Submitter : Dr. Zheng Wang **Date:** 08/13/2007

Organization : Hillary Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5714-Attach-1.DOC

#5714

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. David Andres** **Date: 08/13/2007**

Organization : **Northstar Anesthesia, P. A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Mr. Alan Leventhal **Date:** 08/13/2007

Organization : Council of Licensed Physiotherapists of N.Y.State

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

I am thc Medicare Chairman of the Council of Licensed Physiotherapists of New York State, Inc.- an organization that has been in continuous existence since 1926. Our statewide membership is composed of licensed physical therapists who are primarily in private practice but also practice in other settings as well.

In general, we applaud and support the directions these proposals take in providing the public with quality physical therapy care in ALL settings while taking steps to control unnecessary expenditures and eliminate quasi-legal and outright fraudulent practices. These goals correspond to long standing expressed positions of this organization.

DEFINITION OF WHO QUALIFIES AS A PHYSICAL THERAPIST OR PHYSICAL THERAPIST ASSISTANT. We believe that a patient is entitled to treatment by a fully qualified PT or PTA in ALL settings including "incident to a physician's service". (We will have more to say on that subject later.) We agree that all PTs and PTAs must meet the new qualifications after 1/1/08 with the exception of those who have been licensed, certified or otherwise regulated in their respective states before 1/1/08 or qualify as graduates prior to 1977. We do NOT believe the uninterupted criteria is necessary provided they have and continue to hold a valid state licnse. The important matter is that starting 1/1/08, all persons rendering physical therapy treatment under Medicare be fully qualified. The public deserves no less.

We further believe that these standards should be applicable in all settings, including home health and hospice settings. To think that these settings are immune from employing non qualified people is naive and ignores the temptation of lower costs for less qualified people.

Likewise, financial teptations to use lowe quality personnel in "ineident to" situations may be very strong. There is no reason why CMS cannot enforce full qualifications in these situations, including licensure, - regardless of statute 1862(a)(20). Medicare has often imposed its own regulations over and abovc state standards.

We also feel that inpatient services must meet the same standards as outpatient servcies.

OUTPATIENT THERAPY CERTIFICATION REQUIREMENTS. We believe that physical therapists are qualified, professionally responsible practitioners and as such must take profcssional and fiduciary resposibility for the care of the patients they treat.We agree that the 30 day recertifcation requirement is restrictive and unreasonable. However, we feel that the PT has a responsibility to refer the patient back to the referring physician - or consult with the referring physician AS SOON AS NECESSARY WITHOUT REGARD TO TIME LIMITS. A 90 day limit is silly and the referring physician always has the option of scheduling a retrurn visit. We support the correction to thc rule-"as often as the individual's condition requires" but not any specific time timits for recertification.

ANNUAL CAP ON PT SERVICES. We strongly believe the CAP should be repealed. It is a poor method of cost control asreferral-for-profit situations discharge patients before the cap is reached with a steady source of replacement patients available. The present poltical climate suggests that repeal may not happen this year and that an extension of the Exeception Proeess for perhaps 2 years will be enacted. Since the Exceptions Process was well conceived and is working well, we can accept this temporary solution andwill work toward a system where monies can be saved by emiminating unnesary treatment by unqualified people and especially in referral-for-profit situations.

CAP Issues

CAP Issues

CONTINUATION OF COMMENTS BY THE COUNCIL OF LICENSED PHSIOTHERAPISTS OF NEW YORK STATE.

PHYSICIAN SELF REFERRAL PROVISIONS. We strongly concur with CMS's concerns that thc in-office ancillary services exception to physician self referral laws have been a thriving environment for fraud and abuse. It is nothing more than referral-for-profit and with few exceptions works against the best interests of the patient. With the exception of board certified physiatrists, it should NOT BE ALLOWED in Medicare REGARDLESS OF THE GEOGRAPHIC SETTING OF THE PT SERVICES RELATIVE TO THE PHYSICIAN (owner)REFERRER.The only exception should be for diagnostic or evaluation purposes- NOT TREATMENT.We believe these would be few and far betwecn.

We also bclieve that, in general, multiple specialty practices listing a plethora of physicians (and PTs)in one building without any names or professional designations should be closely monitored to assure that quality specialist care is being delivered and substandard care is not being paid for by Medicare.

