**Submitter :** **Miss. Lori Plasek** **Date: 08/23/2007**

**Organization :** **Miss. Lori Plasek**

**Category :** **Health Care Industry**

**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.
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,

Lori Plasek MSN CRNA
520 Opal Sky Court
League City TX 77573

**Submitter :** **Dr. Bruce Miller** **Date: 08/23/2007**

**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.

Bruce L.Miller,M.D.
35 Glen Lake Dr.
Medford,NJ 08055

**Submitter :** **Mr. Barry Perper** **Date: 08/23/2007**

**Organization :** **AANA**

**Category :** **Congressional**

**Issue Areas/Comments**

**Background**

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,
Barry Perper
1028 Quince Lane
BelAir, MD. 21014

**Submitter :** **Edward Smyth** **Date: 08/23/2007**

**Organization :** **Edward Smyth**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Background**

Background

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Sincerely,

Edward Aaron Smyth, CRNA
18001 Points East Ridge
Dripping Springs, TX 78620-5222

**Submitter :** **Dr. Todd Hermann** **Date: 08/23/2007**

**Organization :** **American Society of Anesthesiology**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.
Sincerely,
Todd G Hermann, MD

**Submitter :** **Dr. Ian Welsby** **Date: 08/23/2007**

**Organization :** **Duke University Health Systems**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

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Sincerely,
Ian J Welsby BSc MBBS FRCA
Assistant Professor
Department of Anesthesiology and Critical Care
Duke University
Durham NC 27710

**Submitter :** **Dr. Donna Pisera** **Date: 08/23/2007**

**Organization :** **West Jersey Anesthesia Associates**

**Category :** **Ambulatory Surgical Center**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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Donna M. Pisera, MD

**Submitter :** Ms. Mekelayaie Brown **Date: 08/23/2007**

**Organization :** Ms. Mekelayaie Brown

**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

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Sincerely,

Mekelayaie K. Brown
Student Nurse Anesthetist
12365 SW 151 St #207
Miami, FL 33186

**Submitter :** **Date: 08/23/2007**

**Organization :**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Background**

Background

Attention Office of CMS Administrator: I am a practicing CRNA working in a tertiary care, University medical center setting which cares for a high proportion of Medicare and Medicaid patients in our overall mix. I urge you to adopt the AANA proposal for increasing the value of anesthesia work and the conversion factors in order to correct for overall value and inflation. Thank you for your consideration.

Jerry Condra.
Greenville, South Carolina.

**Submitter :** **Mr. Louis Bartrug** **Date: 08/23/2007**

**Organization :** **Mr. Louis Bartrug**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Background**

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**Submitter :** **Dr. Mack Thomas** **Date: 08/23/2007**

**Organization :** **Am. Society of Anesthesiologists**

**Category :** **Health Care Professional or Association**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-1385-P-7351-Attach-1.PDF

+7351

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

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

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

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

**Submitter :** **Gregory Hemelt** **Date: 08/23/2007**

**Organization :** **Gregory Hemelt**

**Category :** **Other Health Care Professional**

**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

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Sincerely,
Gregory M. Hemelt
4800 Eastwind Rd.
Virginia Beach, VA 23464

**Submitter :** **Mark Richardson** **Date: 08/23/2007**

**Organization :** **Mark Richardson**

**Category :** **Other Health Care Provider**

**Issue Areas/Comments**

**Background**

Background

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Sincerely,

Mark L. Richardson, CRNA, MSN, Ret LTC USAF

3701 Wolf Creek Circle
Edmond, OK 73034
Phone 405-285-9444

**Submitter :** **Date: 08/23/2007**

**Organization :**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

It is unethical for physicians to have the ability to refer their trusting patients to physical therapy clinics in which they have a profit sharing capability. Although they state that patient's are aware that they can chose any provider that they would like, most patients are not aware of that right. And many who are aware, feel obligated to go to the clinic their physician recommended. Please end this ability and put in place a checks and balance system for physicians.

**Submitter :** Dr. Thomas Farrell **Date: 08/23/2007**

**Organization :** Dr. Thomas Farrell

**Category :** Physician

**Issue Areas/Comments**

**CAP Issues**

CAP Issues

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 anatomic and clinical pathologist, board-certified dermatopathologist and a fellow member of the College of American Pathologists. I practice in Bradenton, Florida as part of 4-member pathology group based at Manatee Memorial Hospital, also providing pathology services tt Lakewood Ranch Medical Center. In addition, we provide independent pathology services to several outpatient surgery centers and physician offices in our community.

Earlier this year, we were approached by a small group of gastroenterologists for whom we provided significant anatomic pathology services. The gastroenterologists informed us that they had begun negotiations with a company called EndoSoft to institute, among other things, electronic medical records (EMR) for their office and soon-to-be-opened outpatient surgery/endoscopy center. On EndoSoft's recommendation, the gastroenterologists then offered us the opportunity to pay 85% of the installation costs and yearly maintenance fees for their EMR hardware and software, in return for our keeping their anatomic pathology business. Considering the financial impact ($50,000.00 initially, followed by $4,000.00 yearly) and the legal ramifications (our lawyer interpreted this practice as a "kick-back"), we chose to not participate in these proceedings. Since then, we receive no specimens from these physicians from their outpatient surgery/endoscopy center. The estimated loss to our practice is $70,000.00 annually. Last week, a separate gastroenterologist called me personally to warn me that word of this has spread and that we should be prepared for other gastroenterology groups, including his, to follow suit.

