Submitter : Dr. Brien Grow **Date:** 08/12/2007

Organization : Brien N Grow, DO, PC

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

I cannot see the sustained growth rate able to address my real costs or caring for the elderly and the pay 4 performance costs of 7% to gain an additional 1% by me or my hospital a reasonable business practice. On either subject, you will doom the elderly and indigent to extreme restrictions in care.

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

Organization : **Dr. Jeffrey Luy**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CODING-ADDITIONAL CODES FROM 5-YEAR REVIEW
72 Federal Register 38122 (July 12, 2007)

To whom it may concern:

I am a cardiologist in private practice in the northern Virginia area. I specialize in noninvasive imaging, especially nuclear cardiology and echocardiography. I am particularly concerned regarding the impact that bundling of color flow imaging as part of the basic echocardiographic examination will have on patient care and in the practice of providing such services.

Color flow imaging involves additional physician time and sonographer time. While it is an integral part of the basic echocardiographic examination, it is not routinely employed in all exams. For example, stress echocardiography does not routinely employ color flow imaging and is therefore not billed. Serial 2-D echocardiographic exams for serial follow up of a pericardial effusion does not routinely use color doppler, and is therefore not billed.

However, many situations call for color doppler such as evaluation of a complex valve problem. Not only are special skills requisite in the performance and interpretation of color flow doppler but also additional time in terms of sonographer time and physician time is required to correctly interpret the data. This translates to additional overhead necessary in terms of sonographer time to perform the studies and special equipment to perform the study.

As a physician, my obligation is to provide the utmost in terms of patient care. Noninvasive imaging has made great strides in terms of technology. While expenditures for imaging as a whole may have gone up, the bottom line is that better technology has translated to better patient care and less utilization of invasive procedures needed in the past to diagnose such complex problems. Bundling of services ignores our efforts to provide outstanding care for our people and unfairly will limit patients' access to such services. Our time and efforts will not be adequately and fairly compensated. This sends a message of discouragement for individuals contemplating a career in medicine and a lack of appreciation for people currently in practice. This already being seen in the marked decrease of physicians in certain subspecialties due to financial obstacles in place, whether it be declining reimbursements form third-party payors, rising malpractice premiums, rising malpractice claims, etc.

Our attempts to slow the cost of health care services should not be directed at the expense of noninvasive imaging or physician payments. Provision of services might be better directed at requiring certification and ensuring quality measures.

I thank you for your efforts and ask for you cooperation in this most important issue.

Sincerely,

Dr. Jeffrey Luy

Submitter : Mr. Brandon Couchman **Date:** 08/12/2007

Organization : Student

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1385-P-5664-Attach-1.DOC

#3664

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

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Sincerely,

Brandon Couchman

Submitter : Dr. Bradley Fry **Date:** 08/12/2007

Organization : Dr. Bradley Fry

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5679-Attach-1.DOC

#5679

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 aware and 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.

Bradley C Fry. M.D.
765 McClendon Court
Brentwood, TN 37027
bcfry@comcast.net

Submitter : **Dr. Stephen Sawada** **Date: 08/12/2007**

Organization : **Indiana University**

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 cardiologist who provides echocardiography services to patients in Indianapolis, IN. I am writing in opposition to the CMS proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography 'base' services. This proposal would discontinue separate Medicare payment for color flow Doppler based on the premise that the technique has become 'intrinsic' to the performance of all echocardiograms.

I practice in a large academic medical center. We evaluate many patients referred from community clinics and other hospitals in the city with complex heart valve disease, prior valve surgery, and a growing number of adults with congenital heart disease . Color flow Doppler is an important tool used alone and in conjunetion with other echocardiographic methods in evaluating these patients. At times I perform a portion of the color flow exam along with our sonographers to determine abnormalities in valve or heart function that are best demonstrated by this technique. The CMS proposal to bundle and eliminate the reimbursement for color flow Doppler ignores the practice expense and physician work involved in performancc and interpretation of these studies. The performance of color Doppler increases the time spent by our sonographers in doing an echocardiographic exam, especially as the complexity of our patient population continues to increase. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative valuc units for any other echocardiography 'base' procedure.