I the final analysis, the obligation of CMS is tgo promote regulations to ensure that what is right and proper for Medicare patients prevails. I know from my conversations and correspondence with people at CMS that this is their desire and objective. We understand that it is not always easy because different interests have their own objectives. Perhaps, it is also because it is made too complicated.REFERRAL FOR PROFIT IN ANY FORM IS WRONG and should not be tolerated particularly by an ageney charged with thc proper expenditure of precios Medxieare dollars. REIMBURSING UNQUALIFIED PEOPLE IS ALSO WRONG. While it is desireable to adequately compensate qualificd professionsls for necessary services, IT IS WRONG TO PAY FOR UNNECESSARY ONES. We,as always stand ready to assist in formulating rules that we feel are the correct oncs and are in the public interest. We know that this is the goal of CMS also.

Repectfully submitted.

Alan Leventhal, PT
Medicare Chairman, Council of Licensed Physiotherapists of N.Y. State Inc

Submitter : **Dr. Keith Craig** **Date: 08/13/2007**

Organization : **Dr. Keith Craig**

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
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Thank you for your consideration of this serious matter.

Sincerely,
Keith D. Craig MD

Submitter : **Dr. richard geller** **Date: 08/13/2007**

Organization : **emerson hospital**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

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 Concord mass. in a hospital group practice of 4 pathologists.

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

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 geller m.d.

Submitter : Mr. Adam Roberts **Date:** 08/13/2007

Organization : Mr. Adam Roberts

Category : Individual

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

RE: 72 Federal Register 38122 (July 12, 2007)

To whom it may concern:

To be brief, I am an echocardiographer recently graduated and now working full time at a major heart hospital in Houston, TX. I wanted to address the issue on the docket of the proposed changes in the coding of echocardiography procedures. The proposed changes will result in Color Doppler being attached as part of the echocardiogram, instead of being charged as a seperate entity, without increasing the cost of the overall exam. This will result in payment reductions for a comprehensive echo exam.

As a newly graduated echocardiographer, I have a clear understanding of the skill and time it takes for an echocardiographer and a cardiologist to acquire and anaylze Color Flow Doppler. When doing an echocardiogram, Color Doppler is a seperate area of focus, which takes time to master and complete, from a technical perspective, in a single exam. Watching cardiologists in the reading room, and seeing case studies presented by these specialized analysts, I also understand how much extra expertise and training is needed to interpret Color Flow Doppler.

Furthermore, I know from my experience here at the hospital that not every echocardiogram needs Color Flow Doppler. When a physician wants to order an echocardiogram to rule out pericardial effusion, more often than not, all that is needed is a 2D Echo without Color Doppler. Also, there have been many times when all the physician wants to see is wall motion to determine the ejection fraction. Keeping Color Doppler as a seperate code for reimbursment is essential for proper charging when a patient only needs a 2D echocardiogram.

I feel that the proposed changes are unecessary and perhaps do not take into account the issues from a echocardiographer's perspective. Please consider carefully the implications from making the proposed changes on the docket concerning Color Doppler.

Sincerely,

Adam Roberts
1406 Richmond Ave. #331
Houston, TX 77006
713-384-0120

Submitter : Dr. THOMAS BRALLIAR **Date:** 08/13/2007

Organization : AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Category : Health Care Professional or Association

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 : Dr. F. Gregory Brusino, M.D. **Date:** 08/13/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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F. Gregory Brusino, M.D.
Raleigh, NC

Submitter : **Dr. Dina Kogan** **Date: 08/13/2007**

Organization : **Dr. Dina Kogan**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Centers for Medicare and Medicaid Services
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Submitter : **Dr. Peter Hildebrand** **Date: 08/13/2007**

Organization : **Dean McGee Eye Institute**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Peter L. Hildebrand, MD

Submitter : **Dr. Shoyab Panchbhaya** **Date: 08/13/2007**

Organization : **Greater Houston Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

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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.

Sincerely,

Shoyab Panchbhaya, MD

Submitter : **Mrs. Ann Villar** **Date: 08/13/2007**

Organization : **AANA**

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,

_Ann H. Villar , BSN CRNA_____
_1383 Bullock Hollow Rd. _____
_Bristol, Tenn. 37620_____

Submitter : **Dr. Mary Ellen Warner** **Date: 08/13/2007**

Organization : **Dr. Mary Ellen Warner**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

*****See attachment*********
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.

Submitter : **Dr. Erik Shupe** **Date: 08/13/2007**

Organization : **Dr. Erik Shupe**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Rc: CMS-1385-P

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

Organization : **Richard Pechter**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. Coding-Additional Codes from 5-year review.