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,

Thomas J. Farrell, MD, FCAP

**Submitter :** **Dr. MIRZA BAIG** **Date: 08/23/2007**

**Organization :** **AMERIPATH**

**Category :** **Physician**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Physicians owning there own labs and gctting spccimen of their patients processed and diagnosed is "SELF REFERAL" which should bc illcgal and banncd.

**Submitter :** **Mr. Robert Kloth** **Date: 08/23/2007**

**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

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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,

Robert Kloth, CRNA
3250 Drew Street
Downers Grove, Illinois 60515

**Submitter :** **Mrs. Esther Reynolds** **Date: 08/23/2007**

**Organization :** **TheraMatrix**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

I have been a health professional for over 25 years and must say that I am appalled that physicians can own (or a family member) a physical therapy practice and self refer to it. I would think that there would be some conflict of interest somewhere here. I have marketed to doctors only to have them tell me 'we take all of the primary insurances for our own practice but we do need someplace to send our Medicaid. We don't bother with them because of poor reimbursement!!

We look at ways to cut costs in Medicare yet we allow physicians to profit from self referrals. I have approximately 12 more years before I am eligable for Medicare. If we run out of money and I am denied my benefits I know why - because of laws that are poorly reinforced by our government such as the Stark Law. I urge you to close the loop holes that are draining our resources and stopping independent practice. Thank you.

**Submitter :** **Dr. Marcia Campbell** **Date: 08/23/2007**

**Organization :** **Southern Indiana Pathologists, L.L.P.**

**Category :** **Physician**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

August 23, 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 Bloomington, Indiana as part of Southern Indiana Pathologists, LLP, a 4-member pathology hospital based practice.

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,

Marcia J. Campbell, M.D.

**Submitter :** **Dr. Ken Mason** **Date: 08/23/2007**

**Organization :** **Associated Anesthesiologists, Inc**

**Category :** **Physician**

**Issue Areas/Comments**

## GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** **Dr. Paul Yochim** **Date: 08/23/2007**

**Organization :** **ASA**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

It is imperative that the conversion factor for anesthesiologists be increased as proposed. Paul D. Yochim, DO

**Submitter :** **Date: 08/23/2007**

**Organization :**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

I understand that physical therapy is currently listed as an in-office ancillary service for physicians on the federal physician referral laws. Physicians who provide physical therapy in their office will profit from these services. I don't believe that physicians should profit from physical therapy because it can lead to an overutilization of PT services. Currently a physical therapy prescription is required for all patients in the state of MO to receive treatment. Allowing physicians to profit from these services will also increase the number of physician owned PT practices and force independent providers out of business. States that allow physician's to own PT clinics have virtually NO private practices operating there. Physicians need to be restricted in the ways they can profit from their referrals so that they can make sound decisions about what is best for the patient without being distracted by money.

CMS-1385-P-7363

**Submitter :** Dr. Anthony Passannante **Date:** 08/23/2007

**Organization :** University of North Carolina Anesthesiology

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear CMS Administration,
I have been in academic anesthesiology practice since 1991, and I have firsthand watched severe deterioration in the financial situation of our practice. We train physicians who are going to provide safe anesthesia care for our burgeoning medicare population, and there is demand for our expertise 24 hours a day, seven days a week. When extraordinarily low conversion factors make it economically impossible to provide the level of care demanded by our hospital's population without massive subsidy, there is a problem in the reimbursement mechanism. Thank you for your consideration. Anthony Passannante, Professor of Anesthesiology and Vice- Chair, Department of Anesthesiology, UNC Chapel Hill. 919-966-5136

**Submitter :** **Date: 08/23/2007**

**Organization :**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Hello: I am a physical therapist in private practice for the past 18 years in the Chicago suburbs. I have been a PT for 25 years and would like to make a comment on the July 12 proposed 2008 physician fee schedule rule specifically about the self-referral "in-office ancillary exception." My staff and I work very diligently with outpatients, 25% of them who are on the Medicare program. We have seen an increase in the number of physician-owned therapy clinics in the area and have [illegible] a number of patients report to us that their doctor had tried to have them recieve therapy at their "own" clinic. Since many of our clients have had great [illegible]ment/outcomes with us before,they don't succumb to the pressure of the doctor trying to convince them that they should just "go down the hall and see their therapist." However, some have done just that. Their experiences in many cases have been short lived as they soon found out that the "therapy" they began to receive was not adequate, personal or sometimes even done by someone who held a license to do so. Furthermore, there have been reports that many times patients were told they needed treatment, when in fact they were not feeling there was much wrong with them... Unfortunately this sentiment and activity has been mirrored many times by my colleagues who have heard of similar experiences. Physicans are tempeted to "over" refer and place people in a "cookie cut-out" mold of care, thus crowding their own clinics with clients,some who truly need therapy and others that may not, thus losing the professionalism and protentially corrupting the medical model of rehabiliative care that we as PT's work so hard to uphold. Instead,the PT referral in this environment has the potential to focus only on the financial productivity for the doctor's practice. I urge strong consideration of removal of PT services from the in-office ancillary exception, both from the standpoint of a quality rehabilitation provider as well as that of a solid tax-payer. Let's get the most from our tax dollars in the Medicare system to truly benefit those who need and deserve the care, not for lining the pockets of those who choose to abuse the system. Thank you.