I believe that CMS is incorrect in assuming that color flow Doppler is intrinsic to the performance 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 show that color Doppler is routinely performed in conjunction with CPT code 93307 used for routine two-dimensional echocardiography. However, at times color Doppler is utilized with transesophageal echocardiography CPT 93312, and stress echocardiography CPT 93350. Color Doppler is not uniformly performed in these procedures but at times color Doppler is needed when a person with a heart murmur, prior valve or congenital heart disease surgery undergoes these other procedures.

In light of the above, I hope you will not finalize the proposed 'bundling' of color flow Doppler into other echocardiography procedures. This is particularly important to those of us who utilize the technique in a tertiary care/academic medical centers and who are called upon to evaluate the sickest and most complex patients.

Sincerely yours,

Stephen G. Sawada
Professor of Medicine
Indiana University School of Medicine
Krannert Institute of Cardiology
1801 North Senate Blvd
Indianapolis, IN 46202
ssawada@iupui.edu
317 962-0533

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

Organization : **Philip Hanlon**

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.

Cordially,

Philip R. Hanlon

Submitter : **Dr. Thomas Heiman** **Date: 08/12/2007**

Organization : **Self-employed**

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,

Thomas D. Heiman, M.D.
Long Beach, California

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

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)

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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,

Kodi Clark, RHIT

Submitter : **Mr. David Agnew** **Date: 08/12/2007**

Organization : **Anesthesia Associates of Gainesville, LLC**

Category : **Physician Assistant**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this scrious matter.

Submitter : **Dr. Steven Sween** **Date: 08/12/2007**

Organization : **Physician Specialists in Anesthesia**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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 : **Mrs. Susan Hawes** **Date: 08/12/2007**

Organization : **Mrs. Susan Hawes**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

Susan M. Hawes___CRNA_____

16819 W. Sharon Drive_____

Surprise, AZ 85388_____

Submitter : **Dr. Gary Gonsalves** **Date: 08/12/2007**

Organization : **Gary D. Gonsalves, MD Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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.

Gary D. Gonsalves MD

Submitter : **Dr. yang sun** **Date: 08/12/2007**

Organization : **clinical partner, PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Aug.12,2007

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Yang Sun MD, MS
1500 S. Mill Ave,
Tempe AZ 85281

Submitter : **Dr. Alfred Martello** **Date: 08/12/2007**

Organization : **Dr. Alfred Martello**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. James Blake** **Date: 08/12/2007**

Organization : **Dr. James Blake**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CODING ADDITIONAL CODES FROM 5-YEAR REVIEW

I personally perform all of my own echocardiographic study. Therefore I am very aware of the work involved. Accurate assesment of valvular regurgitation (leaks) using color flow doppler is very time and resource intensive. In our office we routinely obtain multiple different views with multiple different machine settings before making a final decision. The process is far more involved then simply turning on the machine, involving nuance, continued medical education and seperate interpretation and reporting.

Pleasae reconsider this decision.

Submitter : Dr. Ann Linnebur **Date:** 08/12/2007

Organization : Medical Associates of Northern New Mexico

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Please don't bundle the Color Flow Doppler into The total Echocardiograph code. It takes extra time to do Color, the machines are more expensive but it truely adds to the quality of the study. I am in private practice here in New Mexico and already we are paid less for studies than other parts of the USA.

Submitter : **Dr. Luis Esparza** **Date: 08/12/2007**

Organization : **Oldf Pueblo Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Luis Esparza, M.D.
Old Pueblo Anesthesia
Tucson Arizona

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

Organization : **Kistreia Martin**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

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

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment. Thank you.