Dear Sir,

I am writing to object to the proposed "bundling" of color flow doppler (93325) into the other doppler codes. I am a cardiologist who performs echocardiograms in Vero Beach, Florida. Color flow is helpful for quantitating the degree of valve insufficiency and intracardiac shunting which helps medical and surgical decision making. If I am just interested in wall motion and thickness, then I only perform 93307. Color flow requires expensive equipment, additonal acquisition time, and additional interpretation time and expertise. Medicare already chopped reimbursement over 8% last year at a time of supposed budget neutrality. Enough is enough! If you want to cut spending, try prohibiting all but cardiologists or other physicians with comparable Extensive Training from interpreting these studies and holter monitors.

Please refrain from finalizing the proposed "bundling" of color flow doppler into other echocardiography procedures.

Sincerely,

Richard A Pechter MD, FACC

Submitter : **Dr. Justin Sell** **Date: 08/13/2007**

Organization : **Michigan Society of Anesthesiologists**

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 : Mr. Wayne Winfree **Date:** 08/13/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a Rural Nurse Anesthetist who has to bill for myself, I want to express my support (need) for the proposed anesthesia reimbursement increase. This adjustment is a long time coming and is much needed.

Trying to pay someone to cover for me with the current reimbursement is not even close to adequate. Typical coverage cost me close to double what Medicare currently pays. This does not correct this but it helps.

Thanks Wayne Winfree, CRNA, Carthage TN.

Submitter : Dr. Douglas Berebitsky **Date:** 08/13/2007

Organization : Anesthesia Consultants of Indianapolis

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

Rc: CMS-1385-P
Anesthcsia 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. Roman Langston **Date:** 08/13/2007

Organization : South Denver Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Failure to adjust the conversion factor in a way that fairly compensates anesthesia providers will greatly affect access to care in underserved areas.

Submitter : **Ms. Sue Balistrieri** **Date: 08/13/2007**

Organization : **Cardiovascular Consultants Medical Group, Inc.**

Category : **Other Technician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

see attached

CMS-1385-P-5735-Attach-1.DOC

#2735

CARDIOVASCULAR CONSULTANTS
MEDICAL GROUP, INC.

Board Certified in Cardiovascular Diseases

Alameda County
David J. Anderson, M.D.
John H. Chiu, M.D.
Robert C. Feldman, M.D.
Robert E. Gwynn, M.D.
Eric J. Johnson, M.D.
Steven Kang, M.D.
Michael A. Lee, m.D.
Paul L. Ludmer, M.D.
Richard W. Terry, M.D.
Jeffrey A. West, M.D.
Gary R. Woodworth, M.D.

Contra Costa County
Kristine W. Batten, M.D.
Andrew J. Benn, M.D.
Shaun Cho, M.D.
Matthew S. DeVane, D.O.
John R. Krouse, M.D.
Mark D. Nathan, M.D.
Pramodh S. Sidhu, M.D.
Neal W. White, M.D.
Christopher W. Wulff, M.D.

Electrophysiology
Shaun Cho, M.D.
Robert C. Feldman, M.D.
Steven Kang, M.D.
Michael A. Lee, M.D.
Paul L. Ludmer, M.D.

Vascular
John H. Chiu, M.D.
Robert E. Gwynn, M.D.
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106 La Casa Via
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Walnut Creek, CA 94598-3084
925.274.2860
FAX 925.4527

www.ccmgonline.com

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

Dear Mr. Kuhn:

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

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

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

Moreover, CMS is incorrect in assuming that color flow Doppler is "intrinsic" to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography "base" codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

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

Sincerely yours,

Sue Balistrieri, RDCS, ASE Member
Cardiovascular Consultants Medical Group, Inc.

Submitter : **Dr. Lara Pesavento** **Date: 08/13/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

re: CMS-1385-P

To whom it may concern,

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,

Lara Pesavento, MD

Submitter : **Dr. Jacqueline Drummond-Lewis** **Date: 08/13/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 13, 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)

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.