**Submitter :** **Mrs. Shunta Taylor-Geter** **Date: 08/23/2007**

**Organization :** **Student Registered Nurse Anesthetist**

**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,
Shunta C. Taylor-Geter, Student Registered Nurse Anesthetist
6040 Harrison-Ooltewah Road
Harrison, TN 37341

**Submitter :** **Dr. ALLAIN GIROUARD** **Date: 08/23/2007**

**Organization :** **ST JOHNS ORTHO**

**Category :** **Physician**

**Issue Areas/Comments**

## GENERAL

GENERAL

I appreciate the opportunity to review some of CMS' decision making processes as it contemplates changes to the Stark self-referral regulations. While CMS does not make specific proposals with regard to some of the self-referral provisions, I would like to submit comments and clarifications.

ANTI-MARKUP PROVISION: The fiscal and ethical integrity of the Medicare program is a goal shared by all of us who participate in it. CMS' decision to focus on the billing of diagnostic tests of one physician or group where the diagnostic test is performed by someone other than a full time employee is appropriate. CMS's approach of paying less of the Medicare fee schedule amount, actual charges, or the charges of the physician performing the diagnostic test is inherently reasonable.
HOWEVER, WE DO REQUEST THAT CMS ENSURE THAT THE CALCULATION OF PAYMENT LEVEL UNDER THE ANTI-MARK UP PROVISION PLACE NO NEW ADMINISTRATIVE BURDENS ON THE BILLING PHYSICIAN OR GROUP.

IN-OFFICE ANCILLARY EXCEPTION:
We strongly challenge some of the characterizations articulated in this section of the proposed rule. CMS refers to "hundreds of letters from physical therapists and occupational therapy practices". CMS does not elaborate any further on the propriety or harm of this activity.
The advantages of physician owned physical and occupational therapy practices to physicians, therapists and, most importantly, patients are well understood. These practices give patients more places to choose from to get physical therapy services. In some cases, it may be more convenient for patients to obtain thecapy at their physicians' offices than to have to travel elsewhere for the services.
In addition, some patients feel more comfortable knowing that their therapists and physicians are working together at the same location. There is more physician involvement, better care and better outcomes in many circumstances.
We request that CMS elaborate on its concerns in this area, acknowledgining that the number of letters received on a subject is not always indicative of the gravity of the issue or need for correction.
We also request that CMS engage in discussions with stakeholders on this issue given the obvious importance of physician expertise, patient needs, clinical quality, and the appropriate use of Medicare resources in the area of physical thearpy. A drastic change to this exception would be harmful to patient ability to access necessary care in an appropriate and convenient setting with the oversight of their treating physician.

ALTERNATIVE CRITERIA FOR SATISFYING CERTAIN EXCEPTIONS:
We recommend CMS on its attempt to bring rationality to the strict enforcement of inadvertent form violations of the self-referral regulations. However, we also believe that CMS should amend the proposal so as not to be so unilateral on the part of CMS.
Surely, CMS can preserve its authority, while simultaneously ensuring that those that are subjected to this rule and exception are able to access the benefits of it.
Thank you for allowing us to comment on this subject and thank you for your anticipated attention to our concerns in this regard.

**Submitter :** **Ms. Marilyn Dahler** **Date: 08/23/2007**

**Organization :** **Avera Health**

**Category :** **Hospital**

**Issue Areas/Comments**

**Medicare Telehealth Services**

Medicare Telehealth Services

Please find attached a letter and research study
Thank you
Marilyn Dahler
On Behalf of:
Avera Telehealth
Sioux Falls, SD

CMS-1385-P-7367-Attach-1.DOC

CMS-1385-P-7367-Attach-2.DOC

Date: August 23, 2007

Herb Kuhn, Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS- 1385-P
P.O. Box 8018
Baltimore, MD 2 1244-8018

**Regarding: Medicare Telehealth Services**

The elimination of the CPT codes 99251-99263, has left telehealth providers without an option for billing for follow-up care. The request to add CPT codes 99231-99233 for subsequent inpatient care has been denied by CMS because of lack of comparative analyses showing the efficacy of using telemedicine for acute cases. Attached you will find the preliminary results of a study undertaken by Avera Research, Sioux Falls, SD that addresses this issue.

