

Submitter : Dr. Kirk Hansen
Organization : Anesthesiology Assoc. of Wisconsin
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Date: 08/14/2007

Issue Areas/Comments

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Thank you for your consideration of this serious matter.

Submitter : Mr. John Dennis
Organization : Physical Therapy at Dawn
Category : Physical Therapist

Date: 08/14/2007

Issue Areas/Comments

GENERAL

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August 14, 2007

To Whom it May Concern,

I am very concerned about the proposed cuts in Medicare reimbursement.

Costs for providing service to Medicare patients are increasing. For example, our clinic experienced an 11% increase in health insurance rates for our employees and a roughly 7% increase in lease rates.

If one combines these increases with the 2-3% cost of living increase in salary I try to provide yearly, it becomes clear that the proposed 9.9% reduction in the 2008 fee schedule would be ruinous to providers and result in diminished provider participation in the Medicare program, to the detriment of Medicare beneficiaries.

It has been a pleasure for our clinic to provide high quality services to Medicare beneficiaries. I do not see how we will be able to continue to do so if reimbursement is diminished at all, much less 9.9%. In fact, holding the 2007 schedule rates is an effective reimbursement cut relative to increasing costs of providing care.

Please resist any cuts in the Medicare reimbursement schedule and push for increased reimbursement at least consistent with inflation.

Thank you in advance for your attention to this matter.

Respectfully,

John P. Dennis, Jr., PT OCS
Physical Therapy at Dawn
600 Central Ave. SE, Ste. D
Albuquerque, NM 87102
johnd@physicaltherapyatdawn.com
Phone: 505 242-2294
Fax: 505 242-2917

Submitter : Dr. Teresa Duty

Date: 08/14/2007

Organization : Rocky Mountain Orthopedic

Category : Physical Therapist

Issue Areas/Comments

**Payment For Procedures And
Services Provided In ASCs**

Payment For Procedures And Services Provided In ASCs

Please abolish the proposal for a 9.9% reduction in physical therapy fee schedule. We operate in rural New Mexico with most of our patients having medicare. If the 9.9% reduction passes, we will have to close our clinic, and the area will not be served. Thank you for your consideration.

Submitter : Mr. Tristan North
Organization : American Ambulance Association
Category : Health Care Provider/Association

Date: 08/14/2007

Issue Areas/Comments

Ambulance Services

Ambulance Services

See Attachment

CMS-1385-P-5782-Attach-1.DOC

#5782



American Ambulance Association
8201 Greensboro Drive, Suite 300
McLean, Virginia 22102
Phone: (703) 610-9018
Fax: (703) 610-9005
Website: www.the-aaa.org

"The American Ambulance Association promotes health care policies that ensure excellence in the ambulance service industry and provides research, education, and communications programs to enable members to effectively address the needs of the communities they serve."

August 13, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1541-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions.

Dear Ms. Norwalk:

The American Ambulance Association (AAA) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions" (the "Proposed Rule"), 72 Fed. Reg. 38122 (July 12, 2007).

The American Ambulance Association is the primary trade association representing ambulance service providers that participate in serving communities with emergency and non-emergency ambulance services. The AAA is composed of more than 600 ambulance operations and has members in every state. AAA members include private, public and fire and hospital-based providers covering urban, suburban and rural areas. The AAA was formed in 1979 in response to the need for improvements in medical transportation and emergency medical services. The Association serves as a voice and clearinghouse for ambulance service providers who view pre-hospital care not only as a public service but also as an essential part of the total public health care system. The comments submitted herein are on behalf of our members.

BENEFICIARY SIGNATURE

The AAA commends CMS for recognizing that providers and suppliers of emergency ambulance transportation face significant hardships in seeking to comply with the beneficiary signature requirements of 42 C.F.R. §424.36. Ambulance services are atypical among Medicare covered services to the extent that, for a large percentage of encounters, the beneficiary is not in a condition to sign a claims authorization during the entire time the supplier is treating and/or transporting the beneficiary. Many beneficiaries are in physical distress, unconscious, or of diminished mental capacity due to age or illness. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

However, the AAA believes strongly that the relief being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and on the hospitals. Accordingly, we urge CMS to abandon this approach, and to instead eliminate the beneficiary signature requirement for ambulance services entirely.