Jacqueline Drummond-Lewis MD, FAAP

Submitter : Dr. Kevin Shannon **Date:** 08/13/2007

Organization : UCLA

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am very concerned about the planned bundling of the code 93325, without an appropriate increase in the RVU's for the bundled code. Pediatric cardiologists will be greatly affected by this change, since almost all of the diagnoses that we make require color doppler. peadiatric cardiologists are already at a financial disadvantage due to the lower re-imbursements for pediatric patients, this proposed increase will dramatically reduce income and thus limit the availability of specialists for children with heart disease. Please reconsider this change and develop a plan to protect the care of children with heart disease.

Submitter : Dr. Stephen Janecek **Date:** 08/13/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5739-Attach-1.WPD

#5739

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. Carrie Goettsch **Date:** 08/13/2007

Organization : Brighton Hill Chiropractic PC

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

Greetings.

I am disturbed at the trending in the Medicare system to progressively undermine and perpetually disrespect the role that chiropractors play in the health care arena. The absurdity and double standard of eliminating reimbursement for chiropractors to take or order xrays is just one example. The data showing the benefits of spinal manipulation, the importance of xrays in the Medicare aged population for accurate diagnosis of spinal dysfunction and disease and the overwhelmingly positive patient satisfaction data regarding chiropractic need to be in front of rational minded decision makers.

Chiropractors are well educated and skilled in the complex art of taking and reading xrays to better understand the complexities of spinal misalignment and progressive degenerative spinal disease. Palmer College of Chiropractic in Davenport, Iowa was the very first health care facility to utilize xray. Chiropractors initiated the use of the open mouth cervical view, now a standard view in upper cervical spine evaluation by the medical profession. Chiropractors also utilized upright xrays as a standard to evaluate the spine using a weight bearing model, which is more accurate for evaluating the biomechanical adaptation to weight bearing stresses on the spine. Medical science has just recently started recognizing and adopting routine upright (standing) xrays for spinal evaluation.

Chiropractors are relatively new to the collaborative health care arena and have had a major learning curve to navigate regarding documentation. Getting an entire generation of chiropractic providers (spanning 40 plus years of differing ages and levels of record keeping) up to the documentation standards set by the insurance industry takes time. "Subpar" documentation in a percentage of the chiropractic community doesn't mean that chiropractors are providing less than exceptional health care services to their patients. The decision makers that are influenced by any other than the facts of the treatment benefits and cost advantages of skilled and caring chiropractors providing evaluation and management spinal manipulation based services to chiropractic patients need to be exposed. Special interest influence, inaccurate assumptions and double standards do not enhance appropriate public policy decision making.

I am respectfully requesting that the xray proposal to eliminate all chiropractic access for xrays be RECONSIDERED and reversed. In addition, I am requesting that full reimbursement be initiated to chiropractic providers for the professional and technical components associated with taking and reading xrays for their patients.

The present idea of eliminating all reimbursement for xrays requested by chiropractors is just plain absurd, discriminatory and undermines the rights of chiropractic patients to receive cost effective, appropriate care. This is not a cost saving action, it is a higher cost substitution action. Dr. McAndrews once said that it will take until an entire generation of chiropractic hating administrators die off before the value and positive impact of chiropractic care has the opportunity to be assimilated more fairly in the health care arena. Is it really necessary to wait that long?

Sincerely,

Carrie Goettsch, DC
Brighton Hill Chiropractic, PC
170 Intrepid Lane
Syracuse, NY 13205
chiropractic documentation seminar presenter, Excellus BCBS, Syracuse, NY
graduate of Palmer College of Chiropractic (Davenport, Iowa) 1980

Submitter : **Mr. Brad Keller** **Date: 08/13/2007**

Organization : **Mr. Brad Keller**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

Ms. Norwalk
Currently at issue is the proposed increased in anesthesia work values by 32%. Under the current system, Medicare anesthesia reimbursement was decreased by 8% Jan 2007. As a nurse anesthetist, I am asking that the SGR cuts be removed and the proposed increases of the anesthesia conversion factor be implemented (72 FR 38122). Without these changes, 2008 anesthesia reimbursement, will be equivalent to 2/3 the 1992 levels (adjusted for inflation).

Thank you helping to continue ensuring access for all Medicare recipients.

Bradley S. Keller, CRNA

Submitter : Dr. Judith Becker **Date:** 08/13/2007

Organization : Mass general Hospital for Children

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am a Pediatric Cardiologist concerned about the proposal to bundle CPT 93325 into 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350. After research & discourse between RUC, ACC, & ASE, the CPT editorial panel recommended bundling 93325 with 93307(implement on 01/01/09). They did not recommend that the above codes be bundled as well with 93325.

