not drive, lives 2 hrs away & her 89 yr husband w/ poor vision is having to drive & wait on her. Their visits were at times scheduled late in the day where they had to drive thru rush hr city traffic after dark. A 5 hr jaunt for an 86 & 89 yr old couple. In tears, deciding to abandon therapy, she called not knowing what to do. She was of the old school that you follow your doctor's orders w/o questioning his authority. I explained her options & she was both grateful & later angry at what this surgeon had made them endure for 2 wks when a CHT was w/in 2 miles of their home. Physicians w/ therapy clinics do not let their patients know of alternative options & I think this is what the law should address. Pt's should be INFORMED that THEY CAN CHOOSE WHERE THEY WANT TO GO TO THERAPY just as they can choose a pharmacy. I do not think it is ethical for a physician to insist, persuade or otherwise cajole a pt to use a particular therapy vendor, but ethics are not a strong suit in our current society. If a pt asks for a recommendation I think a physician should be able to give their personal opinion but they should be REQUIRED to DISCLOSE that they have a PERSONAL GAIN or investment in the facility they are recommending IF they STATE A PREFERENCE. A simple list of providers may be a good way to get around the problem. A section could be added to consent forms that the pt was made aware of other area options for therapeutic treatment & it should require a separate signature so as not to be lost in the fine print. I think the same is true for DME providers, as recently the hosp I work for took over mngt of a local DME provider. Employees are being encouraged to promote this provider & I think it is wrong. I mention their name just as I do the other area providers & encourage cost shopping. I do let them know that this provider has agreed to carry the items we frequently recommend, (not all local providers do that), since the hospital no longer provides brace & other prefab orthotics due to regulation changes put in place to try to encourage competitive pricing. I also let them know that the hospital took over the management of this DME. As always, mixing medical care and business ethics is complex. Thanks for considering my concerns.

Submitter : **Dr. Michael Connor** **Date: 08/11/2007**

Organization : **OSF-St. Francis Hospital**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 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 : **Date: 08/11/2007**

Organization :

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

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

Julienne Kurland MD

Submitter : **Dr. James Yates** **Date: 08/11/2007**

Organization : **University Cardiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CODING--ADDITIONAL CODES FROM 5-YEAR REVIEW.
Color flow doppler should not be considered part of the reimbursement for the standard echo. This portion of the the study is not required in all patients. It is a time consuming addition to the study and requires additional sonographer skills and interpretive skills by the physician. It should continue to have a separate code and reimbursement.

Submitter : **Dr. Carlton Brown** **Date: 08/11/2007**

Organization : **Private Practice/Academic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-1385-P-5619-Attach-1.DOC

#3619

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 proposed increase in anesthesiology payments under the 2008 Physician Fee Schedule. I appreciate that CMS now recognizes their gross undervaluation of anesthesiology services and that the Agency is considering some incremental redress for this long-standing under-compensation for our physician services.

When the RBRVS was initially proposed in 1990, it created a huge payment disparity for compensating anesthesiology care. Professor Hsiao inflicted a simplistic linear conversion between the existing ASA Relative Value time units and the new RBRVS time units. This calculation ignored the fact that a major component of workload measurement in the traditional ASA Relative Value system is not derived solely from time units. This simplistic RBRVS calculation resulted in anesthesiology services being grossly undervalued compared to other physician services. I used public-source CMS data to calculate the effect of the RBRVS on anesthesiology payments. In a letter to the ASA Newsletter in October 2004, I showed that **anesthesiology was DEAD LAST amongst all medical specialties** in the "CMS allowed/billed services" ratio. (Table and Letter attached) A cynic might say that we "just bill too much," but even CMS now recognizes that our services have been markedly undervalued since the implementation of the RBRVS. At $16.19 per unit, current CMS compensation for anesthesiology services is less than 33% of the fair market value for our services.