Current Requirement

When the beneficiary is physically or mentally incapable of signing, the industry has been following the requirements listed in the CMS Internet Only Manual, Pub. 100-02, Chapter 10, Section 20.1.2 and Pub. 100-04, Chapter 1, Section 50.1.6(A)(3)(c). These sections require the ambulance provider or supplier to document that the beneficiary was unable to sign, the reason and that no one could sign for the beneficiary.

Summary of New Exception Contained in Proposed Rule

The Proposed Rule would create a new exception to the beneficiary signature requirements for emergency ambulance transport services. Under this exception, an ambulance provider would be permitted to submit a claim to Medicare for payment without the beneficiary's signature provided each of the following conditions was met:

1. The beneficiary was physically or mentally incapable of signing the claim at the time of service;
2. None of the individuals listed in 42 C.F.R. §424.36(b)(1) – (5) was available or willing to sign the claim on the beneficiary's behalf at the time the service was provided; and
3. The ambulance provider maintains specific information and documentation for at least 4 years from the date of service. The required information and documentation includes:
 - a. A contemporaneous statement from an ambulance employee present during the transport, stating that the beneficiary was physically or mentally incapable of signing, and that no other authorized person was available or willing to sign the claim on the beneficiary's behalf.

- b. Documentation providing the date and time of the transport, and the name and location of the receiving facility.
- c. A contemporaneous statement from a representative of the receiving facility, which documents the name of the beneficiary and the date and time the beneficiary was received by that facility.

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. If "provider" in this context was intended to mean a facility or entity that bills a Part A Intermediary, the language should be changed to also include "ambulance supplier". The proposed exception essentially mirrors the existing requirements that the beneficiary be unable to sign and that no authorized person was available or willing to sign on their behalf, while adding additional documentation requirements.

Therefore, we believe that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed subdivision (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, the AAA does not object to the requirements that an ambulance provider obtain (1) a contemporaneous statement by the ambulance employee or (2) documentation of the date, time and destination of the transport. Nor do we object to the requirement that these items be maintained for 4 years from the date of service. However, we do not see any reason to include these in the Regulation, as they are already required and standard practice.

The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. The American Ambulance Association **strongly objects** to this new requirement as:

- Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.
- Hospital personnel will often refuse to sign any forms when receiving a patient.
- If the hospital refuses to sign the form, it will be the beneficiary that will be responsible for the claim.
- The ambulance provider or supplier would in every situation now have the additional burden in trying to communicate to the beneficiary or their family,

- at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.
- Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ER Admitting Record, etc.

The AAA also strongly objects to the requirement that ambulance providers or suppliers obtain this statement from a representative of the receiving facility *at the time of transport*. Since the proposed rule makes no allowances for the inevitable situations where the ambulance provider makes a good faith effort to comply, but is ultimately unable to obtain the statement, we believe this requirement imposes an excessive compliance burden on ambulance providers and on the receiving hospitals. Consider what this rule requires—the ambulance has just taken an emergency patient to the ER, often overcrowded with patients, and would have to ask the receiving hospital to take precious time away from patient care to sign or provide a form. Forms such as an admission record will become available at a later time, if CMS wants them for auditing purposes.

Institute of Medicine Report on Hospital Emergency Department Overcrowding

The Institute of Medicine Committee on the Future of Emergency Care recently released a report citing hospital emergency department overcrowding as one of the biggest issues in emergency health care. According to that report, demand on hospital emergency departments (EDs) increased by 26% between 1993 and 2003. During that same period, the number of EDs fell by 425. Combined with a similar decrease in the number of inpatient hospital beds, this has resulted in serious overcrowding of our nation's ED. A further consequence has been a marked increase in the number of ambulance diversions, with 50% of all hospitals—and nearly 70% of urban hospitals—reporting that they diverted ambulances carrying emergency patients to a more distant hospital at some point during 2003.