The new code is to address issues involving Medicare use of 93307. But also as a result, we will be faced with resolving, in less than 2 months (normally addressed over a multi-year period) an issue that directly impacts a non-Medicare population (children). Surveys conducted to set the RVUs for echo codes used by pediatric cardiologists were performed > 10 years ago. New surveys of these practices would demonstrate work & risk components of studies involving Color Flow Mapping have shifted to a significantly greater work & a lesser technology component. This shift is reflected in development of national standards like those of the ICAEL initiative to develop & implement an echo lab accreditation process. Many payers will mandate Echo accreditation in the next year.

In 1997 specific CPT echo codes were implemented for congenital cardiac anomalies to complement existing codes. These codes were developed & to delineate more distinctively the different services involved in assessing and performing echocardiography on infants & young children with congenital cardiac anomalies. (CPT Assistant 1997). Consistent with this, I have great concern with treating adult & pediatric patients as equivalent entities when evaluating the work needed to provide care for these very different patient groups. The adult cardiac population is much larger, & RVUs for procedures common to both are established using adult patients as the basis, ignoring the work & expense associated with providing care to pediatric patients resulting from anatomical differences (size, development, etc. - see references from the CPT Assistant below) or the issue of getting a child to be still for complex imaging procedures.

CPT Code 93325 defines Doppler color flow velocity mapping typically performed along with another echo imaging study to define anatomic & dynamic abnormalities, to highlight flow aberrations & to provide landmarks for positioning the sample volume to record cardiac flow velocities. Pediatric echo uniquely frequently requires Color flow mapping for diagnostic purposes forming the basis for clinical management decisions. CPT Assistant in 1997 adds that color flow mapping is &even more critical in the neonatal period when rapid changes in pressure...can cause significant blood flow changes, reversals of fetal shunts & delayed adaptation to neonatal life. Color flow mapping is an essential service provided to patients with congenital & non-congenital heart disease. Several vignettes from CPT Assistant 1997 illustrate the importance of this remaining as a separate medical service & as an add-on code (+) for pediatric echocardiography services.

I m concerned that the proposed change will adversely impact access to care for our patients. Pediatric cardiac programs provide care to patients with or without insurance. A key impact of this change will be to significantly reduce resources available now that support programs providing this much-needed care to our patients. This change will cause an increased need for subsidies from already resource-challenged children s hospitals & academic programs, and/or an increase in Medicaid reimbursement for the proposed bundled services, in order for pediatric cardiology patients to have the same access to care they have today.

I strongly urge CMS to withdraw this proposal of bundling 93325 with other pediatric cardiac echo codes until there has been a complete review of all related issues, working within the prescribed process & timeframe, in order to achieve the most appropriate solution.

CMS-1385-P-5742-Attach-1.RTF

#5742

August 12, 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 arteriousus as a possible diagnosis. A ductus arteriousus, connecting the pulmonary artery and the aorta, is an essential structure during fetal life. Normally, the ductus arteriousus closes in the first few days after birth in healthy term infants. A persistent ductus arteriousus 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 arteriousus 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 arteriousus from the aorta to the pulmonary artery. Color flow Doppler in this baby revealed no cardiac defects or patent ductus arteriousus 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 anastomsis 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 change to bundle 93325 with other pediatric cardiology echocardiography codes be implemented.

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Judith A. Becker, MD
Director of fetal echocardiography
Mass General Hospital for Children

Submitter : **Mr. George Benton** **Date: 08/13/2007**

Organization : **CRNA**

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,

George Benton, CRNA
1237 Brenner Drive
Nashville, TN 37221

Submitter : **Mrs. Allison Davis** **Date: 08/13/2007**

Organization : **Mrs. Allison Davis**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Date: 8/13/07

Re: CMS-1385-P

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,

Allison Davis PTA QB02118

Submitter : **Dr. Anthony Meluch** **Date: 08/13/2007**

Organization : **Dr. Anthony Meluch**

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

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

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

Thank you for your considcration of this serious matter.

Sincerely,

Anthony M. Meluch MD

Submitter : **Mr. Terrance Kuper** **Date: 08/13/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

August 13, 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

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" This proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
" CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services.
" 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).

