Submitter : **Dr. Beth Ann Traylor** **Date: 08/22/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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,

Beth Ann Traylor M.D.

Submitter : **Mr. Christopher Brandon Ream** **Date: 08/22/2007**

Organization : **Virginia Sports Medicine and Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 2007

I am writing this letter to express my concern regarding the in-office ancillary service arrangements that have impacted the delivery of quality physical and occupational therapy.

The in-office ancillary services exception has created a loophole which has resulted in many physician-owned arrangements that provide substandard physical and occupational services.

Physicians are in a position to refer Medicare beneficiaries to in-office physical and occupational services in which they have a financial interest. There is an inherent financial incentive to over-utilize services under the in-office ancillary services exception.

Therapy treatments are repetitive in nature. Patients receiving outpatient physical and occupational therapy can just as easily return to a therapy clinic as to the physician office.

Thank you for considering these comments and eliminating this in-office ancillary services .

Sincerely,

C. Brandon Ream, MPT, CSCS
Virginia Sports Medicine and Physical Therapy
Richmond, VA
ph. 804-527-1460

Submitter : **Dr. Karl Loomis** **Date: 08/22/2007**

Organization : **Dr. Karl Loomis**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to comment on CMS-1385-P. I am a pathologist who is board certified in Anatomic and Clinical Pathology. Cytopathology and Forensic Pathology. I practice primarily in Battle Creek, Michigan. Our practice is a 5-member group which is hospital based but also runs a large regional laboratory which supplies anatomic and clinical pathology services to over 300 physicians. Therefore, no one can seriously state that any "captive" or "pod" laboratory can or will enhance patient care in any way. Nevertheless, it is happening in our area.

Therefore, I applaud CMS for taking this step to end this abuse. I believe these arrangements amount to fee splitting and are an obvious abuse of the Stark law on self-referral. The confliet of interest raised by these arrangements is staggering.

Specifically I support expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary excetion to the Stark law. The clinician should not be able to profit from pathology services unless he is trained and qualified to perform pathology. A clinician who could not interpret a pathology slide or run a laboratory if his life depended on it should not be allowed to bill for that interpretation or the technical component to prepare the slide. Somehow a system which was meant to allow a clinican to bill for say a simple urine analysis for which he may be marginally qualified has been perverted into one which is presently allowing him to bill for anatomic pathlogy interpretation for which he has no qualification at all.

In summary, the present system allows financial conflict of interest and financial self interest to imperil the clinical decision making process thus compromising the credibiltiy and the integrity of Medicare. This must be changed. Thank you for your consideration in this matter.

Sincerely, Karl F. Loomis,MD

Submitter : **Mrs. Cynthia Taylor** **Date: 08/22/2007**

Organization : **Sheridan Healthcorp**

Category : **Nurse**

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,
Cynthia Taylor
C.R.N.A.

Submitter : **Dr. Jay Cunningham** **Date: 08/22/2007**

Organization : **American Society of Anethesiologist**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Douglas Galvin** **Date: 08/22/2007**

Organization : **Summit Physical Therapy**

Category : **Health Care Professional or Association**

Issue Areas/Comments

CAP Issues

CAP Issues

Dear CMS Representative: Please consider elimination of the "in-office ancillary service" exception allowing physicians to self refer for physical and occupational therapy. Allowing this exception creates an unaccetable conflict of interest in which physicians can prescribe treatment from which they will financially benefit. There are excellent providers of therapy throughout the country who can provide these services in a manner which limit the opportunity for fraud and abuse. Patients should not be pressured to receive therapy at a physician owned office and unfortunately in many cases these patients do not know their rights to choose a provider.
In 2002 the OIG completed a study in which they found that 91% of therapy claims billed by physicians did not meet medicare requirements. This is an obvious example of why this exception should be eliminated.
On a seperate issue, plese consider the elimination of the therapy cap due to the limitations on access to treatment of medicare recipients.

Sincerely,

Doug Galvin, MHS,PT,OCS

Submitter : **Mrs. Roberta Chizen** **Date: 08/22/2007**

Organization : **Mrs. Roberta Chizen**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. 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 myself and our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

Thank you for your consideration of this serious matter.

Sincerely,
Roberta Chizen

Submitter : **Dr. Ara Meradian** **Date:** **08/22/2007**

Organization : **Morristown Memorial Hospital**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Morristown Memorial Hosp.as part of 10-member private group.