The report recommended that hospitals find ways to improve efficiency in order to reduce ED overcrowding. However, the requirement that ambulance providers or suppliers obtain a statement from a representative of the receiving hospital at the time of transport would only compound the existing problem, by adding an additional paperwork burden. To meet this requirement, ambulance crews would be forced to tie up already overtaxed ED staff with requests for this statement. The Institute of Medicine report makes clear that this time would be more efficiently spent moving patients through the patient care continuum.

Difficulty in Obtaining Hospital Records

The PCS requirement is an excellent analogy for the difficulty ambulance providers and suppliers have in obtaining forms signed by facilities, and how CMS has adopted acceptable alternatives.

Medicare requires ambulance providers and suppliers to obtain a physician certification statement (PCS) from the facility for most non-emergency transports. CMS understood the problem experienced in trying to obtain PCS forms – and that was for non-emergencies. For non-repetitive patients, Medicare regulations provide the ambulance provider with up to 21 days *after* the date of transport to obtain this PCS. Where the ambulance provider is unable to obtain the PCS within this extended period of time, the regulations still permit a claim to be submitted, provided the ambulance provider documented its attempts to obtain the PCS and uses the alternative permitted, i.e. proof of the attempt to obtain the PCS, e.g. by Certified Mail or Proof of Mailing.

In other words, Medicare regulations recognize that obtaining the PCS is, to some extent, outside the control of the ambulance provider, and, accordingly, permit claims to be submitted so long as the ambulance provider takes reasonable steps to comply with the PCS requirement. We believe that, at a minimum, a similar exception should apply to medical emergencies. Treatment and care of the beneficiary should be the overriding focus of all parties, not another form signed by already overburdened ER personnel.

Purpose of Beneficiary Signature

a. Assignment of Benefits – The signature of the beneficiary is required for two reasons. The first purpose of the beneficiary signature is to authorize the assignment of Medicare benefits to the health care provider or supplier. However, assignment of covered ambulance services has been mandatory since April 2002. Furthermore, 42 C.F.R. §424.55(c), adopted November 15, 2004 as part of the Final Rule on the Physician Fee Schedule (67 Fed. Reg. 6236), eliminated the requirement that beneficiaries assign claims to the health care provider or supplier in those situations where payment can only be made on an assignment-related basis. Therefore, the beneficiary's signature is no longer required to effect an assignment of benefits to the ambulance provider or supplier.

CMS recognized this in the Internet Only Manual via Transmittal 643, by adding Section 30.3.2 to Pub. 100-04, Chapter 1. As a result, the beneficiary signature is no longer needed to assign benefits of covered ambulance services.

b. Authorization to Release Records – The second purpose of the beneficiary signature is to authorize the release of medical records to CMS and its contractors. However, the regulations implementing the HIPAA Privacy Rule, specifically 45 C.F.R. §164.506(c)(3), permit a covered entity (e.g. an ambulance provider or supplier) to use or disclose a patient's protected health information for the covered entity's payment purposes, without a patient's consent (i.e. his or her signature). Therefore, federal law already permits the disclosure of medical records to CMS or its contractors, regardless of whether or not the beneficiary's signature has been obtained.

Signature Already on File

Almost every covered ambulance transport is to or from a facility, i.e. a hospital or a skilled nursing facility. In the case of emergency ambulance transports, the ultimate

destination will always be a hospital. These facilities typically obtain the beneficiary's signature at the time of admission, authorizing the release of medical records for their services or any related services. The term "related services", when used by hospitals and SNFs, can mean more than only entities owned by or part of the facility. We believe that ambulance transport to a facility, for the purpose of receiving treatment or care at that facility, constitutes a "related service", since the ambulance transports the patient to or from that facility for treatment or admission. Therefore, we believe a valid signature will be on file with the facility. Additionally, for those transports provided to patients eligible for both Medicare and Medicaid, a valid signature is on file at the State Medicaid Office as a product of the beneficiary enrollment process.

