Submitter : **Maricela Kolbeson** **Date: 08/17/2007**

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.
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Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Maricela Kolbeson
ADN, BSN, CCRN, SRNA
P.O. Box 63087
Memphis, TN 38163

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a licensed physical therapist for nearly 20 years. I have wittnessed the proliferation of physician self referral patterns. The obvious defense to self-referral is continuity of care and convenience however these determinants are over stated. As with surgical center ownership, surgeon's benefit financially by the self-referral situation. I personally have friends who are surgeons who speak of the financial benefit and question whether the legal/ethical principals are worthy. I urge the legislative action to limit self-referral specifically for physical therapy service. The Stark legislation should be enforced to it's primary purpose and this potiential fraud/abuse of the payor system limited to its legal extent.

Submitter : Dr. Craig Ramsdell **Date:** 08/17/2007

Organization : South Oakland Anesthesia Associates, PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Craig D. Ramsdell, M.D.

Submitter : **Ms. Andrea Belcher** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Provider**

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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Sincerely,
_____Andrea D. BElcher, SRNA_____
Name & Credential
__3960 bell RD 942_____
Address
__Hermitage, TN, 37076_____
City, State ZIP

Submitter : Mr. James Milder **Date:** 08/17/2007

Organization : Mr. James Milder

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician self referral has been recognized as an abusive conflict of interest for many years. The Stark legislation of the early 1990s recognized the abuse and attempted to address the problem. Exceptions for therapy services provided in-office and now through centralized billing have undermined the legislative intent of Stark. Many have noted recent dramatic increases in utilization of health care services including physical therapy. These increases are noted to be far in excess of proportional increased need of an aging population. One obvious, an often ignored, explanation is physician self referral. There has been an explosion of physician owned physical therapy services in the past 36 months.

I practice in a suburb of Chicago when we opened 7 years ago we were the first physical therapy clinic in the area. Two additional small independent clinics joined us in the first few years after we opened. Those three clinics provided more than enough physical therapy services for the area. Last summer three large physician owned physical therapy clinics opened, two belonging to orthopedic surgery practices and one to a multi-specialty practice. These new clinics tripled the number of physical therapists available in our community which has seen only moderate population growth over the last few years.

Each of those physician practices referred patients to our practice prior to opening their own clinics. Those same physicians professed completed confidence in our services and never voiced concerns about the quality of care provided. Each of the private clinics in our area would gladly have rented space from those physicians had there been a need to provide the services within the doctor s office building. Physicians claim convenience and quality are the motivation for physician owned physical therapy practices. The truth is that the motivation is profit from a captive audience facilitated by willing and apparently naive third party payors.

I urge you to remove physical therapy and occupational therapy from the list of Designated Health Services eligible for the in-office and centralized billing exceptions.

Submitter : **Mr. Michael Cragun** **Date: 08/17/2007**

Organization : **American Association of Nurse Anesthestists**

Category : **Other Health Care Professional**

Issue Areas/Comments

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August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,
Michael Cragun, CRNA
1389 N 70 E
American Fork, UT 84003

Submitter : Dr. SHAHID HUSSAIN **Date:** 08/17/2007

Organization : UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Joseph Talarico **Date:** 08/17/2007

Organization : University of Pittsburgh Medical Center

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

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

Submitter : **Mr. Giuseppe Galati** **Date: 08/17/2007**

Organization : **Mr. Giuseppe Galati**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
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Sincerely,

Giuseppe Galati
1238 Redbud St.
Jackson, MO 63755

Submitter : **Mr. David Nicholson** **Date: 08/17/2007**

Organization : **Mr. David Nicholson**

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)
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Sincerely,
David Nicholson, CRNA, MA
Albuquerque, NM

Submitter : **Ms. Jennifer Hammond** **Date: 08/17/2007**

Organization : **Ms. Jennifer Hammond**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a healthcare professional, I am concerned about the possibility of fraud and abuse that exists when physicians are able to refer Medicare beneficiaries to entities in which they have a personal financial interest. Physicians who are able to benefit financially from referring their patients to physical therapy, may make unnecessary referrals in order to increase their profits.

If physical therapy was not included as a DHS under the in-office ancillary services exception, overuse of medicare services may not be such an issue. Instead patient care would remain the main focus of healthcare.

In my profession, I have come across many patients who were referred to PT by their physician but were not allowed to choose their practicioner of choice. Instead they were referred to "in-house" care. Patients should have the right to choose and should not be influenced by a physician trying to benefit from financial gains.