How did this travesty occur? In 1990, our professional society (the ASA) was too busy building a new headquarters building and squabbling with other providers to effectively counter the computational errors inflicted within the initial RBRVS. The rest of "organized medicine" hardly rushed to our specialty's defense! Frankly, our leadership "dropped the ball" accepting the initial calculations for RBRVS. Consequently, our specialty has endured this compensation inequity for well over a decade. The RUC has recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation, or about $4.00 per unit. It is a partial redress for this long-standing undervaluation of anesthesiology a services. I am pleased that the Agency accepted this recommendation in its proposed rulemaking and I support the immediate and full implementation of the RUC's recommendation. It is about time!

To ensure that all our patients have access to expert anesthesiology medical care, it is imperative that CMS immediately implement the anesthesia conversion factor increase as recommended by the RUC. The substantial historical and current inequities in CMS professional anesthesiology compensation contribute to medical care cost-shifting, the high cost of private health insurance, and the lack of affordable or even available private insurance for many citizens. It is bad public policy to create a market-inefficiency that denies patients full access the good healthcare. As an aside, this systematic underpayment for anesthesiology services has particularly devastating effects on our GME training programs. In all, your efforts to rectify this small part of over-all healthcare reform are most appreciated.

Thank you for your consideration of this serious matter.

Sincerely,

Carlton Brown, MD

October 2004

Dear (ASA Newsletter) Editor -

I was amused by your recent missives in our April 2004 NEWSLETTER touting the merits of "AMA membership for ASA members." Notwithstanding some interesting distant history and your invocation an ancient guilt-trip, it is hard to see the contemporary AMA as a stalwart defender of the interests of anesthesiologists. While many other examples abound, I offer the following information:

The Medicare "allowable/charged" ratio is absolutely the lowest for anesthesiologists amongst all medical specialties. Simply restated, Medicare pays a higher percentage of the bills from every other specialty compared to anesthesiologists. That hardly sounds to me like the AMA has been looking out for our specialty's best interests. In fact, we are remarkably lower than many other specialties, receiving only about half the average for all specialties! In the current zero-sum game of Medicare funding, the AMA and other specialties are balancing their budgets on our backs! Some allies!

The data supporting my disturbing statement come from *Physician Practice* magazine in their April 2004 edition. They lifted the data from the public records of Medicare. *Physician Practice* assembled these data to complain about the high incidence of "rejected claims" across all specialties. However, by simply taking a ratio of "allowed charges per billed charges" one can see where we stand as anesthesiologists in the Medicare food chain. **Dead last.** I have attached the data table from *Physician Practice*. The last column is my additional analysis. If these numbers are wrong, please offer me a better source of data.

To my ear, these data hardly speak well for the advocacy of our interests by the AMA. Frankly, it speaks poorly for any of our advocacy groups! Thoughts?

Carlton Q. Brown, MD
Great Falls, Virginia

Editor's Note: Dr. Brown, I agree with your data. Why would the AMA want to look out for a specialty that doesn't participate? If we are not in the forefront of AMA politics, and to get there we need members, for AMA representation is based upon the number of AMA members within a specialty, we will be forgotten. Now that there is an anesthesiologist within the highest councils of the AMA, hopefully some of these past wrongs will be righted. ....
— D.R.B.

Submitter : **Dr. James Fortman** **Date: 08/11/2007**

Organization : **University Hospitals-Case Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

James Fortman, MD
University Hospitals-Case Medical Center
Cleveland, OH

Submitter : **Ms. Marie Sacco** **Date: 08/11/2007**

Organization : **Ms. Marie Sacco**

Category : **Other Health Care Professional**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

To include colorflow as a standard in all echo procedures would be a disservice to patients, physicians & technologists. 1st not all echo procedures require colorflow. @nd to make it 'standard' would mean that patients would be subjected to longer scan times repeatedly and needlessly. Techs would be scanning longer subjecting themselves to possible injury due to increase in scan time and physicians would be spending more time reading rather than with patient care as they would have longer studies to read , again , needlessly. Some patients are just not good colorflow candidates, but better spectral doppler candidates due to body habitus. MOST IMPORTANT>>>>>>> not all echo studies use colorflow. What would be the point of making someone have a test they don't need? How does that help limit the number of unnecessary studies performed, when you are dangerously close to mandating that an unnecessary test be done?