Electronic Claims

It is also important to note that, as a result of section 3 of the Administrative Simplification Compliance Act and the implementing regulations at 42 C.F.R. §424.32, with very limited exceptions (e.g. providers or suppliers with less than 10 claims per month), ambulance suppliers must submit claims electronically. Thus, the beneficiary does not even sign a claim form. When submitting claims electronically, the choices for beneficiary signature are "Y" or "N". An "N" response could result in a denial, from some Carriers. That would require appeals to show that, while the signature has not been obtained, an alternative is accepted. As a result, many Carriers allow a "Y", even though the signature was not actually obtained, if one of the exceptions is met.

While this may be a claims processing issue, since you are now looking at the regulation, this would be a good time to add language indicating that the signature requirement will be deemed to be met if one of the exceptions to the requirement exists.

Program Integrity

It is important for CMS to realize that, for every transport of a Medicare beneficiary, the ambulance crew completes a trip report listing the condition of the patient, treatment, origin/destination, etc. AND the origin and destination facilities complete their own records documenting the patient was sent via ambulance or arrived via ambulance, with the date.

Thus, the issue of the beneficiary signature should not be a program integrity issue.

Conclusion

Based on the above comments, it is respectfully requested that CMS:

- Amend 42 C.F.R. §424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that "good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not

sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported”.

- Amend 42 C.F.R. §424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
- Amend 42 C.F.R. §424.36(b) (5) to add “or ambulance provider or supplier” after “provider”.

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

AMBULANCE SERVICES – AMBULANCE INFLATION FACTOR

The AAA has no objection to CMS’ proposal to revise 42 C.F.R §414.620 to eliminate the requirement that annual updates to the Ambulance Inflation Factor be published in the Federal Register, and to thereafter provide for the release of the Ambulance Inflation Factor via CMS instruction and the CMS website.

Thank you for your consideration of these comments. If you or your staff should have any questions regarding our comments, please contact myself or Tristan North, AAA Senior Vice President of Government Affairs, at 703-610-9018.

Sincerely,

A handwritten signature in black ink, appearing to read "J. McPartlon", written in a cursive style.

Jim McPartlon
President

Submitter : Dr. Alphonsus Cheung
Organization : O'Connor Hospital
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Sincerely,

Al Cheung, M.D.
Diplomat, American Board of Anesthesiology

Submitter : Dr. BARRE BERNIER

Date: 08/14/2007

Organization : SAC

Category : Physician

Issue Areas/Comments

**Coding-- Additional Codes From
5-Year Review**

Coding-- Additional Codes From 5-Year Review

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Submitter : Dr. Brian Hershey
Organization : Dr. Brian Hershey
Category : Physician

Date: 08/14/2007

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Submitter :

Date: 08/14/2007

Organization :

Category : Physician

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Submitter : Mr. David Cloninger
Organization : Mr. David Cloninger
Category : Health Care Industry

Date: 08/14/2007

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Thank you for your consideration.
David Cloninger

Submitter : Ms. Kendra Ostrander
Organization : Ms. Kendra Ostrander
Category : Individual

Date: 08/14/2007

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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.

Kendra Ostrander

Submitter :

Date: 08/14/2007

Organization :

Category : Physician

Issue Areas/Comments

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GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. bobbi tucker
Organization : cardiology pc
Category : Private Industry

Date: 08/14/2007

Issue Areas/Comments

**Coding-- Additional Codes From
5-Year Review**

Coding-- Additional Codes From 5-Year Review

a transthoracic echocardiogram must be done in a accredited lab and must be interpreted by a physician who is in the quality assurance program, and must have alevel II training or equivalent. A certified sonographer must do the study.

Submitter : Dr. Thomas Sinclair

Date: 08/14/2007

Organization : Dr. Thomas Sinclair

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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Although this letter is a copy taken from the California Society of Anesthesiologists web site, it does express my sentiments exactly. A lot of experience, education, and training goes into the ability to handle the often critical nature of the problems our seniors present to us in the operating room. The current Medicare unit value for our local area is about \$17.50, which comes to \$70 an hour. Though I do not wish to disparage the work of others, I do find it incongruous that local TV service repairmen and auto mechanics charge more than what we currently receive on an hourly basis from Medicare.