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

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program

Submitter : **Dr. Jacques Beauchamp** **Date:** **08/22/2007**

Organization : **Dr. Jacques Beauchamp**

Category : ***Physical Therapist***

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

see attachment

CMS-1385-P-7155-Attach-1.RTF

#7155

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

Dear Mr. Weems,

I am a physical therapist and business owner in Savannah, Georgia. I would like to express my opinion in regards to **CMS-1385-P** and a physician's ability to refer to him/herself for profit. First, let me give a brief background about who I am.

I earned degrees in: Bachelor of Science in Exercise Science, Masters of Physical Therapy, and a Doctorate of Physical Therapy. I presently hold advanced practice certifications: Athletic Training Certified (ATC), Certified Strength and Conditioning Specialist (CSCS) from the National Strength and Conditioning Association (NSCA), Sports Clinical Specialist (SCS) and Orthopedic Clinical Specialist (OCS) from the American Physical Therapy Association (APTA). I have 9 years experience as a licensed PT and opened my practice, Spine & Sport, 3 years ago and now practice with my best friend and college roommate, Dr. Eric Bull, PT, DSc., MPT, MMT, OCS, who, as you can see, has as many accomplishments in our profession as I do.

Our credentials to appropriately evaluate and treat musculoskeletal pathology is apparent. The success of our business to date is solely due to that fact. For an individual to put that much time and effort in learning how to most effectively and efficiently treat musculoskeletal pain, one must love what s/he does. I do! But, ever increasingly, I am finding it more difficult to perform my craft and work for myself. One of the reasons for that fact is a physician can refer to him/herself for rehabilitation services and receive compensation for that referral. I have issue with that.

The definition of MONOPOLY according to the dictionary: (an organization or group which has) complete control of something, especially an area of business, so that others have no share.

Physician referral for profit is a monopolistic practice. Five years ago, large orthopedic surgeon groups were the main public to start their own physical therapy. In the last 3 years, I have witnessed a three member General

Practitioner (GP) group open its own physical therapy service. *What will happen to my profession 3 years from now?* How is that not defined as a monopoly?

It is extremely difficult for a physical therapist to compete as a business with a physician in an environment where the physician can refer in-house and make money on it. The same profession I love and practice, I may be forced to work under a physician to earn a wage to live.

Further evidence: Savannah, GA has three large physician groups that have their own physical therapy and occupational therapy departments. There presently are only 4 private practice physical therapy providers. In Hilton Head/Bluffton, SC, where State Law prohibits referral for profit, there presently are over 10 private practice clinics that provide physical therapy services. The main difference between the two areas is the Hilton Head/Bluffton area is significantly less populated (by well over 100,000 people!). The point is that in an area where referral for profit is restricted physical therapists are able to thrive.

I have addressed this letter in regards to the business practice of physical therapy only. The fact that physical therapy is significantly over-utilized when billed under a physician is a whole other topic.

Thank you for your time.

Kind regards,
Jacques Beauchamp, PT, DPT, SCS, OCS, ATC, CSCS

Submitter : **Dr. Santosh Kalhan** **Date: 08/22/2007**

Organization : **Cleveland Clinic Health System**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Serviees
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 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
Santosh Kalhan M.D.
Staff Anesthesiologist
Cleveland Clinic Health Systems
9500 Euclid Ave.
Cleveland, OH 44195

Submitter : **Dr. Donald Volkmann** **Date: 08/22/2007**

Organization : **Olympia Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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 a region, such as ours, which has a high percentage of Senior citizens this becomes a matter of inability to recruit anesthesiologists which will eventually limit access and quality of care.

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.

Donald L. Voolkmann, MD

Submitter : **Dr. Timothy Pederson** **Date: 08/22/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Christian Downs** **Date:** 08/22/2007

Organization : **The Foundation for Evidence-Based Medicine**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Drug Compendia

Drug Compendia

See Attachment

CMS-1385-P-7160-Attach-1.DOC

#7160

THE FOUNDATION FOR EVIDENCE-BASED MEDICINE

11600 Nebel St. Suite 201
Rockville, Maryland 20852
(301) 984-1242

August 8, 2007

Kerry N. Weems
Administrator Designee
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1385-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments to Proposed Rule [CMS-1385-P: Drug Compendia Section 414.930]

Dear Administrator Weems:

On behalf of the Foundation for Evidence-Based Medicine (FEBM) we appreciate the opportunity to comment on the Notice of Proposed Rulemaking regarding the Medicare Physician Fee Schedule for Calendar Year 2008 published in the Federal Register on July 12, 2007 ("NPRM"). These comments focus solely on the Drug Compendia Section 414.930.