Submitter : **Dr. Chunhuai Chao** **Date: 08/11/2007**

Organization : **Dr. Chunhuai Chao**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I welcome the CMS decision to consider an increase in anesthesia fee schedule. This will make anesthesiologists more accessible to beneficiaries of the Medicare system.

Submitter : **Geoffrey Kuzmich** **Date: 08/11/2007**

Organization : **Geoffrey Kuzmich**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

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

This increase in Medicare payment is important for several reasons.

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

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

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

Submitter : **Dr. Brian O'Neill** **Date: 08/11/2007**

Organization : **American Chiropractic Association**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment Please.

CMS-1385-P-5624-Attach-1.DOC

#5624

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

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Sincerely,

Dr. Brian K. O'Neill

Submitter : **Dr. Paul Dalton** **Date: 08/11/2007**

Organization : **Dr. Paul Dalton**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Miguel Benet** **Date: 08/11/2007**

Organization : **South Denver Anesthesiologists, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Jack Canton**

Organization : **Allied Anesthesia Medical Group**

Date: 08/11/2007

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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

Re: CMS-1385-P

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

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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.

Jack Canton, MD

Submitter : **Mrs. Kimberly Stone** **Date: 08/11/2007**

Organization : **American Society of Echocardiography**

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 an ASE member and work as a RDCS in Atlanta,Georgia. I just received an email regarding the bundling of color flow in echocardiographic exams. Please do not take away the cost of color flow imaging in echocardiography exams. Color flow plays a huge part in determining Valvular Disease and Cardiac shunting in Adults as well as Fetal Pediactric Exams. Years ago Physicians could not determine why someone had a HEART MURMUR or how severe that MURMUR was! Color Flow Imaging helps determine the severity of Valvular problems and has saved numerous lives!! If you take away the cost of color flow imaging it hurts not only the Sonographer performing the study, but also the Physician who interprets the study. I have worked hard to have the career that I do and have also payed quite a bit of money to obtain this career. Physicians also have worked hard and deserve to receive proper payment for the work that they do. I beg you please do not take billing of color flow away!!

Kimberly Stone, RDCS

Submitter : **Dr. Thomas Dooley** **Date: 08/11/2007**

Organization : **Dr. Thomas Dooley**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Re: "TECHNICAL CORRECTIONS"

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a MD or DO and used by a Doctor of Chiropractic to determine subluxation, be eliminated.
I am writing to indicate my strong opposition to this proposal.
By limiting Doctors of Chiropractic from refering an X-ray, the cost to the Medicare patient will go up significantly due to the necessity of a referal to an Orthopedist or Rheumatologist for evaluation PRIOR to the referal to the Radiologist as it is now. Medicare patients with limited resouces and fixed incomes may forgo X-ray exams due to the added expense. This will certainly lead to the missed opportunity to discover life threatening conditons in some patients.
While X-rays are not required to diagnose a subluxation,they may help determine the need for further testing, additional treatment or the necessity for referal to a specialist.
Again, I srongly urge that this proposal be tabled. X-rays, if needed, should be considered integral to patient treatment. Ultimately, it is the patient who will suffer should this proposal become standing regulation.
Dr. Thomas M. Dooley

Submitter : **Dr. John George, III** **Date: 08/11/2007**

Organization : **The Cleveland Clinic**

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.

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

Thank you for your consideration of this serious matter.

John E. George, III, MD, MS

Submitter : **Dr. Neal Templeton** **Date: 08/11/2007**

Organization : **Dr. Neal Templeton**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Neal S. Templeton, D.O.
Edmond, Oklahoma 73013

CMS-1385-P-5632

Submitter : **ajay varma** **Date: 08/11/2007**

Organization : **ajay varma**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Dr A Varma

Submitter : **Dr. Duncan Macdonald** **Date: 08/11/2007**

Organization : **Dr. Duncan Macdonald**

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.