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Sincerely,

Terrance L. Kuper CRNA PA
211 Sommersby Dr.
Jackson, TN 38305
731-668-6036

Submitter : Dr. Linda Calhoun **Date:** 08/13/2007

Organization : WIlmington Cardiology, PLLC

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am very concerned regarding current plans to bundle color flow doppler with the other echo base codes. I am a practicing cardiologist with particular interests in valvular heart disease, and congestive heart failure. I have great appreciation to what a good color flow doppler study adds to my management of patients. This study requires the highest level of skill by the sonographer, and a very high level of expertise by the echo reader. It is not done with every study, and the intensity and depth to which it is done in patients with murmurs, heart failure, valvular heart disease leads to important considerations regarding medications, surgery,prognosis. I have sent my sonographer for additional courses, and have attended additional courses myself to keep on top of imaging techniques and guidelines for diagnosis and management in valvular heart disease to make sure we are performing useful,high quality studies, and the absence of a good quality color flow doppler study could lead to invalid diagnoses, and improper treatment of the disease. A color flow study done for valvular heart disease might add an additional 20 min to an imaging study, and certainly increases my workload for interpreting the study. This proposal ignores the additional practice expense,sonographer work, and physician workload involved. Underpayment for this service would possibly lead to swiftly done, poor quality studies due to need for more numerous studies to pay for the cost of the expensive, high quality echo machines required to perform high quality echo studies. Poor reimbursement would also lead to physician disincentives for reading such necessary studies in a quality fashion(noninvasive cardiology) for more expensive,invasive procedures such as cardiac catheterization. I believe that you get what you pay for.
Reimbursement has been unfairly rachetted down for echocardiography eventhough this has clearly been one of the most useful, relatively low cost studies in cardiology, especially with congestive heart failure and valvular heart disease, which are clearly increasingly more prevalent in our aging population.
Please refrain eliminating payment for color flow doppler studies.

Sincerely,
Linda P. Calhoun MD

Submitter : Dr. Douglas Groswald **Date:** 08/13/2007

Organization : Anesthesia Consultants of Indianapolis

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#5748

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

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

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

Submitter : Mr. Scott Cole **Date:** 08/13/2007

Organization : Mr. Scott Cole

Category : Other Technician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am a cardiac sonographer from Indianapolis. The use of color doppler is an important tool when performing an echocardiogram. Not only does it add more time to the technical component of a study but it also adds much more time to the professional or the reading of said echocardiogram. Not all patients require this modality during a regular 2D echocardiogram, but when ordered it is an invaluable tool that greatly aids in the treatment of the patient. Please reconsider any code changes to this very useful tool.

Sincerely,

Scott A. Cole, R.D.C.S.
Director, Mobile Echo
The Care Group, L.L.C.

Submitter : **Dr. Eric Saunders** **Date: 08/13/2007**

Organization : **Anesthesia Consultants of Knoxville**

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

Thank you for your consideration of this serious matter.

Sincerely,

Eric J. Saunders, M.D.
Anesthesia Consultants of Knoxville

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

Organization :

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

As a doctor of chiropractic and Medicare provider, I am gravely concerned that if senior patients are not reimbursed for necessary x-ray studies determined necessary and ordered through a radiologist, it is the same as it not being able to order these x-ray studies at all. I am afraid that given fixed incomes and limited resources, these seniors may choose to forgo x-rays and thus needed treatment.

Submitter : **Dr. Tom Tu** **Date: 08/13/2007**

Organization : **Upland 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

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

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

Organization : **American Society of Anesthesiologists**

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. stan abshier** **Date: 08/13/2007**

Organization : **Dr. stan abshier**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am very pleased that Medicare is finally attempting to correct the harsh treatment of anesthesia reimbursement under the original RVRVS.

Submitter : **Dr. Ryan McQuillan** **Date: 08/13/2007**

Organization : **ACI (Anesthesia Consultants of Indianapolis)**

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,

Dr. Ryan J McQuillan

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

Organization : **rebecca freese**

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 : Mrs. Molly Wright **Date:** 08/13/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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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).

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Submitter : **Dr. Ali Fahimi** **Date: 08/13/2007**

Organization : **Dr. Ali Fahimi**

Category : **Health Care Professional or Association**

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. CMS risks wholesale loss of care for medicare recipients if this disparity of payments continues.

Thank you for your consideration of this serious matter.

Sincerely,

Ali Fahimi, M.D.