The FEBM is a newly formed 501(c)(3) foundation with a mission of providing educational resources for health care providers and their patients, and promoting the use of authoritative, evidence-based research for use in health care decisionmaking models. Specifically, the FEBM is working closely with providers and patient groups, academic entities, government decisionmakers, and manufacturers to create new evidence-based models that address medically accepted indications for off-label uses of drugs and biologicals for complex and specialized areas, such as cancer care.

FEBM agrees with CMS that clarity and consultation with the public and stakeholder groups is necessary in any potential compendia expansion process. However, it is also important to recognize that within currently recognized

compendia, there is room for improvement. Overall, FEBM supports more, quality evidence based compendia than less.

The Medicare Evidence Development and Coverage Advisory Committee (MedCAC) identified nine desirable characteristics for all current and future compendia to have in order to be recognized or to remain recognized.[1] FEBM agrees that approved compendia should strive to attain all of the recommended characteristics, though it may be difficult in terms of resource availability, timeliness, and the availability of certain types of data, given the life-threatening nature of cancer. It is important to recognize that none of the existing compendia display all of the recommended characteristics. In fact, there is significant variability among statutorily defined compendia.[2] CMS should also realize in the current environment, it may be difficult to achieve all of these characteristics. Therefore, FEBM suggests that CMS assign a priority value to each criterion to help determine which of the characteristics are most important for a recognized compendium.

In the arena of oncology, an efficient and quality compendia process often proves vitally important to a patient's course of treatment. As chemotherapy regimens become more personalized, and as more clinical trials are conducted to discover the efficacy of certain drugs on differing types of cancers, a compendia listed drug may be a patient's only chance of having access to new therapies.

The FEBM feels that there are two vital requirements for any approved compendia. The first is that the compendia seek out and verify only those clinical trial results that maintain clinical accuracy and the highest levels of scientific integrity for inclusion in the compendia. The second most important criteria is that a compendia decision rendered be made in a timely manner to allow for patient access to medically appropriate therapies.

All compendia must have a rigorous review process in order to retain the integrity of the compendia system. There should be a baseline of data that are necessary in order for an independent review board to make Medicare-based coverage decisions. We realize this may not be the appropriate forum to discuss these issues, but FEBM would be happy to have this discussion with CMS at an appropriate time.

Timeliness is a major issue for current compendia and should remain a focus of attention in the future. FEBM feels that in order to best serve patients, a more defined time frame should be in place so everyone involved in the scope of care can have a better idea of when to expect coverage determinations. This includes all

---

[1] 72 Fed. Reg. 38178 (July 12, 2007)
[2] 42 CFR § 1395x(t)

stakeholder groups, most importantly patients and physicians, as well as clinical researchers, pharmaceutical manufacturers, and the government agencies sponsoring these trials. In the current environment, some manufacturers of cancer therapies have opted to wait through a long and extensive Food and Drug Administration review process instead of submitting an application with a compendia because the timing of determinations have been known to take a year or more. With a more defined timeline, clinically appropriate treatments may get be accessible to patients who need them.

The FEBM agrees with the need for an independent review board to be in place in order to return the best determinations possible. The process should be similar to that of the FDA review process, comprised of physicians knowledgeable in the scope of medicine under consideration, with as few ties to the outcomes as possible. Having that said, FEBM also asks CMS to understand that it may be impossible to have reviewers who have no financial interest in the industry for which they are being asked to evaluate. The FDA understands this fact, and we ask that CMS understand as well.

Overall, it is vital that CMS continue to utilize a strong and comprehensive compendia process, as was mandated by Congress in 1993. We recognize the desire of CMS to update that system when and where possible, and we are in agreement with that policy. However, a total overhaul or dismissal of the system will prove difficult, both for providers and patients, and we would advise against it. In the end, it is the patients who stand to gain the most and lose the most from this decision, and we ask CMS to remain cognizant of that fact.