The study, *A Brief Retrospective Review of Medical Records Comparing Outcomes for Impatients Treated via Telehelath versus Face-toFace Protocols: Is telehealth equally effective as face to face visits for treating neutropenic fever, bacterial pneumonia and infected bacterial wounds,* compared the patient outcomes for three specific diagnosis receiving care from an infectious disease specialist by both face to face and via telemedicine. The results show that patients treated via telehealth had fewer days on antibiotics than patients treated face to face for all three diagnosis. Likewise, patients receiving telehealth consults spent fewer days hospitalized then the face to face. Realizing that this is an analysis of efficacy and does not account for comorbid conditions and given the result and the purpose of undertaking the study, the conclusion is that IDS telehealth services, including subsequent inpatient care, are an effective form of care delivery in rural area. (Please refer to attached study for further information)

Another example of the impact of subsequent care involvement by a specialist is dramatically demonstrated through the outcome statistics of organizations that have implemented telemedicine intensive care monitoring.[2,3,4] Remote intensive care monitoring allows a specialist to be involved in the ongoing care of a patient. Comparing Avera Health's outcome data to the APACHE III (Acute Physiology and Chronic Health Evaluation) scoring database routinely used to predict an individual's risk of dying in the setting of critical illness, Avera has observed a 70% less mortality than predicted by the APACHE III scoring and a decrease of 23% in the patient's length of stay.[2] Again, this demonstrates how subsequent inpatient care delivered via telemedicine can positively impact the care of an acutely ill patient.

While the focus of the first study is on infectious diseases, it is important to understand that many specialties are affected. These two studies both confirm that subsequent inpatient care delivered by telemedicine is as good as, or in some cases better than, face-to-face consultations.

CMS' vision as stated on your website is "to achieve a transformed and modernized health care system." Telehealth is one of the steps that can help achieve this goal by allowing the right care to be delivered at the right time in the right location. Please allow for the billing of subsequent inpatient codes by adding CPT codes 99231-99233 to the allowable telehealth billing codes.

Sincerely,

Marilyn Dahler, RN, BSN
*On behalf of:*
Avera Telehealth
P.O. 5045
Sioux Falls, SD 57117

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**References:**

1. Assimacopoulos A, Alam R, Arbo M, Nazir J, Chen D, Weaver S. A Brief Retrospective Review of Medical Records Comparing Outcomes for Inpatients Treated via Telehealth verusus Face-to-Face protocols: Is telehealth equally effective as face-to-face visits for treating neutropenic fever, bacterial pneumonia, and infected bacterial wounds. Avera Research Preliminary report, 2007
2. Zawada ET Jr, Kapaska D, Herr P, Aaronson M, Bennett J, Hurley B, Bishop D, Dagher H, Kovaleski D, Melanson T, Burdge K, Johnson T; Avera eICU Research Group. Prognostic outcomes after the initiation of an electronic telemedicine intensive care unit (eICU) in a rural health system. S D Med. 2006 Sep;59(9):391-3.
3. Smith AC, Coulthard M, Clark R, Armfield N, Taylor S, Goff R, Mottarelly I, Youngberry K, Isles A, McCrossin R, Wootton R.. Wireless telemedicine for the delivery of specialist paediatric services to the bedside. J Telemed Telecare. 2005;11 Suppl 2:S81-5.
4. Breslow MJ, Rosenfeld BA, Doerfler M, Burke G, Yates G, Stone DJ, Tomaszewicz P, Hochman R, Plocher DW. Effect of a multiple-site intensive care unit telemedicine program on clinical and economic outcomes: an alternative paradigm for intensivist staffing. Crit Care Med. 2004 Jan;32(1):31-8.

**A Brief Retrospective Review of Medical Records Comparing Outcomes for Inpatients Treated via Telehealth versus Face-to-Face Protocols: Is telehealth equally effective as face-to-face visits for treating neutropenic fever, bacterial pneumonia, and infected bacterial wounds?**

Aristides Assimacopoulos, MD, Infectious Disease Specialists, PC; Rabiul Alam, MD, Infectious Disease Specialists, PC; Manuel Arbo, MD, Infectious Disease Specialists, PC; Jawad Nazir, MD, Infectious Disease Specialists, PC; Din Chen, PhD, South Dakota State University; Susan Weaver, MSN, CNP, Avera Research Institute.

**Abstract**

**Context:** The incidence of infectious diseases in the US has been increasing since 1980. Re-emergent conditions, multidrug-resistant bacteria, newly identified infections, and bioterrorism, have prompted public health surveillance and control initiatives, including the use of telehealth technology. Infectious diseases, such as West Nile Virus, pose a particular threat to rural areas, where access to infectious disease specialists (IDS) is limited. However, reimbursement for in-patient consultation, follow-up consultation, or subsequent care visits is not provided when these services are delivered via telehealth measures. **Objective:** The purpose of this study is to investigate the efficacy of telehealth technology in providing timely, efficient and prudent infectious disease care for rural patients. **Design:** We conducted a retrospective, comparative review of medical records (n=107) from inpatients at a rural hospital who received face-to-face IDS treatment, with records from inpatients at outlying hospitals who received telehealth IDS treatment. Outcome measures, including number of days hospitalized, number of days receiving IV antibiotic, survival, and transfer to another hospital, were compared for 3 commonly occurring infectious diseases: neutropenic fever, bacterial pneumonia, or bacterial wound infection. **Results:** Patients treated via telehealth had fewer days on antibiotics and fewer days hospitalized than patients treated via face-to-face intervention. Survival rates did not differ significantly between groups, but was lower for telehealth patients. Fewer telehealth patients required transfer to another hospital. Results were statistically significant only for selected outcomes and conditions. **Conclusions:** IDS treatment for the conditions studied is equally effective when delivered via telehealth measures, as when delivered via face-to-face methods.