I have been a participating provider for Medicare patients since shortly after I started in private practice in 1984. Despite my strong beliefs in this entitlement, the 2007 reimbursement cuts have caused me to wrestle with a decision to end my participation, and possibly stop serving (elective) Medicare patients.

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

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

Thank you for your consideration of this serious matter.

Duncan E. Macdonald, M.D.
1329 Lusitana St., #604
Honolulu, HI, 96813

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

Organization :

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 11, 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 Fall River, Massachusetts, as part of a 5-member Pathology Group Practice in a 350 bed community hospital setting.

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

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

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I do not agree, and I support the concept 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,

Richard L. Wolbarsht MD

Submitter : **Dr. Lee Balaklaw** **Date: 08/11/2007**

Organization : **Dr. Lee Balaklaw**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Gentlemen:

The RUC has recommended a $4 per unit increase in the anesthesia conversion factor. The fee increases from 1989 onward have not kept pace with inflation or the cost of living index, making maintaining an anesthesia practice extremely difficult. The anesthesia fees have trailed other specialists reimbursement thus making the RUC recommendation necessary. If fees are not increased as recommended, medicare recipients will be deprived of anesthesia providers in many areas since in inner city and rural environments Medicare is the primary payor. Medicare anesthesia providers cannot continue to survive under the current reimbursement arrangement in underserved areas for Medicare recipients.
Thank you for your consideration in this matter.

Lee Balaklaw, MD

Submitter : **Dr. Gary Nalavany** **Date: 08/11/2007**

Organization : **Hanover Anesthesiology and Pain Medicine**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Sincerely,
Gary Nalavany M.D.
1603 Carlisle Pike
Hanover, PA 17331

Submitter : **Mr. Steven Bouck** **Date: 08/11/2007**

Organization : **American Association of Nurse Anesthetist**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

August 11, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

Steven B. Bouck CRNA
158 Churchill Lane
Linn Creek, MO 65052

Submitter : **Dr. JOSEPH KIM** **Date: 08/11/2007**

Organization : **SUMMIT ANESTHESIOLOGY, LTD**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter

Submitter : **Mr. Jerry Ruff** **Date: 08/11/2007**

Organization : **Spine & Sport Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS Representative:

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

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

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

Sincerely,

Jerry Ruff, PT

CMS-1385-P-5640

Submitter : Dr. chiranjeev saha

Date: 08/11/2007

Organization : Rush University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P.

Submitter : **Mr. Joseph Enright** **Date: 08/11/2007**

Organization : **Mayo Clinic - Scottsdale**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 11, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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This increase in Medicare payment is important for several reasons.

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

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

Sincerely,

Joseph Enright, CRNA
10401 E. Charter Oak Drive
Scottsdale, AZ 85259

Submitter : **Dr. Colin Phoon** **Date: 08/12/2007**

Organization : **New York University School of Medicine**

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:

I am a pediatric cardiologist who provides echocardiography services to young patients at NYU Medical Center and Bellevue Hospital Center in New York City. I am writing to strenuously 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. Furthermore, there is no provision to increase the RVU for this bundled service.

Separate from, and over and above 2-D echo, color Doppler is especially important in detecting congenital heart defects, the most common birth defect. It is also used for identifying cardiac malfunction (such as valvular leakage), and for quantitating the severity of these lesions. Color Doppler information is critical to the decision-making process in patients with all manner of heart disease and appropriate selection of patients for surgery or medical management.

CMS s proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the time and 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 children's heart disease 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 RVU's for any other echocardiography base procedure. 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. I can tell you that color Doppler flow mapping easily takes up one-third of my echo studies consistently, including fetal echocardiograms.