CMS-1385-P-5684-Attach-1.DOC

#5684

August 13, 2007

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

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

To CMS:

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

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

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

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

2. The surveys performed to set the work RVUs for almost all of the echo codes utilized specifically by pediatric cardiologists and affected by this proposed change were performed more than 10 years ago. As a result, particularly with respect to the 93325, the RVUs are reflective of a focus on the cost of the technology and not the advances in care that have been developed as a result of the technology. Particularly among pediatric cardiologists, much needed new surveys would provide evidence that the work and risk components of the procedures that involve Doppler Color Flow Mapping have evolved to the point where the relative value of the procedures have shifted to a significantly greater work component and a lesser technology component.

   This shift is reflected in the development of national standards such as those present in the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL) initiative to develop and implement an echo lab accreditation process. The

focus of this initiative is on process, meaning work performed, and not on the technology associated with the provision of echocardiography services. This echocardiography accreditation initiative will be mandated by many payors within the next year.

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

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

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

Pediatric echocardiography is unique in that it is frequently necessary to use Doppler flow velocity mapping (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 for the pediatric population stating that Doppler color flow velocity is "... even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." It should also be recognized that Doppler flow velocity mapping is an essential medical service being provided to patients with congenital and non-congenital heart disease in the pediatric population.

The following vignettes will illustrate the importance of the Doppler color flow velocity mapping (93325) remaining as a separate and distinct medical service and as an add-on code (+) for pediatric echocardiography services. These are just a few examples of the many complex anatomic and physiologic issues that we as pediatric cardiologists face on a daily basis when performing echocardiograms on infants, children, and adults with complex congenital or non-congenital heart disease. These are not unusual cases for us.

Vignette 1 *(quoted from CPT Assistant 1997)* (example of Congenital Heart Disease)

"A three-day-old neonate with transposition of the great vessels was initially treated with an atrial septostomy with a planned arterial switch procedure at seven days. On the third

day post Raskind balloon septostomy increasing cyanosis is seen with saturation dropping to the low 70s. A repeat transthoracic echocardiography (93304) with color flow Doppler study is performed *(color flow Doppler is coded in addition as a 93325).* The physician reviews the echocardiographic images and prepares a report. The echocardiogram shows a closed patent ductus arteriousus and a small atrial septal defect. The child is returned to the cath-lab for a repeat septostomy and prostaglandin is restarted."

Vignette II (example of non-congenital heart disease)

A two-month-old infant is referred by the pediatrician to a pediatric cardiologist for a persistent murmur in an otherwise healthy infant. The pediatric cardiologist is concerned about a patent ductus arteriosus as a possible diagnosis. A ductus arteriosus, connecting the pulmonary artery and the aorta, is an essential structure during fetal life. Normally, the ductus arteriosus closes in the first few days after birth in healthy term infants. A persistent ductus arteriosus can give rise to long-term complications and needs to be followed carefully to evaluate if further intervention is needed (medical vs. surgical). Echocardiography permits an accurate diagnosis of a patent ductus arteriosus with assessment of both the hemodynamic impact if there is a shunt. Estimated pulmonary artery pressure is obtained by Doppler imaging and can exclude other associated defects also. Color flow Doppler will be able to outline the flow of a patent ductus arteriosus from the aorta to the pulmonary artery. Color flow Doppler in this baby revealed no cardiac defects or patent ductus arteriosus and the murmur was determined to be innocent.

Vignette III (example of congenital heart disease)

An eight year-old child (or a 23-year-old young adult), with complex cyanotic congenital heart disease (functional single ventricle) is post-op completion of a fenestrated Fontan procedure several years ago. He has had a progressive decrease in saturations over the last year. There are several possible explanations and the pediatric cardiologist performs an echocardiogram to help determine the etiology. Color flow Doppler (93325) is essential to help elucidate the postoperative anatomy and blood flow patterns, but the process is complex and time-consuming involving assessment of the surgically constructed lateral tunnel or extracardiac conduit searching for a residual fenestration shunt or obstruction to flow, assessment of flow patterns through the previously surgically constructed Glenn anastomosis between the superior vena cava and pulmonary artery, assessment for obstruction to flow through the bulboventricular foramen, assessment for significant AV valve or semilunar valve insufficiency, and assessment for collateral vessels directing venous (desaturated blood) into the heart that may have developed over time. Any or all of these findings will then help dictate the next step in the care of this patient.