**Introduction**

Mortality from infectious diseases has declined in the US since 1900; yet, the incidence of these diseases has been increasing since 1980.[1] Newly-identified infections, such as avian flu, and re-emergent diseases, such as rubella,[2] are continuing to create a substantial health and economic burden. Emerging infectious diseases (EIDs) are now defined as those whose incidence has increased in the last 20 years or is expected to increase in the near future[3] (eg., Acquired Immune Deficiency Syndrome [AIDS], Legionnaire's disease, Lyme disease, and multidrug-resistant tuberculosis, among others).[1] In addition to the acute health care threat of these diseases, there now is increasing evidence that certain infectious microbes may cause or contribute to the development of various chronic diseases, including heart disease, stomach ulcers, and some forms of cancer.[4] With the current threat of bioterrorism (such as anthrax), and the outbreak of unexpected diseases, public health officials now stress the importance of being prepared to address infectious diseases.[2]

**Infectious Diseases in Rural Areas:** The threat of EIDs also is relevant in rural America, an area occupied by nearly 25% of the US population, but only by 10% of physicians.[5] Minnesota, for example, which accepts more refugees per capita than any other state,[6] has an increasing incidence of infectious diseases, such as malaria and tuberculosis, commonly carried by refugees.[7] South Dakota, another rural state, reported the most US cases of West Nile virus in humans, as of July 2007.[8] Currently, South Dakota is served by 8 Infectious Disease Specialists (IDS) who practice either in Sioux Falls or in Rapid City, the two largest towns in the state, located on the extreme eastern and western borders, respectively (a distance of 400 miles). According to the National

Rural Health Association, rural residents requiring health care are disadvantaged over urban residents due to greater transportation difficulties, disparate Medicare payments to hospitals and physicians, and a current health professional shortage of 2,157, compared with 910 in urban areas.[5]

**The role of telehealth in combating EIDs:** Within its published strategy to combat EIDs (*Preventing Emerging Infectious Diseases: A Strategy for the 21st Century*), the Centers for Disease Control and Prevention (CDC) established 4 goals: surveillance and response; applied research; infrastructure and training; and prevention and control.[2] In promoting this strategy, the CDC found that surveillance and systematic compilation of data, and sharing of data among providers and public health agencies, is fundamental to prevention and control.[1] It also is apparent that current modes of care, such as shortened hospital stays and the increasing number of patients receiving home health care, require new ways to assess and to monitor patients.[2]

Telehealth technology is a valuable tool in meeting the challenges of EIDs within rural populations. Both primary care and IDS providers employ telehealth to assess patients quickly, thus avoiding the risks and costs of travel. Telehealth enables timely follow-up as test results become available and/or as the patient's condition changes. Pertinent laboratory results, reports, and other materials are faxed between facilities, as necessary. Electronic medical records may be accessed, and information shared among providers and public health agencies. Telehealth technology enables accumulation of patient and demographic data simultaneous to providing patient care. The Institute of Medicine notes several benefits to using telehealth technology in rural areas, including: i) enabling rural hospitals to keep more inpatients in the community and to increase their quality of care;

ii) providing a learning experience for primary care providers through interactive consultation with remote specialists; iii) compensating for the supply shortage of specialists; and iv) enhancing the delivery of care and the stability of rural health care systems by promoting networks among physicians.[9] Of 455 telemedicine projects assessed worldwide in 1999, the Agency for Healthcare Research and Quality (AHRQ) found that 80% utilized this technology mainly for consultations or second opinions.[10]

In 2006, the American Medical Association (AMA) deleted the Current Procedural Terminology (CPT) codes by which physicians/providers bill for telehealth inpatient confirmatory consultations (99271-99275) and for follow-up inpatient consultations (99261-99263), and the Centers for Medicare and Medicaid Services (CMS) ceased to reimburse for these services. Subsequent care codes currently are not approved by CMS for telehealth billing. CMS, however, continues to reimburse for subsequent care when the service is delivered via face-to-face visits from IDS providers. The IDSs involved in this study currently provide telehealth subsequent care with no means of reimbursement for their services.

**Purpose**

The purpose of this study is to investigate the efficacy of telehealth in providing timely, efficient and prudent infectious disease care for rural patients.

**Hypothesis**

Delivery of infectious disease treatment for neutropenic fever, bacterial pneumonia, and infected bacterial wounds via telehealth technology is equally effective as equivalent

treatment delivered via conventional, face-to-face patient consultation. Efficacy is defined as clinical treatment outcomes for each condition studied (Table 1).

**Table 1** Definition of study diagnoses and treatment outcomes measured as indicators of efficacy.

| Condition | Definition | Treatment Outcomes Measured Following IDS Consultation |
| --- | --- | --- |
| Neutropenic fever | Fever (>100.5°F) resulting from opportunistic infection due to abnormally low neutrophil granulocyte count (<1000 cells/mm$^3$). | • Number of days receiving IV antibiotic therapy<br>• Number of days hospitalized<br>• Patient survival<br>• Patient transfer to another hospital |
| Bacterial pneumonia | Acute inflammation of lungs due to bacterial infection, leading to plugged alveoli and bronchioles, and fibrous exudates. | |
| Bacterial wound infection | Bacterial invasion of a break in the skin, causing local cellular injury, secretion of toxin, or antigen-antibody reaction in the host, with acute infection leading to sepsis. | |