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,

Colin K.L. Phoon, MPhil, MD, FACC, FASE, FAAP
Associate Professor of Pediatrics
Director, Pediatric & Fetal Echocardiography Lab
NYU Pediatric Cardiology Program

Submitter : **Date: 08/12/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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

Dear CMS,
I write regarding your plans to eliminate separate reimbursement for the color flow doppler portion of the cardiac echo examination. This is a critical part of an echo exam that is not performed on all patients. However, when it is performed, this takes additional physician and tech time to complete and interpret. For this reason, I strongly feel that the present separate and added reimbursement has been fair, and I hope that you do not change it.

Thanks.

Submitter : **Jianhua Guo** **Date: 08/12/2007**

Organization : **Jianhua Guo**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Submitter : Dr. Mark NELSON

Organization : AMAET

Date: 08/12/2007

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-5646

Submitter : **Dr. John Sauter** **Date: 08/12/2007**

Organization : **Self-employed**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

A 10% reduction in Medicare Payments for physicians is going to balance your budget a bit better but will result in cost-shifting to other patients- an indirect tax on those patients. And, it is not addressing the problem which is increasing amounts of care required for medicare patients resulting form increase numbers as the population ages and increasing diagnostic studies which are now being required for malpractice risk averse physicians. Fix the Malpractice problem by reducing settlements for malpractice lawyers by 10%. Reduce the payments for repetitive studies. And, don't expect that small incremental 1.5% increases in payments for providing quality assurance data will sway us. It costs money to refine the computer systems and time of office personnel to add these additional qualtiy indicators to our billings in excess of the 1.5% payments. Raisc the reimburscments, don't drop them, or I will have to reconsider my participation agreement with Medicare.

Submitter : Dr. gerald peiser

Organization : Anesthesia Specialists, Ltd

Category : Physician

Date: 08/12/2007

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 Medieare populations. It is not unreasonable to say at this point that many anesthesiologists are actively dropping surgeons if they carry more than a small fraction of medicare patients. I have personally witnessed this multiple times.

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 rulc, 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.

Gerald Peiser, D.O.

602 273 6901

Submitter : **Dr. Paul Schaner** **Date: 08/12/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Ms. Norwalk:

I urge your support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. Thank you for recognizing the gross undervaluation of anesthesia services and for the Agency taking action to address this complicated issue.

Once the RBRVS was instituted, it created a huge disparity for anesthesia care, mainly due to significant undervaluation of anesthesia work compared to other physician services. Since the RBRVS took effect over a decade ago, Meidcare pyament for anesthesia services is just $16.19 per unit. This does not cover the cost for the care for the Medicare population. The result has created an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

To rectify this untenable situation the RUC has recommended the CMS increase the anesthesia conversion factor to offset a calculated 32% work undervaluation with an increase of nearly $4.00 per anesthesia unit and serve as a major step forwardin correcting the long-standing undervaluation of anesthesia services. I strongly support the full implementation of the RUC's recommendation.

Patient acess to expert anesthesiology medical care is critical. It is imperative that CMS follow through with the proposal in the Federal Register by full and immediate implementation of the anesthesia conversion factor as recommended by the RUC.

Thank you for your consideration of this critical matter.

Sincerely yours,
Paul J. Schaner, M.D,

Submitter : **Dr. Betty Bowers** **Date: 08/12/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Aeting Administrator
Centers for Medieare and Medieaid Servioes
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Submitter : Dr. David Willian
Organization : Dr. David Willian
Category : Physician

Date: 08/12/2007

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Sincerely,
David Willian

Submitter : **Hector Lozano** **Date: 08/12/2007**

Organization : **Florida Heart and Vascular**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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

I am extremely worried about the plans of bundling payment for 2D echo and color/doppler by the CMS. As a Cardiologist practicing in an underserved area I know how difficult it is already to get my patients to have a complete non-invasive evaluation by echo since there are not may sonographers in the area. Color and doppler flow mapping in my experience are completely separate exams which have the advantage of providing supplementary information,though. Perhaps the impression that they are all part of one single exam is the advantage of having the technology to do them all with one single machine. In my practice, however, we not always perform 2d Echo doppler and color flow together since it takes much more time for the tech to perform the 3 exams and for me to intrepret them as well. I hope you reconsider your position and keep the coding separate. Otherwise, I am sure I am going to have more difficulties getting a Tech that do my echos if all of them must include the 3 tests. This in turn, will ultimately restrict further the aceess of CMS benefitiaries to standard of care services for their cardiac conditions

Submitter : **Dr. kulwinder sehmbey** **Date: 08/12/2007**

Organization : **sacramento anesthesia medical group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter

Sincerely,

Kulwinder Sehmbey, M.D.