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

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

Respectfully,

Thomas Sinclair, M.D.

Submitter : Chelsea Ostrander
Organization : Chelsea Ostrander
Category : Individual

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore, MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Chelsea Ostrander

Submitter : Dr. Kurt Dittmar
Organization : Dr. Kurt Dittmar
Category : Individual

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Submitter : Pam Jinks
Organization : Hands On Theray
Category : Occupational Therapist

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

I am writing this letter to express my concern regarding the proposed Medicare Physician Fee Schedule revision that will dramatically affect the reimbursement of physical and occupational therapy services provided to medicare beneficiaries in my community.

The proposed method for reduction in payment will result in lack of patient access to necessary medical rehabilitation which helps prevent higher cost interventions such as surgery and/or long term inpatient care.

I understand that the AMA, APTA and AOTA, 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,

Pamela Jinks

Submitter : Ms. Gretchen Seif
Organization : Ms. Gretchen Seif
Category : Physical Therapist

Date: 08/14/2007

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

As a concerned member of the physical therapy profession and the American Physical Therapy Association, I am writing to urge you to take action to prevent the implementation of policies that would severely impact rehabilitation coverage for Medicare beneficiaries. In less than 6 months, physical therapists providing their care are facing payment cuts of nearly 10% due to the changes in the Medicare physician fee schedule.

The profession's ability to treat Medicare patients will also be severely limited if the proposed cuts in payments under the 2008 Medicare physician fee schedule go into effect as scheduled on January 1. The past two years Congress has blocked payment cuts determined by the flawed "sustainable growth rate" formula. While Congress froze 2006 and 2007 payments to prevent the cuts, the cost of providing patient care has increased. Now providers are again faced with the possibility of another 10% cut in 2008. The impact of this policy will severely inhibit the ability of the profession to provide patient care to Medicare beneficiaries without going out of business.

I realize that Medicare needs to be reformed, but allowing these serious cuts to providers demand your immediate action to protect beneficiaries' access to care.

Thank you for your time,

Gretchen A. Seif, PT, MHS, OCS, FAAOMPT
Rehabilitation Centers of Charleston
2881 Tricom Street
North Charleston, SC 29406
(843) 824-2183

Submitter : Dr. Peter Panzica

Date: 08/14/2007

Organization : Beth Israel Deaconess Medical Center-Boston

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 an anesthesiologist who teaches residents in anesthesia training. We cannot sustain quality academic anesthesiologists with the current CMS reimbursement. We are taking care of the nations elderly, which happen to be some of our sickest patients at a financial loss.

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Jonathan Nunley
Organization : Dr. Jonathan Nunley
Category : Physician

Date: 08/14/2007

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.

Jonathan Nunley MD

Submitter : Dr. Balachundhar Subramaniam
Organization : Beth Israel Deaconess Medical Center
Category : Academic

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Yours truly,
Bala

Submitter : Leslie Braun
Organization : Cleveland Clinic
Category : Other Practitioner

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

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

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Thank you for your consideration of this serious matter.

Submitter : Dr. Edward Hendricks

Date: 08/14/2007

Organization : Beth Israel - Deaconess Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I wholeheartedly agree with the Medicare Anesthesia payment increase. The proposed increase will help bring parity for anesthesia services rendered to our patient population.

Submitter : Dr.
Organization : Dr.
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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.

Submitter : LaDonna O'Brien

Date: 08/14/2007

Organization : Ozark Anesthesia Associates, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : Dr. Paul Krummen
Organization : Cleveland Clinic
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

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

Sincerely,

Paul J. Krummen MD MHA

Submitter : Dr. Noel Zweig

Date: 08/14/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1385-P-5806-Attach-1.DOC

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.