Thank you for your consideration,

Jennifer Hammond, PT
Therapeutic Associates

Submitter : **Mr. James Richardson** **Date: 08/17/2007**

Organization : **Physiotherapy Corporation**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

It is simply wrong to allow physicians to refer patients to themselves. It encourages corruption and decreases quality of care, especially physical therapy. Anytime there is the potential for abuse of the system, it will occur when money is the ultimate driving force. The physician must refer based solely on patient need. Any other influences must be eliminated when identified. I have been a PT for 25 years and a blind man could see this is wrong.

Submitter : **Mr. Melvin Self** **Date: 08/17/2007**

Organization : **Mr. Melvin Self**

Category : **Other Practitioner**

Issue Areas/Comments

Background

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August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
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Sincerely,
Melvin Self, CRNA, MNA

Submitter : **Mrs. Rhoda Weerts** **Date: 08/17/2007**

Organization : **Mrs. Rhoda Weerts**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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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Sincerely,

___Rhoda Weerts, CRNA_____
Name & Credential
___951 Holly lane_____
Address
___Boca Raton, FL 33486_____
City, State ZIP

Submitter : **Dr. Dennis Kirsten** **Date: 08/17/2007**

Organization : **Dine Healthcare, P.C.**

Category : **Chiropractor**

Issue Areas/Comments

Impact

Impact

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

Re: TECHNICAL CORRECTIONS

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

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

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

I practice on the Navajo Nation Indian Reservation, my patients appreciate the care I can provide them. They are not in a position to afford additional expenses, which is exactly what this proposal would do.

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

Sincerely,

Dennis W. Kirsten, D.C.
Window Rock Chiropractic Clinic
Dine Healthcare, P.C.

Submitter : Mrs. Meagan Wells **Date:** 08/17/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 17, 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)
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Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Meagan Kennedy Wells, CRNA
266 Ridgepointe Dr
Cold Spring, KY 41076

Submitter : **Dr. sam anderson** **Date: 08/17/2007**

Organization : **partners**

Category : **Physician**

Issue Areas/Comments

Impact

Impact

Equity in reimbursement for physicians is paramount for ensuring the highest quality of patient care. Medicare reimbursement for anesthesia needs to match that of other specialties in teaching hospitals.

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

When the RBRVS was instituted, it created a huge payment disparity for 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,

Amir Littman, M.D.

Submitter : Dr. Kay Kirkpatrick **Date:** 08/17/2007

Organization : Dr. Kay Kirkpatrick

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would like to speak in favor of maintaining PT as an in-office ancillary service. As an orthopaedic hand surgeon, my patients need specialized therapy care. I work closely with our hand therapists and directly supervise them. The patients like the convenience, and I like the close follow-up and access to their records. When I send them to outside entities, I am not quite sure what they are going to get. I think the best and frequently least expensive care is that directly supervised by the ordering physician. For that reason, the in-office exception for PT should be maintained.

Submitter : **Date: 08/17/2007**

Organization :

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.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
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Sincerely,
_Charlotte Simmons _SRNA_____
Name & Credential
_1969 Walk Jones Place_____
Address
_Southaven, MS 38672_____
City, State ZIP

Submitter : **Dr. Elizabeth Kingsley** **Date: 08/17/2007**

Organization : **Cardiology Associates, PC**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

August 17, 2007

RE: CODING--ADDITIONAL CODES FROM 5-YEAR REVIEW

I am a board certified cardiologist practicing at Cardiology Associates, P.C., the largest and most comprehensive provider of cardiovascular care in Annapolis, on the eastern shore, in Bowie and in DC. I have been delivering state-of-the-art cardiovascular care since July 1984. Along with my colleagues, we continuously strive to provide the most technologically advanced diagnostics for our patients. I believe that the proposal to bundle reimbursement for color flow Doppler into the basic echocardiography examination is seriously misguided.

Historically color flow Doppler has provided significant additional information above that provided by 2D echo and Doppler technology alone. It traditionally has aided in the assessment of valvular lesions, directionality of cardiac flow, and was originally intended to visually quantify blood flow velocity in the heart and vascular systems. In recent years however, the use of Color Doppler in the assessment of cardiovascular abnormalities has become more complex and provides new and evolving tools for the noninvasive cardiologist. Now more than ever, it is being used to improve the assessment of more cardiovascular abnormalities seen on echo. The technology for the assessment of diastolic dysfunction is rapidly progressing and color flow mitral propagation velocity is just one example of a valuable, newer technique which requires specialized technologist training to perform and sub-specialized non-invasive cardiology training to interpret. PISA (proximal isovelocity surface area) is another example critical to the quantification of regurgitant and stenotic lesions. Obtaining accurate images is extremely operator dependent and requires extensive technologist training to perform these measurements accurately. It also requires additional training for those physicians who wish to interpret and utilize these results properly. Color Doppler has moved beyond simple visual analysis of regurgitation. This technology requires complex calculations from fluid dynamic equations, and a thorough understanding of it benefits and limitations to be used accurately.