## Methods

We conducted a retrospective, comparative review of medical records (January 1, 2006-December 31, 2006) from an inpatient population at Avera McKennan Hospital (a 490-bed facility located in Sioux Falls, South Dakota) and records from sister telehealth hospitals (Figure 1). The Avera Health System patient records database was queried to retrieve records for patients diagnosed with one of 3 commonly occurring infectious diseases: neutropenic fever, bacterial pneumonia, or bacterial wound infection. Records were excluded if patients were not seen by an infectious disease specialist. A total of 107 records were selected and divided into two groups: Group A (n =59), inpatients at Avera

**Table 3** Study population, Groups A and B

| Group | n | Total Female | Total Male | Mean age | Diagnosis: Neutropenic fever | Bacterial pneumonia | Bacterial wound infection |
|---|---|---|---|---|---|---|---|
| A | 59 | 22 | 37 | 59 | 13 | 19 | 27 |
| B | 48 | 27 | 21 | 66 | 13 | 9 | 26 |

**Results**

Results show favorable outcomes for telehealth on most measures, compared with face-to-face interventions (Table 4). Patients treated via telehealth had fewer days on antibiotics than patients treated via face-to-face intervention (Figure 1). These results were statistically significant for all 3 study conditions. Likewise, patients receiving telehealth spent fewer days hospitalized than patients receiving face-to-face, for all 3 study conditions (Figure 2); however, this result was statistically significant only for patients with bacterial pneumonia. Survival rates did not differ significantly between Group A and Group B, although this was lower for telehealth patients. Fewer total patients from Group B required transfer to another hospital, but this result was not statistically significant for any of the study conditions. Patients in Group B received fewer subsequent care visits from infectious disease specialists while hospitalized, than did patients in Group A.

McKennan Hospital who received treatment via face-to-face consultation with an infectious disease specialist; and Group B (n =48), patients from sister hospitals who received treatment via telehealth with an infectious disease specialist. Providers were contacted to confirm endpoints that were not available on the patient records. Records were reviewed and data recorded in accordance with HIPAA guidelines. The study was conducted in accordance with FDA Good Clinical Practice Regulations (CFR 21, parts 50, 56, and 312), ICH GCP Guidelines (E6), clinical safety data management guidelines (E2A), and was approved by the Avera Institutional Review Board.

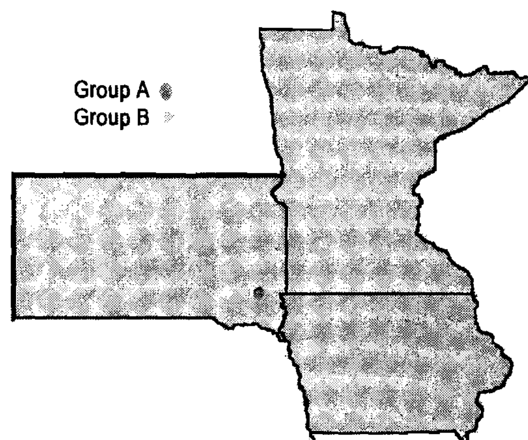


**Figure 1** Locations of hospitals represented in this study.

**Study population:** Data from records included patients ranging in age from 23-75 years, with a mean age of 62 years. Of 107 records analyzed, 46% of patients were female, 54% male, with 55% from a metropolitan area of the rural Midwest (Sioux Falls) and 45% from outlying rural areas (Table 3). Ethnicity was not addressed as a variable in this study.

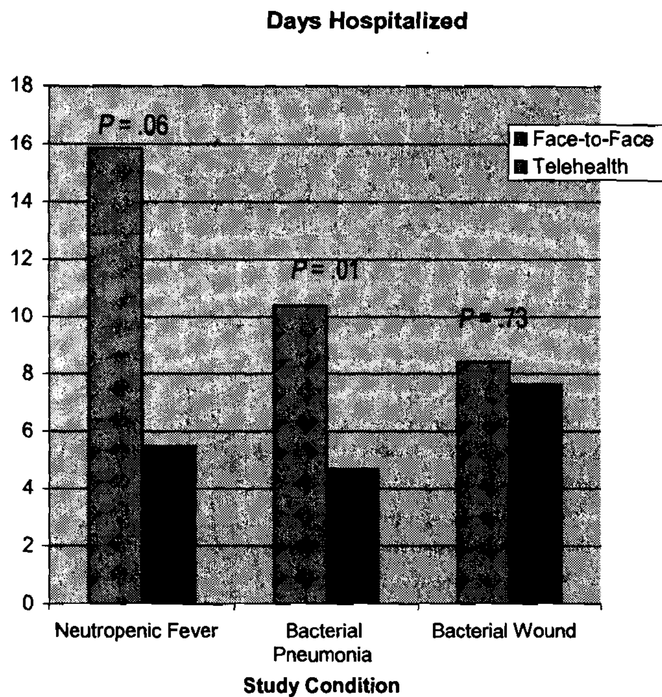


**Figure 2** Days hospitalized for face-to-face vs. telehealth consultation for all study conditions.

## Discussion

This initial retrospective comparison of medical records indicates IDS telehealth services are clinically more effective than face-to-face visits for some outcome measures for the conditions studied. The study, however, is only an initial analysis of efficacy and does not account for comorbid conditions, demographic characteristics, patient satisfaction and other confounding variables. Given these results and the purpose of undertaking this study we conclude that, for the conditions studied, IDS telehealth services are an effective form of care delivery in rural areas. If CMS codes for this subsequent care have never been reimbursed for the AMA's stated reason that telehealth delivery of subsequent care presents a potential decreased usage of rural primary care physicians, then we must

consider two additional questions: 1) is specialist consultation clinically effective; and 2) what are the clinical and economic implications for rural patients if telehealth specialist consultations are not available?