Noel Zweig M.D.
Chairman, Department of Anesthesiology
Central DuPage Hospital
25 N. Winfield Rd.
Winfield, IL 60190

Submitter : Dr. Kaylyn Krummen

Date: 08/14/2007

Organization : Cleveland Clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. baroukh levi
Organization : Dr. baroukh levi
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Attention: CMS-1385-P
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Baltimore, MD 21244-8018

Re: CMS-1385-P

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CMS-1385-P-5808

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 2124

Submitter : Dr. James Klamik
Organization : Dr. James Klamik
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

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

Rc: 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 : Dr. JONATHAN WYATT MD
Organization : MIDWEST ANESTHESILOGISTS LTD
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Submitter : Dr. michael hruskocy
Organization : Dr. michael hruskocy
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Mr. Michael Oleyar
Organization : Michigan State University
Category : Individual

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

Michael J Oleyar

Second Year Medical Student
(810) 523-8153

Submitter : Jason Bartlett
Organization : Action Physical Therapy - Bellaire
Category : Physical Therapist

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5813-Attach-1.DOC

Action Physical Therapy

Date: August 14th, 2007

Re: CMS-1385-P

Dear CMS Representative:

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

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

I understand that the American Medical Association, the American Physical Therapy Association and the American Occupational Therapy Association, as well as other organizations are preparing an alternative solution and preserve these patients' right to adequate and necessary medical care.

Sincerely,

Jason Bartlett, PT

Submitter : Dr. Gary Guglielmino
Organization : Dr. Gary Guglielmino
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Dr. Bruce Van Dop
Organization : Interventional Pain Care LLC
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Sincerely,

Bruce A. Van Dop, D.O., M.S.
7120 Trillium Trail
Pendleton, IN 46064

Submitter : Dr. Leisa De Venny
Organization : American Society of Anesthesiologist
Category : Physician

Date: 08/14/2007

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.

Leisa W. DeVenny M.D.
Board Certified Anesthesiologist
Tuscaloosa, AL

Submitter : Mrs. Sonia Perinovic
Organization : OUHSC Dept. of Anesthesiology
Category : Individual

Date: 08/14/2007

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.

Sonia G. Perinovic

Submitter : Dr. Howard Duncan
Organization : American Society of Anesthesiologists
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

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

Submitter : Dr. Debra Pulley
Organization : Washington University Dept of Anesthesiology
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

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August 14, 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
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Thank you for your consideration of this serious matter.

Debra Pulley, MD
Washington University Dept of Anesthesiology

Submitter : Dr. Patrick Moore
Organization : Shannon Health System
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

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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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Submitter : Dr. Gregg Lobel
Organization : American Society of Anesthesiologists
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Gregg Lobel MD
22 Donnybrook Drive
Demarest, NJ 07627

Submitter : Mrs. Elizabeth de Herder
Organization : Mrs. Elizabeth de Herder
Category : Occupational Therapist

Date: 08/14/2007

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am opposed to the physician owned practices. As a therapist that has worked in an out-patient hospital setting and in private practice I have seen that physicians that own their own therapist increase in referrals due to the increase in reimbursement. If this is better controlled, the physicians would not profit from therapy and there would be a better check and balance between the therapist and physician. The physician would not refer for unnecessary treatment and the therapist could not perform excess treatment until approved by the physicians that does not make a profit, but only wants the patient to return to full function. I have seen abuses both ways, and by having separate practices Medicare wins by cost and patients that require treatment receive the treatment. Also, it has come to my attention that a nurse or tech can perform rehab services through the physician and the physician can bill for the codes and get paid. This lowers the standard of care given to the Medicare beneficiary. Please help to provide the best care for you patients keep the physicians from profiting from extra services.

Submitter : Dr. Christ Stoyanovich
Organization : BiCounty Anesthesiologists,PC
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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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Christ Stoyanovich

Submitter : Dr. Celia Groenhout
Organization : Dr. Celia Groenhout
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

August 1, 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

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Thank you for your consideration of this important matter.

Celia Groenhout, MD

Submitter : Dr. Donald Bernardini
Organization : Beth Israel Deaconess Medical Center
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

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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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Sincerely,

Donald J. Bernardini, MD
Resident in Anesthesiology
Beth Israel Deaconess Medical Center
Harvard Medical School
Boston, MA 02115

Submitter : Dr. James Manyak
Organization : Dr. James Manyak
Category : Physician

Date: 08/14/2007

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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Sincerely,

James D. Manyak, M.D.