For this reason, it is imperative that Doppler technology be a separate entity that cardiologists can rely on as we advance our ultrasound technology to aid in the correct diagnosis and management of cardiac diseases. As these subspecialty technologies evolve, physicians and technologists alike must continue to learn new skills, and elevate their level of training to match these advances. The fact that national CME courses exist in Echocardiography specifically designed to teach practicing cardiologists out of fellowship this technology speaks to the importance of this rapidly evolving field. The fact that ultrasound technologists also require specialized training to perform these examinations further confirms that color flow Doppler represents a distinct and valuable diagnostic entity.

Based on the aforementioned facts, I believe it is critical that color Doppler not be bundled with 2D echo reimbursement. It is a technology that requires additional training and expertise to perform and interpret and since it is not used in every study, and will not be part of the standard exam, it should continue to be reimbursed as a separate additional procedure that enhances the diagnostic utility of the basic echocardiographic exam.

Please feel free to contact me if I can provide any further clarification. Thank you for your consideration

Sincerely,

Elizabeth M. Kingsley, MD
Board Certified by the American College of Cardiology

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
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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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 : **Rebekah Robinson** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Practitioner**

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.
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Sincerely,
Rebekah Robinson,CRNA
3403 marsh hawk court
Wilmington, NC 28409

Submitter : al amato **Date:** 08/17/2007

Organization : al amato

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please remove Physical Therapy from in office ancillary services exclusion under Stark Ammendments. This is a fertile ground for fraud and abuse of the Medicare system by billing under PT codes for services not performed by PT and mostly modalities that are passive in nature and not requiring skilled services and are provided by unskilled office staff. Physicians are not even requireed to comply with regulations that other PT privders must adhere to, which leads to overuse and ineffectual care. Stop this abuse.

Submitter : **Mr. Darren Brown** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 17, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

Darren Brown, CRNA
3504 Stirling St.
Wichita Falls, TX 76310

Submitter : Mrs. Gwendolyn Zavarella **Date:** 08/17/2007

Organization : AANA

Category : Other Practitioner

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.
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Sincerely,
__Gwendolyn M Zavarella CRNA_____
Name & Credential
__9990 Cobblestone Dr_____
Address
___N. Huntingdon, PA, 15642_____
City, State ZIP

Submitter : Mr. D N **Date:** 08/17/2007

Organization : self

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Hello-
I am a registered Physical Therapist with 32 years of experience.
It has come to my attention that policymakers in Washington are reconsidering the option to remove physical therapy from the in-office ancillary services exception to the federal physician self-referral laws.
I am particularly interested in this issue because I have personally witnessed and experienced abuse in this area, as follows:
1) Working for a Physical Therapy group that had a rental and business agreement with a large orthopedic group, in which the physician billed for 'exclusively referred' Physical Therapy services and paid my employer a fee for the therapy staff. THe physician's group would refer exclusively to that group regardless of the patient's geopgraphic location. In this Physical Therapy practice, untrained Physical Therapy aides and trainers provide services that should be provided by a registered therapist, yet the Physician's group charges for therapy services as if a registered therapist provided the service.
2) ANother physician with a 'close relationship' with a physical therapy practice in Bay St Louis Mississippi who would intimidate his patients into receiving their therapy services from his associated Therapy group, not allowing them to receive therapy elsewhere.
3) A chiropractic group that utilized non-therapists to provide services, charged the services as Physical Therapy, and in fact used inappropriate codes in order to derive higher compensation.

I would prefer not to publish my name, as that may establish me as a 'whistleblower',and perhaps compromise my reputation and hinder my ability to seek further employment in a private practice setting. Physicians are my referral sources.

Sincerely

D.N., P.T.

Submitter : **Mr. Brian Miller** **Date: 08/17/2007**

Organization : **Mr. Brian Miller**

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.