**Is specialist consultation effective?** This study was not designed to assess this variable for the conditions studied; however, we can contribute evidence from studies previously conducted. Hospital by-laws generally stipulate any patient admitted to a local hospital must have an attending onsite physician or primary care provider (PCP). The PCP monitors the patient and manages comorbidities, based on experience with the patient over time. For infectious diseases, an IDS may provide specialist consultation services at the request of the PCP, but the PCP remains in charge of the patient's case. This system illustrates two hallmark developments of current medical care for health professionals: working with an expanding knowledge base and coordinating patient care.

Current medical care now entails a significantly increased volume of research and new knowledge. In at least two studies examining this issue, researchers concluded that it no longer is possible for clinicians to remain fully abreast of this expanding information and to apply it to patients. [11, 12] The effectiveness of specialist participation in disease treatment has been documented in areas such as cardiology[13] and infectious diseases.[14] Specialists have been shown to utilize more resources, but also to be more knowledgeable about their area of expertise than generalists, and to achieve superior patient outcomes.[15] In its 2007 report examining quality improvement strategies, the AHRQ found that coordination of patient care, including shared primary-specialty care, is a fundamental element in achieving improved patient outcomes.[16] This collective evidence indicates that specialist involvement is generally beneficial for patients.

**What are the clinical and economic implications for rural patients if telehealth specialist consultations are not available?** If specialty care is, therefore, considered beneficial to patients, and is indeed reimbursed by CMS for face-to-face subsequent care, can rural primary care physicians effectively address infectious diseases without IDS telehealth assistance? In its 2007 report, the National Rural Assembly found that rural health care continues to be handicapped by limited availability, accessibility, and funding of basic services, as well as by a continual shortage of health care providers.[17] A resource of advice via telehealth may seem a logical route not only to enhanced care for the rural patient, but also to care in parity with that delivered to urban residents. To date, at least one study has examined potential healthcare costs and patient outcomes, if telehealth services are not available.[18] Results from this study indicated that a typical Medicare patient would have traveled approximately 202 miles to an urban center if telehealth facilities were not available. At the time of this study (2000), this equated to approximately $66 per trip, not including meals, lodging, or lost wages. Of patients assessed in this study, 77% reported they would have traveled for care had telehealth not been available and that HCFA would have paid for that care in the traditional manner. The report authors concluded that costs to Medicare would potentially increase, not only from travel expenses, but also from ensuing costs if patients seek local care that results in lack of prevention, early diagnosis, and suboptimal clinical outcomes. [18]

Current initiatives show widespread support for rural telehealth projects within many government and private organizations, such as the Federal Communication Commission's Rural Health Care Pilot Program, [19] the Telehealth and Medically Underserved Advancement Act of 2007 (HR 1601), and the Health Care Access and Rural Equity Act

(H-CARE, HR 2860).[20] Additional government strategies incorporate telehealth specifically as a key tool in addressing infectious diseases. Examples include the CDC's Public Health Information Network (PHIN) and its Emerging Infections Programs.[21,22] The PHIN includes a specific strategy (Rural Information Center Health Service [RICHS]) to promote the development of integrated rural surveillance systems at all levels,[23] thus utilizing telehealth technology already in place within many rural areas, such as South Dakota.

Data from this initial study show that telehealth consultation and subsequent care for 3 commonly occurring infectious diseases is equally effective as face-to-face consultation in a rural population. Future studies can examine the potential costs to patients for increased travel (including ambulance services), lost wages, and exacerbated disease due to delayed treatment. In its report, the Institute of Medicine observes that current telehealth initiatives are impeded by inconsistent and unclear guidelines from major payers, such as Medicare, and that a more comprehensive approach is needed.[9] Given the results of this study and evidence from studies examining various aspects of this issue, refusal of CMS funding for rural telehealth specialist patient subsequent care is in direct opposition to the numerous government and privately funded initiatives outlined in this report, as well as to evidence documenting telehealth efficacy. The availability of needed IDS telehealth services in rural areas may indeed be jeopardized by continued lack of funding.

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**Submitter :** **Mr. Dan Patton** **Date: 08/23/2007**

**Organization :** **Mr. Dan Patton**

**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,
Dan Patton, RN
Name & Credential
816 Lock 4 Road Unit 202
Address
Gallatin, TN 37066
City, State ZIP

**Submitter :** **Amy Moncman** **Date: 08/23/2007**

**Organization :** **Amy Moncman**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Background**

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Office of the Administrator
Dear Administrator:
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Sincerely,
Amy Moncman, MS, CRNA

**Submitter :** **Mr. JAMES humphrey** **Date: 08/23/2007**

**Organization :** **American Association of Nurse Anesthetists**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Background**

Background

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Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,
__James Humphrey CRNA____________________________
Name & Credential
_7109 Santa Rita PL NE ___________________________
Address
_Albuquerque, NM 87113____________________________
City, State ZIP

**Submitter :** **Dr. Mark Zukaitis** **Date: 08/23/2007**

**Organization :** **Pain Management and Anesthesiology Assoc.**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

sec atachment

CMS-1385-P-7371-Attach-1.DOC

#7371

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,

Steven E. McGraw
Chief Executive Officer
Anesthesiologists Associated, P.C.