FEBM will continue to work with stakeholders such as the American Society of Health System Pharmacists, the American Society of Clinical Oncology, the National Comprehensive Cancer Network, and others, in order to improve the current compendia review system. We also pledge to work with CMS toward the goal of the most effective, and efficient compendia review process possible.

If you have any questions about FEBM's current work in the arena of the compendia process, please feel free to call Matthew Farber, at (301) 984-9496.

Respectfully Submitted,

Christian D. Downs

Christian Downs
Executive Director
The Foundation for Evidence-Based Medicine

Submitter : **Date: 08/22/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physical Therapy should NOT be approved for in-office or owned/ partnered affiliation with physicians. I know from experience that patients largely go exactly where the physician tells them. First this referral generally goes to the in house PT department to profit the physician without regard to quality or patient convenience or even ,at times, personal choice. The patient, as every American, has the right to choose where they recieve their care. Medicare patients often are taken advantage of in this way as seniors frequently blindly trust their physicians decisions without question. I strongly oppose any law that would fail to restrict physician ownership/ partnership with ANY referral service.

Submitter : **Dr. Glenn Jonas** **Date: 08/22/2007**

Organization : **physician**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a referring physician to a in house PT I consistently use significantly less PT visits then when i refer outside. The major companies that own the PT facilities maximize profits by over utilizing the visits. In addition, in house PT improves oversight of patient progress, and we try to minimize visits for our patients. Give more credit to the patients. They know cost, and quality. They will make themselves heard if they think there PT is being over utilized.

Doctors and patients will better control costs thaan the large corporations that own majority of PT facilities in this country. Remember HEALTHSOUTH. that is the model for most PT in this country.

Submitter : **DAVID OBANDO** **Date: 08/22/2007**

Organization : **DIAGNOSTIC PATHOLOGY CONSULTANTS**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Communication to CMS

August 22, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

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

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,

David A. Obando, MD
Vicepresident Diagnostic Pathology Consultants

Submitter : **Ms. Christine Meelia** **Date: 08/22/2007**

Organization : **Ms. Christine Meelia**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

My name is Christine W. Meelia, and I am a physical therapist with fourteen years of experience in Columbus, Ohio. I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services.

I work in an outpatient orthopedic facility that is located inside a building owned by a group of nineteen Orthopedic Surgeons. The physicians also own the surgical facilities and three MRI centers located inside this same building. In the fall of 2005, after several years of cultivating a relationship of mutual respect and open communication with the group of surgeons, we were surprised to learn that the physicians wanted to force out the company running our therapy center, and own their own physical therapy practice. In fact, they shared with our clinic director the surprising information that every private insurance company would actually pay them more than we were being reimbursed for the same therapy procedures.

We did not want to work for the physicians, as the referral for profit business has high potential for fraud and abuse. So the physicians began to openly boycott the use of our clinic, persuading their patients to use other therapy clinics, in an effort to put us out of business. Despite the threat that they would not send one patient to our clinic unless we sold the business to them, we were able to remain open. So, in December of 2006, the group of surgeons opened their own physical therapy clinic across the street from our building. This seems to be in conflict with the regulation that in-office ancillary services are provided in their office and not in a building across the street.

In an effort to capture all the physical therapy business, and to prevent patients walking into our center across the hall from their offices, the physicians started scheduling the physical therapy appointment directly from their office. I began to hear my co-workers say their patients were being sent to the physician owned therapy clinic across the street instead of being given the choice to come back to our clinic and be treated by someone who had treated them before.

In February of 2007, a former patient I had seen for several different injuries over a period of two years, walked into our clinic and said she was recovering from hip surgery. She told me she was ready to start physical therapy, but her surgeon was sending her to a new therapist in the clinic he owned across the street. She asked me if she could come back and see me. I told her that she absolutely had a choice in who provides her therapy services. She then walked back over to the physician s office and asked to return to physical therapy with me as her therapist. She was told no. I want you to go across the street. by her physician.

Another former patient came to our clinic for therapy on her shoulder to increase range of motion prior to a rotator cuff repair. In April of 2007, after her surgery, she was scheduled to see a physical therapist at the physician owned clinic across the street. She felt so uncomfortable telling her physician she did not want to see his physical therapist that she waited until the initial therapy evaluation in the physician owned clinic to tell that person she wanted to return to our clinic for care. She told me this after returning to see me.