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

Submitter : **Dr. james justice III** **Date: 08/12/2007**

Organization : **ASA member**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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. H.A. Tillmann Hein, M.D. **Date:** 08/12/2007

Organization : Dr. H.A. Tillmann Hein, M.D.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

H.A. Tillmann Hein,M.D.

Submitter : Dr. Steven Metcalf **Date:** 08/12/2007

Organization : Capitol Anesthesiology Association

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1385-P-5682-Attach-1.PDF

#5682

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Dr. Genevieve Ali** **Date: 08/12/2007**

Organization : **Capitol 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

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Thank you for your consideration of this serious matter.

Sincerely,
Genevieve Ali, MD

Submitter : **Dr. Denisa Haret** **Date: 08/12/2007**

Organization : **UAMS**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Susan Bolton** **Date: 08/13/2007**

Organization : **VCUHS**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Sincerely yours,

Susan C. Bolton, MD, JD

Submitter : **Dr. Christopher Walter** **Date: 08/13/2007**

Organization : **Anesthesiology Consultants, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Rc: CMS-1385-P

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Submitter : **Dr. Heidi Walter** **Date: 08/13/2007**

Organization : **Walter Anesthesia, P.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Dr. Krystof Neumann **Date:** 08/13/2007

Organization : University of Rochester 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

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Thank you for your consideration of this serious matter.

Krystof Neumann, MD

Submitter : Mrs. Geralyn Neumann **Date:** 08/13/2007

Organization : Mrs. Geralyn Neumann

Category : Physician Assistant

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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As a Physician Assisstant who frequently works with anesthesiologists, I have become increasingly more aware of the undervaluation of anesthesia services. There is already a shortage of anesthesiologists which I fear will continue to worsen if this disparity in reimbursment continues as qualified candidates will seek other specialties. There are already many areas in this country, particularly those with a high proportion of medicare patients where a shortage of anesthesiologists exists. I feel that passing this increase to the Medicare anesthesiologist per unit payment will be a move to help ensure continued access to qualified anesthesia care for our growing number of Medicare patients.

Sincerely,

Geralyn Neumann, PA-C

Submitter : Dr. Jerry O'Hara, Jr. **Date:** 08/13/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

We appreciate the Centers for Medicare and Medicaid Services (CMS) for making sure that Medicare beneficiaries have adequate access to care. The American Society of Anesthesiologists has well-founded concerns that current Medicare payment levels do not meet this standard and and request CMS administrators that improving payment is essential.

On July 2, the Medicare program announced that it is considering an increase in payments for anesthesia. If the government follows through on all its proposals, the anesthesia conversion factor could be about $3.30 per unit more than was projected for 2008 before Medicare made its July announcement. We believe this proposal is a positive step toward addressing our concerns about sufficient Medicare payments.

As a Anesthesiologist in an academic setting with a high Medicare population we are appreciative of this reevaluation of Medicare compensation for our services render for patient care. With comparisons for 1992 Medicare reimbursement our current levels remain lower after adjustments in 2007 for inflation etc. from 15 years ago. It is difficult to continue providing advanced care when our value of reimbursement has declined. This readjustment appears reasonable for our specialty.

Thank you for your interest in this matter to allow continued critical patient anesthesiology care to be delivered to some of our most elderly and ill patients.

Submitter : **Dr. Jeffrey D. Shapiro** **Date: 08/13/2007**

Organization : **Georgia Perioperative Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Jeffrey D. Shapiro, M.D.

Submitter : **Bruce Pritschet** **Date: 08/13/2007**

Organization : **ND Department of Health- Division of Health Facili**

Category : **State Government**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Therapy Standards and Requirements

In some states, including North Dakota, the proposed rules will conflict with current licensure requirements, especially occupational therapy. Essentially, developing a Medicare license which will add to the confusion.