Submitter : Dr. John Gainey
Organization : Medical Anesthesia Consultants, Inc.
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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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. Adam Lerner
Organization : Dr. Adam Lerner
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Adam B. Lerner, MD

Submitter : Dr. carlos kurek
Organization : Dr. carlos kurek
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

Background

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Acting Administrator
Centers for Medicare and Medicaid Services
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Submitter : Dr. Luisa Kurek-Lenoble
Organization : Dr. Luisa Kurek-Lenoble
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

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Submitter :

Date: 08/14/2007

Organization :

Category : Ambulatory Surgical Center

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Baltimore, MD 21244-8018

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Submitter : Dr. Don Arnold
Organization : St. John's Mercy Medical Center
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Donald E. Arnold, M.D.
St. Louis, Missouri

Submitter : Dr. Jocelyn McClain

Date: 08/14/2007

Organization : Dr. Jocelyn McClain

Category : Physician

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : Mrs. Michele Yann

Date: 08/14/2007

Organization : CARILION ROANOKE MEMORIAL HOSPITAL

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

This is in regards to bundling of echo charges. I am an RN and registered cardiac sonographer. Not all echo studies use color. If a physician is looking for function sometimes 2D is only required. Color doppler is very technical and can be difficult to determine especially to the untrained eye. It takes expertise and time for both the sonographer and the interpreting physician. This should not be bundled in the charges as it is quite specific in determining various regurgitant or stenotic lesions on the cardiac valves as well as determining shunting of blood that is abnormal in it's flow.

Submitter : Dr. Keith Rathel

Date: 08/14/2007

Organization : Comprehensive Anesthesia Services

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to you to express my support for increased payment under the proposed rules to fund Anesthesia services for Medicare recipients. Currently Anesthesia services are under valued and this will severely impact the ability of senior citizens to obtain quality medical care.

Submitter : Dr. Michael Hammen
Organization : Dr. Michael Hammen
Category : Physician

Date: 08/14/2007

Issue Areas/Comments

GENERAL

GENERAL

August 14, 2007

Michael J. Hammen, M.D.
1820 28th St. SE
Puyallup, WA 98372

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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This also creates a disincentive for anesthesiologists to provide care within tertiary hospitals that serve the most critically ill patients which tend to also be disproportionately older seniors covered by Medicare.

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Thank you for your consideration of this serious matter.

Sincerely,

Michael J. Hammen, M.D.

CMS-1385-P-5836-Attach-1.DOC

August 14, 2007

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1820 28th St. SE
Puyallup, WA 98372

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,

Michael J. Hammen, M.D.

Submitter : Dr. William K Harper MD

Date: 08/14/2007

Organization : Hinds Cardiology Clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS has proposed 'bundling color flow doppler into all the other echo base codes.'

This is liken to saying that we will not pay for the landscaping around the building under construction because it is all part of the new facility. . . Color flow doppler is time consuming for my sonographer and adds significantly to the data that must be both acquired and interpreted. Please do not bundle this service.
William K Harper MD FACC

Submitter : Dr. Michael Hannan

Date: 08/14/2007

Organization : Member ASA

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

We have been undervalued as physicians for years with the Medicare and Medicaid programs, I am reimbursed less than half what a plumber makes an hour. What kind of care do you think a plumber could provide an elderly 90 year old patient. Plumbers are not required to carry malpractice insurance, get out of bed to save a life at 4:00 in the morning and yet they can charge and get paid almost twice what Medicare pays me an hour.

Please consider and pass the legislation to improve Physician reimbursement for Medicare patients before physicians reduce even further their participation in caring for the nations elderly, due to low reimbursement and lack of training facilities.

Submitter : Dr. Frederick J McKibben, M.D.

Date: 08/14/2007

Organization : Dr. Frederick J McKibben, M.D.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
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.