There have been many instances of fraud and abuse I have heard from patients, co-workers, and the physicians themselves. Most recently, one physician from this group who was still sending us patients told us his peers planned to cut his pay if he didn t comply with supporting their own physical therapy center.

Because of these circumstances, I urge you to eliminate physical therapy as a designated health service furnished under the in-office ancillary services exception of the Stark Law.

Christine Meelia, PT
7121 Timberview Dr, Dublin, OH 43017

Submitter : **Dr. Paul Mazzara** **Date: 08/22/2007**

Organization : **Dr. Paul Mazzara**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

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

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,

Paul Mazzara, M.D.

Submitter : **Dr. Domenico Falcone** **Date: 08/22/2007**

Organization : **Blair County Anesthesia PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 22, 2007

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

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

Dear Ms. Norwalk:

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.

Very truly yours,

BLAIR COUNTY ANESTHESIA, PC

Domenico Falcone, MD
President

Submitter : **Dr. David Rasmussen** **Date: 08/22/2007**

Organization : **Blair County Anesthesia PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 22, 2007

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

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

Dear Ms. Norwalk:

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.

Very truly yours,

BLAIR COUNTY ANESTHESIA, PC

David Rasmussen, M.D.

Submitter : **Mr. Greg Bonifay** **Date: 08/22/2007**

Organization : **Riggs Ambulance Service, Inc.**

Category : **Other Health Care Professional**

Issue Areas/Comments

Ambulance Services

Ambulance Services

We also strongly object 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.

Submitter : **Dr. Joseph Martinelli** **Date: 08/22/2007**

Organization : **Blair County Anesthesia, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 22, 2007

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

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

Dear Ms. Norwalk:

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.

Very truly yours,

BLAIR COUNTY ANESTHESIA, PC

Joseph Martinelli, M.D.

Submitter : **Dr. Paul Schultz** **Date: 08/22/2007**

Organization : **Blair County Anesthesia, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 22, 2007

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

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

Dear Ms. Norwalk:

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.

Very truly yours,

BLAIR COUNTY ANESTHESIA, PC

Paul Schultz, M.D.

Submitter : **Dr. John Johnson** **Date: 08/22/2007**

Organization : **Blair County Anesthesia, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 22, 2007
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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

Dear Ms. Norwalk:

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.

Very truly yours,

BLAIR COUNTY ANESTHESIA, P.C

John Johnson, M.D.

Submitter : **Dr. Medford McCoy** **Date: 08/22/2007**

Organization : **Dr. Medford McCoy**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for letting me comcnt on the physician self referral provisions of CMS-1385-P. I am a board-certified pathologist and a member of the College of American Pathologists. I praetice in Dallas, Texas where I am in solo practice at Doctors Hospital.

I am glad that the CMS is trying to end self-referral abuses in the billing and payment for pathology services. There are some physicians in my practice area that share in the revenues from the path services they order for their patients. This seems to me to be an abuse of the Stark law to prevent self-referral or at least circumvents the intent of the law. I support the revisions to close the loopholes that allow non-pathologists to profit from the pathology services they request.

I especially support the anti-markup rule to purchased pathology interpretations and the exlcusion of anatomic pathology form the interoffice ancillary services exception to the Stark legislation. I believe these revisions (to the reassignment rule and self-referral provisions) are necessary to stop financial self-interest in making their clinical decisions. The physician should not prosper from the pathology services unless he can personally do the procedure or supervise the service.

Medicare should ensure that providers funish care in the best interest of their patients. Restrictions on physician self-referral are necessary to safeguard quality in clinical decision making. These changes do not impact the availability or delivery of pathology services and are designed only to remove any financial conflict of interest.

Thank you for your attention.

Very truly yours,

Medford T. McCoy, M.D.

Submitter : **Date: 08/22/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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 : **Ms. Jane Johnson** **Date: 08/22/2007**

Organization : **Community Orthopedic Surgery and Huron Valley Hand**

Category : **Occupational Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Regarding whether certain services should not qualify for In-Office Ancillary Services Exception I believe that OT and PT services should most definitely be allowed under the In-Office Ancillary Services Exception. We provide these services in our physician owned practice billing incident to the physiians services. The coordination and quality of patient care is exceptional with the intimate working relationship with therapists, patients and physicians. I believe that patients do improve more quickly in this enviornment which is most cost effective in the provision of their care. Allowing ongoing services to the patients in the Physician office assures access to the Physician as needed for consultation and or direct supervision.