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Sincerely,

Brian L Miller, CRNA
51 Old River rd
Lincoln, RI 02865

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physical therapy services should not be allowed under the in-office ancillary services exception, due to possibility of fraud and abuse. I've been to physicians offices personally who offered in their words "physical therapy services" in their office. Their facility included a small room with only an ultrasound machine, electric stimulation and maybe a stationary bike. These services are being performed by a none licensed person who is only working under the physician. Physicians are charging insurance companies all types of physical therapy treatments under their name and insurance companies are reimbursing them. This is illegal under APTA laws and regulations. I have personally heard patients complain of the "physical therapy" treatments they have received at their Doctor's offices and how they have exacerbated their conditions. This is truly nonsense and undermines our expertise in what we do and our education we have received. These physicians are profiting from this through payments from insurance companies for services they are not allowed to perform. Does this sound right? As physical therapists we certainly don't prescribe medications or overstep our boundaries. This has got to stop now. I encourage more physical therapists to take this matter seriously and save our profession and our patients for that matter.

Submitter : Steve Hilligoss **Date:** 08/17/2007

Organization : Steve Hilligoss

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

See Attatched

CMS-1385-P-6432-Attach-1.TXT

#6432

August 20, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

Steve Hilligoss, CRNA
225 N Union St
Good Hope, IL 61438

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physican-owned physical therapy is just plain wrong. In order for patients to receive physical therapy they must be referred by a physician. Physician-owned therpay allows a physician to directly gain financially from patients that will follow the doctor's recommendation. This allows the opportunity for over-utilization of therpay services. Physicians will often referr patients to physical therapy where they may not have before or keep them in therapy longer than medically necessary. Physician-owned therapy clinics are often managed by minimally experienced clinicians that will follow the recommendation of the physician over his/her proper clinical judgement allowing more opportunity for over-utilization.

Physical Therapy should not be considered as a DHS (designated health service) and allowed to be physician-owned practices. These situations do not support our practice of evidence-based therapy services and providing quality care in a time-sensative manner.

Submitter : **Ms. Paula Stork** **Date: 08/17/2007**

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:

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Sincerely,

Paula Stork CRNA
Name & Credential
PO Box 434
Address
Gassville, AR 72635
City, State ZIP

Submitter : Dr. Joy Hawkins **Date:** 08/17/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1385-P-6435-Attach-1.TXT

Submitter : **Dr. James Cannon** **Date: 08/17/2007**

Organization : **Dr. James Cannon**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

James J. Cannon, MD
Lemont, Illinois

Submitter : **Dr. David Woodward** **Date: 08/17/2007**

Organization : **Dr. David Woodward**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
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Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To: Mr. Kerry N. Weems
Adminstrator- Desigante

RE: Medicare Program: Proposed Revisions To Payment Policies Under The Physician Fee Schedule

I am a physical therapist in Washington state and have been in private pratice for 19 years. I receive a tremendous amount of satisfaction in helping people get back to the activities that make their lives meaningful and productive.

I am writing to comment on the July 12th proposed physician fee schedule rule as it relates to the issue surrounding physician self-referral and the "in-office ancillary services" exception.

Physicians who own physical therapy practices have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for finacial reasons. The in office ancillary services exception has created a loophole that has resulted in the expansion of physician owned arrangements that provide physical therapy services. It is my understanding that one of the reasons that this provision was included was to make physical therapy services more convenient for patients. However, due to the repetitive nature of physical therapy services it is no more convenient to receive services in the physician's office than in an independent physical therapy practice. I also understand that one of the proposed benefits from having physical therapy services provided at the physician's office is direct supervision by the physician. Physician direct supervision is not needed to administer physical therapy services and in fact in my community 3 of the physician owned physical therapy practices are not at the same site as the physician's office.

I also believe that competition is a necessary component to excellence in any field. It adds incentive to provide the highest level of care and customer service. The consumer is the winner when there is fair competition. Physician owned physical therapy practices circumvent this competition. I have been told by patients who have come to my practice following a session of care at a physician owned practice that they were not given the option to go to other physical therapy offices but were directed to the physician's own physical therapy clinic. The providers of services at these physician owned practices do not have the same incentives and motivations to provide the highest quality of care as independent physical therapy practitioners do.

Thanks you for consideration of my comments

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a private physical therapy practitioner in the north Chicago suburbs I would like to comment on physician self-referral. The market in which I compete for patients in is dominated by physician owned physical therapy practices. Many patients are not aware that they may choose where they go to physical therapy, so they take the recommendation of their physician, who more often than not directs the patient to the therapy clinic attached to their office. I regularly treat patients who have been treated at their physician's office. The level of patient satisfaction with such services in usually low, as evident by the feedback and testimonials patients willingly provide. I have signed comments from patients who were frustrated with the lack of attention and time that they received in such offices. One patient described the experience as "being herded like cattle" through the physical therapy office. Another aspect to the problem is that the quality of physical therapy is probably related more to management issues than staff. Many staff members at the physician offices are experienced and have attained a high level of post graduate education. The problem, based on patient observations, personal family experience and fellow physical therapists, is that qualifictions aside, the physical therapist is required to work with such large volumes of patients.