The proposed rule at 38193 re: 409.17, hospital services, is conflicting, requiring an extensive plan of treatment as required for outpatients, but not requiring physician certification. Considering the shorter lengths of stay and rapid change in hospital inpatient status, an extensive plan of treatment is unnecessary and would require continual, time consuming modifications.

From a professional standpoint

38192 Further research is needed by CMS to identify how many of any professional category these rules may affect. The changes proposed by CMS may be to correct problems with very minimal numbers of professionals and may not be necessary.
- CMS should contact the professional organizations and boards directly rather than basing decisions, in part, on a limited number of websites.
- To be consistent, physician services (physician owned physical therapy services) (POPTS) needs to be added.
- Licensure is a state function and should remain with the state and be based on professional standards. CMS is taking it upon itself to become a licensing agency, which does not consider the work and efforts over the years by professional organizations to establish licensing requirements, direct access, and establish professional standards. This also creates unnecessary duplication.

38193 Re: inpatient plan of treatment (POT). The proposed rule requires the inpatient POT to be the same as outpatient. Considering the decreasing length of stay, the intensity of services and the rapid change in patient status, this proposed rule is unreasonable.

38232 . . . furnish Medicare services at least part time . . . more than 2 years. This proposed rule would effectively eliminate new or recent graduates who are fully licensed, etc. from working independently in many practice sites. This rule would ignore the licensing requirements in every state. For rural states this further limits an already limited pool of professionals.
- What is CMS definition of part time?
- This proposed rule specifies Medicare services. This does not recognize physical therapists and other professionals work in non-Medicare settings (industrial clinics, outpatient sports clinics, pediatrics) and are fully qualified to treat Medicare patients. This rule does not recognize the difficulties of staffing in rural areas where the availability of any therapist may be a luxury.

Overall, the proposed rules are missing the mark regarding improving the consistency of services. CMS is not fully considering the state licensing requirements that currently exist and the efforts of professional organizations for direct access, standardization of training, and licensure. CMS already requires NPI and Medicare provider numbers. If CMS really wants to be consistent, incorporate reasonable requirements into the NPI and Medicare provider numbers process. CMS is proposing to add another layer of requirements to correct a perceived problem that has not been quantified. This only adds an unnecessary burden to professionals, limits clinical practice, increases the cost of health care, and, ultimately, reduces the quality and accessibility of therapy service available to patients. The proposed rules ignore the realities of day to day patient care and especially the realities of rural America and could have a negative impact on provision of quality care

Submitter : **Dr. Dana Smith** **Date: 08/13/2007**

Organization : **Dr. Dana Smith**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

The proposed fee reductions will llimit patient access to quality health care providers. Many will decide to discontinue treating Medicare patients.

Submitter : Dr. Robert O'Bryan **Date:** 08/13/2007

Organization : Anesthesia Associates P.A.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5695-Attach-1.TXT

#5695

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. Wayne Duke** **Date: 08/13/2007**

Organization : **Baystate Health**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 13, 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 as part of 23 member non-profit pathology group at Baystate Health System.

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,

Wayne Duke, M.D.

Submitter : Mr. Tim Wall **Date:** 08/13/2007

Organization : Jacksonville Orthopaedic Institute

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The quality of care provided in a physician owned practice is excellent for Medicare patients for many reasons. The first reason is the one on one daily communication between the PT/OT and the physician. The rapport which is developed by working in the same practice is invaluable. Often times, the therapist will do rounds with the physician to learn exactly what their specific rehabilitation parameters are. The best level of communication is when the physician, the patient and the therapist are in the same room. The second reason is the convenience of having a physician's office, an MRI facility and a rehabilitation center all in one practice or physical location. Appointments can be coordinated so that the patient does not have to travel to three seperate locations on the same day. Hand physicians on a daily basis will refer patients on a walk-in basis for splints after a cast has been removed. These patients can walk right over and get their splints put on. Home exercise programs can also be performed as a walk-in appointment on the same day of the physician office visit. Also, if a patient were to have a complication or a re-injury during their rehabilitation program, the problem could be immediately communicated to the MD and the appropriate action would be initiated without delay. In examples such as DVT's in post-surgical patients, these immedidate actions can be life saving. The last reason which I would like to convey is the outstanding patient outcomes which occur when the physician and the therapists are on the same team. Medicine is a field where advances in technology and surgical techniques occur on a daily basis. The team approach to developing and modifying rehabilitative protocols and treatement parameters is the key to a successful patient outcome. If a physician were to learn a new surgical technique, they would inservice the clinicians and the appropriate changes could be made in the post-operative protocol. Feedback would be given on a daily basis from the therapist to the physician, so that modications to the treatment plan could be immediate and evolving. Not just every 30 days when the patient returns for their physician appointment.