In response to the "definition of same buliding or centralized building" I would suggest that the definition of same building in relationship to the provision of therapy services provided incident to a physician services be expanded to truly be "same building" rather than within the same office suite. When the physicians are in the building either in a meeting or in surgery they are accessible to the therapists for supervision and or consultation. Currently there are many times when we are unable to provide therapy services for patients during physician times off or when all physicians are out of the office suite. During many of these times there is a physician from the corporation in the building however not one in the office suite.

Expanding the definition to "same building" would greatly enhance our ability to treat patients consistently, in a timely fashion and with greater efficiency.

Thank you very much for consideration of my opinions.

Jane Johnson

Submitter : **Vasiliki Saitas** **Date: 08/22/2007**

Organization : **Biopath Diagnostic Associates, PC**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As head of a 3 person pathology practice in Northern New Jersey, I wish to convey my comments regarding the growing trend of abusing laboratory testing by physician self-referrals. The captive pathology arrangements are a detriment to patient care; one local GI group sends their biopsies to an outside laboratory for processing, and the glass slides are returned to the GI group. They were able to find a pathologist desparate for work, who reads the biopsies once a week. The turn around time is atrocious- ONE WEEK for an endoscopic biopsy. CMS has to stop fueling this abuse of quality pathology care. Those of us who refuse to work for way less than fair market value are being put out of business by this abusive practice conducted by physicians who are clueless about the value of quality pathology services, and who hire anyone willing to read slides for any price under any condition. There must be strict regulation by CMS- Do not allow anyone who's primary training and job is NOT pathology to be able to hire a pathologist and to try and run a pathology service, especially since they obviously don't care about quality- it's how much money they can make.
In ending, I support the expansion of the anti-markup rule to purchase pathology interpretations and the exclusion of anatomic pathology from in-office ancillary services. Thank you for the opportunity to voice my comments and concern.
Sincerely, Dr. Vasiliki Saitas

Submitter : **Dr. Niels Chapman** **Date: 08/22/2007**

Organization : **University of New Mexico**

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 enthusiastic support for the proposal to increase anesthesia remuneration under the 2008 Physician Fee Schedule. In my opinion, CMS has taken a great step towards ensuring the continued entry of highly qualified and motivated physicians into our specialty.

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.

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.

Niels Chapman, MD

Submitter : **Dr. Jose Torrent** **Date:** **08/22/2007**

Organization : **Dr. Jose Torrent**

Category : **Physician**

Issue Areas/Comments

TRHCA-Section 104: Physician Pathology Services

TRHCA-Section 104: Physician Pathology Services

see attachment

CMS-1385-P-7177-Attach-1.DOC

CMS-1385-P-7177-Attach-2.DOC

#7177

Jose R Torrent, MD
Medical Director
CorePlus Pathology Laboratory and
Kendall Regional Medical Center
11750 Bird Road
Miami, Fl 33176
305-227-5579

Wednesday, August 22, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008." I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Miami, Florida as part of 5-member pathology group operating an independent laboratory and also practice in a hospital.

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

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,

Jose R Torrent, MD
Anatomic and Clinical Pathologist

Submitter :

Date: 08/22/2007

Organization :

Category : **Physician**

Issue Areas/Comments

Background

Background

It's an unbelievable event given the recent ongoing decreasing reimbursements over the past decade. As a young physician I often question my career choice as I read the news of more and more legislations to decrease the reimbursments in the face of rising costs of living, as well as the costs of providing healthcare.

Submitter : Dr. gary buck **Date:** 08/22/2007

Organization : rancocas anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Anesthersia services have increased over the last 10 years towards the elderly population. The rates have yet to increase over that time period, yet my mal-practice has doubled. If the rates do not increase I will ahve to stop taking those patients