Submitter : **Dr. Laurence Skolnik** **Date: 08/13/2007**

Organization : **Sheridan Healthcare 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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Laurence Skolnik, MD

Submitter : **Mr. David Klappholz** **Date: 08/14/2007**

Organization : **AANA**

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

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? 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,

David Klappholz CRNA, MSN

12804 Pecos Rd.
Knoxville, TN 37934

Submitter : Dr. Edward Lucente **Date:** 08/14/2007

Organization : Anesthesia Services P.A.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#5761

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

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

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

Submitter : **Date: 08/14/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

attachment

CMS-1385-P-5762-Attach-1.TXT

#5762

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. Edward Lucente **Date:** 08/14/2007

Organization : Anesthesia Services P.A.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5763-Attach-1.DOC

#5763

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 : Mr. Scott Leigh **Date:** 08/14/2007

Organization : The Care Group, LLC.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Our practice opposes the "bundling" of color flow doppler with the 2D echo. We do not routinely perform color flow with each echo. When we do, there is additional time spent by the technologist and the physician that is measureable. Bundling color flow into the standard echo would be an inappropriate payment for the service provided.

Submitter : **Mr. Brad Perry** **Date: 08/14/2007**

Organization : **Kingwood Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Date:8/14/2007

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 nccessary medical care.

Sincerely,

Brad Perry, PT, MS

Submitter : **Dr. Douglas Luxenberg** **Date: 08/14/2007**

Organization : **Pediatric Cardiology of Long Island**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

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

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

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

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

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,

Douglas Luxenberg, D.O.
Pediatric Cardiology of Long Island

Submitter : **Dr. Brian Soriano** **Date: 08/14/2007**

Organization : **Children's Hospital Boston**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re: CODING--ADDITIONAL CODES FROM 5-YEAR REVIEW. Federal register citation is 72 Federal Register 38122 (July 12, 2007). Please refrain from bundling 'color flow Doppler' into other codes. This proposal ignores the additional time and effort of both the sonographer performing the study, as well as the physician involved in the interpretation. Such efforts should be recognized.

Brian Soriano, M.D.
Pediatric Cardiology Fellow
Boston, MA

Submitter : Dr. Steven Ford **Date:** 08/14/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please make the needed increase in payment for Anesthesia the Medicare program is considering. This is definitely needed because of the severe under payment currently in place for Anesthesia care. Thanks, Steven Ford,M.D.

Submitter : Mr. Todd Rossi **Date:** 08/14/2007

Organization : Action Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5769-Attach-1.DOC

Submitter : Dr. Alex Fraser **Date:** 08/14/2007

Organization : U. Iowa Health Care

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

When I started the private practice of anesthesiology in 1973 the unit value reimbursement for anesthesia was over $30. Since then the value of the dollar is a fraction of what it was then. The governments practice of cutting anesthesiologists fees to such levels is immoral, particularly fully knowing that most anesthesiologists can n?t or will not withh?ld their services.

Submitter : Ms. Tara Claiborne **Date:** 08/14/2007

Organization : Quad City Physical Therapy

Category : Individual

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

See Attachment

CMS-1385-P-5771-Attach-1.DOC

#5771

August 14, 2007

Re: CMS-1385-P

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,

Tara Claiborne
Business Office manager
Quad City Physical Therapy & Spine

Submitter : **Dr. Dale Ostrander** **Date: 08/14/2007**

Organization : **Dr. Dale Ostrander**

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.

Dale P. Ostrander, MD
Associated Anesthesiologists of Decatur
Decatur Memorial Hospital
Decatur, IL

Submitter : **Mrs. Linda Ostrander** **Date: 08/14/2007**

Organization : **Mrs. Linda Ostrander**

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

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Thank you for your consideration of this serious matter.

Linda A. Ostrander

Submitter : **Mr. Jerry Valentine** **Date: 08/14/2007**

Organization : **RiverWest Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

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Sincerely,

Jerry Valentine PT Partner/Director

Submitter : Mrs. Melissa Whitaker **Date:** 08/14/2007

Organization : Green Oaks Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Dr. Walter Chang** **Date: 08/14/2007**

Organization : **City of Hope National 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
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Thank you for your consideration of this serious matter.

Submitter : **Dr. ali afrassiabi** **Date: 08/14/2007**

Organization : **cedar medical specialties**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Maurice Gross** **Date: 08/14/2007**

Organization : **Peninsula Anesthesia 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

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