In addition, fellow private practitioners and myself have noticed a decline in referrals from orthopedic surgeons. Surgeons themselves comment that "Why should I send a patient out when we have our own physical therapy?" Companies that manage physical therapy services seem to be a sidestep around physician ownership of such services. In the end it is the physicians who hired the management company to administer a profit center for themselves. Like MRI, CT, and other ancillary services, physical therapy is a great way for physicians to counter the shrinking dollar that they receive from various forms of reimbursement for service. The patient is the party who suffers.

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would like to express my concern over the loopholes that have been abused within the Stark Law. I am a physical therapist who has been practicing in outpatient orthopedics for the past 8 years. I have never worked for a physician owned practice, as I believe that there are ethical boundaries being crossed when physicians, or any other healthcare provider, are permitted to make referrals based on potential profit. I have treated several patients who have related horror stories of their experience with the local physician owned physical therapy practices. Specifically, I've been told by patients of treatment being rendered by non-licensed personnel as well as treatment by one therapist of several patients at one time. Neither of these are good practice and cannot possibly be in the best interest of the patient. In the small town in which I live/work, patients look at their physicians as the ultimate authority, thus are unable to discern when they are being referred out for services based on profit vs. based on medical necessity. In addition, they are not informed that they DO have a choice in therapy providers, but are simply told to go "across the hall" for therapy. In an ideal world, one would expect that a close physician-therapist relationship would be beneficial to the patient, however, this has not been my experience. To be compliant with our ethical standards and the hippocratic oath, physicians should be open to ALL other healthcare providers, regardless of employer. I urge you, Acting Administrator and CMS, to prohibit this practice from continuing--- we all have friends and family to protect. Thank you for your consideration from Atlanta, GA.

Submitter : **Mr. Donald Hiltz** **Date: 08/17/2007**

Organization : **Mr. Donald Hiltz**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The loophole in the Stark Legislation, which allows physicians to bill for physical therapy services provided in their respective offices, is a travesty.

It allows, if not encourages, patient abuse and exploitation.

It is easy to see that these "mills" can generate over $50,000 per week, in unearned fees, for the referring physicians.

I urge you to eliminate these "safe harbors" and stop physician self referral in the provision of physical therapy services.

Donald L. Hiltz
110 Fiddlers Folly Road
Rainbow City, Alabama 35906

Submitter : **Ms. Janet Maroney** **Date: 08/17/2007**

Organization : **American Association of Nurse Anesthetists**

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,

Janet Maroney

304 Austin Hill Road

Bennington, VT 05201

Submitter : **Dr. Mark Alley** **Date: 08/17/2007**

Organization : **Holston Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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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.

Mark W. Alley, M.D.
August 17, 2007

Submitter : **Date: 08/17/2007**

Organization :

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attached

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: 08/17/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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August 17, 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)
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Sincerely,

Holly Witt SRNA
2104 Riverchase Blvd
Madison, TN 37115

Submitter : **Miss. Tien Thach** **Date: 08/17/2007**

Organization : **Northwestern University**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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Thank you for your consideration of this serious matter.

Submitter : **Miss. Thuy Thach** **Date: 08/17/2007**

Organization : **University of Washington**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Submitter : Mrs. Ngan Nguyen **Date:** 08/17/2007

Organization : Private

Category : Individual

Issue Areas/Comments

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Submitter : **Mr. Lam Thach** **Date: 08/17/2007**

Organization : **Private**

Category : **Individual**

Issue Areas/Comments

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Submitter : Mr. Thomas Gromczynski **Date:** 08/17/2007

Organization : Mr. Thomas Gromczynski

Category : Individual

Issue Areas/Comments

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Submitter : Mr. Wojciech Gromczynski **Date:** 08/17/2007

Organization : Mr. Wojciech Gromczynski

Category : Individual

Issue Areas/Comments

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Submitter : **Miss. Thuy Tien** **Date: 08/17/2007**

Organization : **Miss. Thuy Tien**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Submitter : **Ms. Amy Zaunbrecher** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

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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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Sincerely,

Amy Zaunbrecher, SRNA

416 Doucet Road #1d

Lafayette, LA 70503

Submitter : **Dr. mukull parikh** **Date: 08/17/2007**

Organization : **riverside anesthesia associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Submitter : **Michelle Jordan** **Date: 08/17/2007**

Organization : **Michelle Jordan**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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August 17, 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,

Michelle Jordan, RN, BSN, BBA, SRNA
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