Submitter : **Holly Mader** **Date: 08/22/2007**

Organization : **Holly Mader**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 2007
RE: Physician Self-Referral Issues
Dear Mr. Kerry Weems:
I am a Physical Therapist practicing in South Carolina in a therapist-owned private outpatient clinic. I am concerned about the growing trend of referral-for-profit and especially Physician Owned Physical Therapy Clinics and would like to see this practice stopped. In SC, Physical Therapists (PT) recently won a major court battle upholding our State Practice Act that states it is unlawful for a PT or PTA to work in a referral for profit setting. I would love to see this happen across the nation.
I have seen too many situations where the physicians who own a PT clinic refer patients to their own clinic for treatment, without letting the patient know about other clinics that may be much more convenient or provide better quality of care for them. It is the patient s right to choose where they go for therapy, but often times they are not given options. This practice of self-referral goes against what is in the best interest of the patient, and ultimately effects costs and quality of care.
There is too much potential for fraud and abuse when physicians are able to refer patients to other services where they have a financial interest. I feel Medicare beneficiaries and the Medicare program itself are especially vulnerable to this, because many elderly people are not fully aware of their rights, and even if they are, they will not stand up to the physician to make sure those rights are protected. There is a huge potential for overutilization of Physical Therapy services if the physicians are determining where and how long a patient needs to go to Physical Therapy.

Physical Therapists are specialists in what they do. They have the education and experience to support their clinical decision-making. It should be the PT who determines the best plan of care for the patient in the Physical Therapy environment. Just as family physicians refer patients to specialists such as orthopedic surgeons or neurologists and let them determine a plan of treatment, the same should happen when physicians refer patients to Physical Therapists.
Many years ago, I was offered a position to work with a very well-known physician in his office as an employee. When I mentioned the Stark Laws to him which prevented that, his response was We can work around that . Thankfully, my ethics were strong enough to not put myself in that situation. Unfortunately, I believe the practice of referral for profit has become much more common over the past 10 years and the Stark Laws need to be changed to close these loopholes . This will help control fraud, abuse and overutilization of Physical Therapy services.
I thank you for your time and consideration of my comments.
Sincerely,
Holly Mader, PT

Submitter : Mr. Dennis Kneller **Date:** 08/22/2007

Organization : Kneller Anesthesia Services

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

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.

Submitter : **Thomas Overman** **Date: 08/22/2007**

Organization : **Nurse Anesthetist**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:
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.
ı 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.
ı 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,
___Thomas J. Overman_____
Name & Credential
____CRNA_____
Address Hinesville, GA. 31313
_____
City, State ZIP

Submitter : **Dr. Joshua Allen** **Date: 08/22/2007**

Organization : **Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

Please know that many in the anesthesia field are grateful for the proposed increase in payments under the 2008 Physician Fee Schedule.
As the population ages, the problem only increases as the percentage of patients utilizing Medicare grows and the financial impact of being underpayed becomes even more troubling. This ultimately effects the availability of anesthesiologists to care for this population. I urge CMS to implement the full proposed increase.

Thank you,
Josh Allen

Submitter : **Maribeth Massie** **Date: 08/22/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

August 22, 2007
Office of the 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 Administrator:
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.
ı 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.
ı 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,
___Maribeth Leigh Massie, CRNA, MS_____
Name & Credential
____219 East Chirchill Street_____
Address
____Baltimore, MD 21230_____ ___
City, State Zl

Submitter : **Dr. Sass Elisha** **Date: 08/22/2007**

Organization : **AANA**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

August 20, 2007
Office of the 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 Administrator:
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.
ı 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.
ı 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 prop

Submitter : **Mr. Ronald Gay** **Date: 08/22/2007**

Organization : **Mr. Ronald Gay**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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.
ı 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.
ı 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,

Ronald J. Gay, CRNA, MS
Instructor, Graduate Program in Nurse Anesthesia
Baylor College of Medicine
1504 Taub Loop
Houston, TX, 77030

Submitter : Mrs. Glenda Zane **Date:** 08/22/2007

Organization : American Association of Nurse Anesthetists

Category : Other Practitioner

Issue Areas/Comments

Background

Background

I am a CRNA who works many hours a week and takes care of many different types of patients from all different backgrounds and economic classes. We are short-staffed, but still offer all the services to everyone regardless of reimbursement. It is IMPERATIVE that anesthesia reimbursement fees are not cut any further to assure that there will be quality providers still taking care of all citizens in this great country! Glenda Zane, CRNA