I believe that the physician owned practice is an invaluable entity in today's healthcare field. If you do not believe me, ask the thousands of patient's who have been treated at physician owned facilities and have positive functional outcomes to show for it.

Submitter : Mr. L.RICHARD SEMENTELLI **Date:** 08/13/2007

Organization : Mr. L.RICHARD SEMENTELLI

Category : Other Practitioner

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I FEEL THAT TO CONTINUE THIS PRACTICE OF COST-CUTTING IS THE PRIMARY REASON FOR THE DUMMING-DOWN OF OUR PRESENT HEALTH CARE SYSTEM

Submitter : Dr. MICHAEL MCCREDIE **Date:** 08/13/2007

Organization : ANESTHESIA ASSOC.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1385-P-5699-Attach-1.DOC

#5699

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 : **Dr. Daniel Mitchell** **Date: 08/13/2007**

Organization : **Dr. Daniel Mitchell**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerly,

Daniel S. Mitchell MD

Submitter : **Dr. Dan Goulson** **Date: 08/13/2007**

Organization : **Dr. Dan Goulson**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,
Dan Goulson, MD

Submitter : **Dr. Ashraf Banoub** **Date: 08/13/2007**

Organization : **Anesthesiology consultants of Toledo, Inc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Mr. Patrick Hinton **Date:** 08/13/2007

Organization : Jacksonville Orthopaedic Institute

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician owned physical therapy facilities, staffed by licensed/certified physical therapists, occupational therapists, and athletic trainers offer excellent care for Medicare patients for many reasons. First, therapists/trainers work closely with and communicate daily with physician owners, which allows for enhanced continuity of care. Second, it is convenient for the patient to see their physician and therapist in the same location. Third, having the physician and the therapist/trainer on the same team contributes to improved outcomes for patients. Patients are more compliant with their therapy regimen, can obtain immediate answers to questions regarding their care/rehabilitation, and are generally more satisfied that the physician and therapist are working together as a team.

It is imperative that physician owned rehabilitation facilities be staffed with physical or occupational therapists who comply with state licensing requirements and there should be no exceptions.

Submitter : **Dr. Donald Ross** **Date: 08/13/2007**

Organization : **Massachusetts Society of Pathologists**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 13, 2007

Dear Sir or Madam:

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the 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 Methuen, Massachusetts as part of a four-member hospital-based pathology group.

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

Donald G. Ross, MD, PhD, FACP
President, Massachusetts Society of Pathologists
Chief Pathologist
Caritas Holy Family Hospital
70 East Street
Methuen, MA 01844

Submitter : **Dr. Michael Caughron** **Date: 08/13/2007**

Organization : **Dr. Michael Caughron**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

August 13, 2007

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I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Billings, Montana as a part time member of Yellowstone Pathology, a 5-member pathology group with an independent laboratory and practice in St Vincents hospital nearby.

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.

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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,

Michael R. Caughron, M.D.

Submitter : **Date: 08/13/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medieaid 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. Cody Smith **Date:** 08/13/2007

Organization : Green Oaks Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5707-Attach-1.TXT

CMS-1385-P-5707-Attach-2.TXT

#5707

Green Oaks Physical Therapy
124 W. Beltline Ste 8
Cedar Hill, Texas 75137

Date: August 13, 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,

Cody Smith, M.S.P.T.
Director

Submitter : **Dr. Rhonda Herbel Linser** **Date: 08/13/2007**

Organization : **CMS**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Rhonda K. Herbe Linser, MD

Submitter : **Dr. ali panbehi** **Date: 08/13/2007**

Organization : **san pedro hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Thank you for your consideration of this serious matter.