Submitter : **Dr. Richard Laborde** **Date: 08/12/2007**

Organization : **Lake Charles Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Walter Rogoff** **Date: 08/12/2007**

Organization : **Dr. Walter Rogoff**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Mark Gantner** **Date: 08/12/2007**

Organization : **Ocean Perioperative Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Sincerely,

Mark Gantner, MD
Anesthesia Attending

Submitter : **Amanda Dennis** **Date: 08/12/2007**

Organization : **Texas Tech University Health Sciences Center**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Richard Trent, Jr.** **Date: 08/12/2007**

Organization : **Northeast Georgia Medical Center**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I urge you to support/ accept the proposed increase in anesthesia work fees for 2008. I am grateful the CMS has recognized this gross UNDERVALUATION an d that CMS isattempting to rectify this issue.

We all want to continue to provide care for medicare patients and without this over due increase, I cannot continue to provide this service.

thank you,
Richard W. Trent, Jr. MD

Submitter : **Ms. Amy Reilly** **Date: 08/12/2007**

Organization : **Duke University**

Category : **Nurse Practitioner**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Please strongly consider the proposed increase in Anesthesia reimbursement for 2008. Without this much needed adjustment, I foresee seniors being denied access to well-trained anesthesiologist's intraoperative care. I don't think any CMS administrator wants their medicare covered parent ushered through a lifethreatening surgery without an anesthesiologist's care and expertise! The future is grim without this long overdue correction.

Thank you.

Submitter : Ms. Sue Kelly

Date: 08/12/2007

Organization : Ms. Sue Kelly

Category : Individual

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Sirs:

I am alive today because an anesthesiologist diagnosed a clot in my heart during coronary bypass surgery. It was NOT my cardiologist or even my heart surgeon-- but my anesthesiologist who had the skill (transesophageal echocardiogram) and ability to communicate with my heart surgeon to remove this prior to separating from the heart-lung machine. In speaking with this anesthesiologist, I was shocked to discover that this is routine care given to medicare patients like myself, but not reimbursed by CMS. In addition, I have also learned of the shocking dispartity in reimbursement offered anesthesiologists by CMS versus non government payors. Since then, I have become an advocate of expert anesthesia care for seniors, like me.

I therefore, urge you to support the proposed CMS pay increase for undervalued, and UNAPPRECIATED services which anesthesioloigsts provide. I also urge you acknowledge the safety that exists because of these Doctors and their daily work.

I am here inspite of CMS and I fear if the trend towards undervaluing these physicians is NOT reversed, other seniors will not be so lucky.

Please do the right thing!

Submitter : **Dr. Jeffrey Ricketts** **Date: 08/12/2007**

Organization : **Metropolitan Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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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 addition, the numbers of anesthesiologists being trained is inadequate, and the ridiculously low payments for anesthesia services is contributing to the perceived unattractiveness of anesthesia careers.

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 thc 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 thc Fedcral Rcgister by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Jeffrey M. Ricketts DO
Staff Anesthesiologist

Metropolitan Anesthesia Associates
Grand Rapids, MI

Submitter : **Mr. Hugh Gilbert** **Date: 08/12/2007**

Organization : **North Valley Physical & Occupational Therapy**

Category : **Occupational Therapist**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5661-Attach-1.DOC

#5061

Date: August 12, 2007

Re: CMS-1385-P

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

Dear CMS Representative:

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

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

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

Sincerely,

Hugh Gilbert, OTR/L, CHT

2000 Notre Dame Blvd., 120, Chico, CA 95928 530-898-9850