Submitter : **Dr. Jacqueline Emery** **Date: 08/22/2007**

Organization : **Palmetto Richland Pathology**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear CMS representatives,
Please find this letter in support of the proposed changes to the physician self referral schedule, CMS-1385-P. I am a practicing pathologist who is board certified in anatomic and clinical pathology, and have specialty certification in cytopathology. I am one of 19 pathologists in one of the largest groups in the state of South Carolina.
I do comment CMS for addressing this issue and intitating the end of self-referral abuses in the medical practice. I am personally aware of arrangements made by clincian physician groups to recoup pathology service charges. An individual physician should not directly benefit from the number of biopsies he/she takes, when that biopsy is interpreted by a pathologist physician. A financial incentive is created and the pathologist's work product is exploited. The pathologist needs to remain the unbiased physician reviewer and the clinician should not accrue monies for each specimen interpreted by the pathologist.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. Thank you for your time, Sincerely, Jacqueline Emery, MD

Submitter : **Mr. Ronad Lenninger** **Date: 08/22/2007**

Organization : **Mr. Ronad Lenninger**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Office of the 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 Administrator:
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.
ı 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.
ı 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,
Ron Lenninger CRNA

Submitter : **Mr. Richard Dickerson** **Date: 08/22/2007**

Organization : **Mr. Richard Dickerson**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 22, 2007
Office of the 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 Administrator:

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.

Submitter : **Date: 08/22/2007**

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.

? 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,

Jeremy S. Heiner CRNA
Name & Credential

357Avocado Lane, Pasadena, Ca 91107
Address

Submitter : **Mr. Stephen Palmerton** **Date: 08/22/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Office of the 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 Administrator:

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,

Stephen F. Palmerton CRNA,MSNA

3118 Headley Rd. Maurertown, VA 22644

Submitter : **Dr. Jennifer Lam** **Date: 08/22/2007**

Organization : **Northwestern Memorial Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Frank Maziarski** **Date: 08/22/2007**

Organization : **Allied Anesthesia Associates**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:
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.
ı 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.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Submitter : **Ms. Anna Baty CRNA** **Date: 08/22/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Office of the 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 Administrator:
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.
ı 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.
ı 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,
Anna Baty, CRNA

Name & Credential
Anna Baty, CRNA

Address
7 Heritage Court

City,
Carlisle, PA 17015-9309

Submitter : **Miss. Andrea thomas** **Date: 08/22/2007**

Organization : **Miss. Andrea thomas**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Administrator:
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.
ı 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.
ı 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,
__Andrea Thomas CRNA_____
Name & Credential
___1205 Old Pylesville Road_____
Address
____Whiteford, MD 21160_____
City, State ZIP

Submitter : **Jill Paulsen** **Date: 08/22/2007**

Organization : **Jill Paulsen**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:
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.
ı 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.
ı 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,

Jill Paulsen, SRNA

47022 Teri Lane
Tea, South Dakota 57064

Submitter : **Mrs. Sara Hawk** **Date: 08/22/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:
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.
ı 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.
ı 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,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Mr. James Woelk** **Date: 08/22/2007**

Organization : **Mr. James Woelk**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:

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.

Submitter : **Mrs. Susan Welton** **Date: 08/22/2007**

Organization : **Mrs. Susan Welton**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:

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 continueto 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 fo rMedicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately80% 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 CRNA s provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Susan Welton, BSN, SRNA
3615 Mill Pond Rd.
Charlotte, NC 28226

Submitter : **Mr. James Mordecai** **Date: 08/22/2007**

Organization : **Mr. James Mordecai**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 22, 2007

Office of the 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 Administrator:

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,

James D. Mordecai
#2 Oaklawn
McAlester, OK 74501

Submitter : **Mr. Doyle Graham** **Date: 08/22/2007**

Organization : **Mr. Doyle Graham**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Finalize the proposal to increase the value of anesthesia work by 32%, and to increase the anesthesia conversion factor by 25% in 2008.

Submitter : **Dr. steve alves** **Date: 08/22/2007**

Organization : **American Assoc. of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:

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,

_____Steve L. Slves, PhD, CRNA
Name & Credential
_____273 Ash St.
Address
_____Brockton, MA 02301
City, State ZIP

Submitter : Dr. Heather Crowley **Date:** 08/22/2007

Organization : Dr. Heather Crowley

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Exeter, NH and Newburyport, MA as part of a 5 member pathology group who contracts with two community hospitals and operates an independant laboratory which provides cytology, molecular and histology services.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and support revisions to close the loopholes that allow physicians to profit from pathology services.

Specifically, I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,
Heather Crowley