Submitter : Dr. Cooper Chao **Date:** 08/13/2007

Organization : Medical Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Despite populist movies such as Sicko, and presidential candidates such as John Edwards, physicians and in particular anesthesiologists have been working with progressively decreased compensation especially in light of increased demands and expectations of what we accomplish, much of it out of the public eye. Media and patients want painless, rapid recoveries, but they never stop to think about what a miracle that anesthesiologists quietly and under increasingly under-or non conpensated eicumstances perform. Now, Medicare wants to further impose even less compenasation for an increasingly ill population undergoing ever more complex procedures. Let the popiticans and administrators suffer proportionate reductions in their pay , then I would respect their proposals more.

Submitter : Ms. Diane Levy **Date:** 08/13/2007

Organization : Lehigh Anesthesia Associates, PC

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

As a health care provider I fail to understand why payments for anesthesia services drops year after year. More and more procedures are being provided outside of the hospital setting such as ASC's and even offiees. With our aging population our patients require more detailed care and knowledge to provide a safe anesthetic for their procedure and this falls on the anesthesia provider. We are being asked to provide more care, time, services, and follow-up than ever before. Our malpractice insurance has not gone down in cost. Our own health insurance coverage has not gone down in price. Our staff does not expect to be paid less and less each year. Our reimbursement converstion factor here in Pennsylvania is now $15.66 per unit. At one point it was over $18. per unit but as our costs rise our reimbursement goes down and our workload also increases. Everyone has had to tighten their belts but realistically you cannot expect people to spend more time for less money year after year after year. I hope you understand the position of anesthesia providers and raise the fee schedule.

Submitter : Mr. Robert Hoenshel **Date:** 08/13/2007

Organization : Jacksonvile Orthopaedic Institue Rehabilitation

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The rule allowing physician owned physical therapy services has benefitted numerous patients under my care. The benefits to the patient include direct contact with the physician about progression, repair quality, and issues during rehabilitation. The physician and I have caught and referred multiple DVT's successfully. We have changed progressions of post-surgical patients with outstanding clinical outcomes. I have experience working with a private rehabilitation company and with a physician owned rehabilitation company. The experiences have been completely different and better with the physician owned practice. The patient outcomes, which are hopefully why we are in the field, with the physician owned practice have far surpassed the outcomes reached while working for the private company and even my own expectations. The patient benefits from a multifaceted approach to their treatment and rehabilitaion process including but not limited to an all-encompassing facility (MD office, PT, MRI, and surgery), more effective and often communication, and on-site physician assistance. I talk with the MDs daily and discuss patient progressions whereas in the past, trying to reach an MD, MA, or secretary was challenging if not impossible. We have the ability to see walk-in patients for home exercise programs that live far away and do not have the ability to attend PT on a regular basis. We also have patients walk over who have just had joint manipulations to start immediate ROM preventing them from getting stiff and guarding early on, thus reducing time spent in therapy. I have also had the ability to sit down with physicians and help write protocols which are given out to other rehabilitation sites across the city and state. The overall benefit to the patient treated in a physician owned practice is immeasurable. The patient outcome has been so much more improved under the physician owned practice that I am not sure I will work any place other than for a physician owned practice. I have hundreds of patients who would be willing to and have told others of the benefit of being treated in a physician owned practice. Thank you for listening to this very important matter of allowing therapists to continue to practice in a facilty that promotes enhanced communication, complete/quality care, and IMPROVED FUNCTIONAL OUTCOMES!!

Submitter : Dr. Ronghuan Liu **Date:** 08/13/2007

Organization : Anesthesia Medical Group of Riverside

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5713-Attach-1.DOC

#5713

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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