2341 McCallie Avenue, Suite 402
P.O. Box 3549
Chattanooga, TN 37404

**Submitter :** **Dr. Daniel Coy** **Date: 08/23/2007**

**Organization :** **Anesthesiology, Chartered**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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Thank you for your consideration of this serious matter.

Daniel Coy MD

**Submitter :** **Dr. Kamel Abraham** **Date: 08/23/2007**

**Organization :** **Associated Anesthesiologists of Springfield**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,
Kamel Abraham, MD

**Submitter :** Ms. Barbara Hahn **Date:** 08/23/2007

**Organization :** AANA

**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
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Sincerely,
__Barbara A Hahn CRNA______________________
Name & Credential
53 Sheffield Ct______________________
Address
_Kingsland Ga 31548______________________
City, State ZIP

CMS-1385-P-7375

**Submitter :** Dr. Karen Bumb **Date:** 08/23/2007

**Organization :** ACI

**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:

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Thank you for your consideration of this serious matter.

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

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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,
Karen L. Bumb M.D.

CMS-1385-P-7376

**Submitter :** Ms. Anne Marie Bicha **Date:** 08/23/2007

**Organization :** American Gastroenterological Association

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

Sce Attachment

CMS-1385-P-7376-Attach-1.PDF

#7376

August 23, 2007

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
7500 Security Boulevard
Baltimore, MD 21244-8018

Re: CMS 1385-P--Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008

The American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE) and the American College of Gastroenterology (ACG) welcome the opportunity to comment on the proposed changes to the physician fee schedule for 2007. Our three societies represent virtually all practicing gastroenterologists in the United States.

We appreciate the opportunity to provide CMS with our comments on the proposed rule for physician payments for 2008 that was published in the *Federal Register* on July 12, 2007:

**Coding—Additional Codes from 5-Year Review--Work Adjustor**
In this proposed rule, CMS announces that the work adjustor flowing from the five-year review of work values will be increased from -10.1% to -11.8%. We strongly urge that CMS eliminate the work adjustor and maintain budget neutrality by adjusting the conversion factor. We recognize that the law requires CMS to adjust for budget neutrality when changes in relative values cause the amount of expenditures to differ by more than $20 million from what they would have been absent these changes. However, it would be clearly preferable if the required budget neutrality adjustment was made to the conversion factor instead of reducing all work relative values.

There are a number of reasons for eliminating the work adjustor. Doing so would be less confusing to other payers whose payments are based on the Medicare Relative Value Scale. It would make the fee schedule more transparent and understandable to physicians and members of the public. Eliminating the work adjustor would have the desired effect of lessening the adverse impact on the values for evaluation and management services. This is a critical issue

since increases in the work values for E/M services achieved through the 3rd five year review were substantially diluted by the reduction in work values for 2007 and by the further reduction proposed for 2008. Finally, it would be more consistent with the manner in which budget neutrality has been maintained throughout most of the history of the physician fee schedule.

Given these reasons and since the budgetary impact is identical, we strongly recommend that CMS eliminate the separate work adjustor and provide for budget neutrality by reducing the conversion factor.

**TRHCA-Section 101(d): PAQI**
Our societies are extremely concerned about the potential 9.9 percent reduction in the conversion factor for 2008 as a result of the impact of the Sustainable Growth Rate system. Needless to say, we are hoping that the Congress will intervene and enact a positive update for 2008. However, in the event that Congress does not act, the law authorizes CMS to use the $1.35 Billion from the Physician Assistance and Quality Initiative (PAQI) Fund to lessen the reduction in the conversion factor. CMS indicates it intends to use the fund to make incentive payments under the Physician Quality Reporting Initiative (PQRI) for 2008 services in lieu of using it to lessen the conversion factor reduction. While we support the objectives of the PQRI program, we believe that in the event legislative relief on the conversion factor reduction is not enacted, it would be preferable to use the PAQI fund to lessen the massive reduction in payment for all physicians, instead of using it to provide bonus payments to a minority of physicians.

**Physician Self-Referral Provisions**
Anti Mark-Up

CMS proposes that Section 414.50 of the regulations be modified so that (1) the professional component (PC) of a purchased test would be subject to the anti-mark-up provision now applicable only to purchased technical components (TC) under certain conditions and (2) that the anti-markup provision apply to all arrangements not involving a reassignment for a full time employee of the billing entity. We have a number of concerns with the proposal.

First, we question the legal authority to prohibit mark-ups of purchased professional components. Section 1842(n) of the Social Security Act which provided the statutory basis for the limit on markups only applies to technical components which are purchased; i.e., the diagnostic test and not the interpretation thereof. This provision predated the enactment of the physician fee schedule and the self referral provisions and, as far as we know, has not been changed. We therefore question CMS' authority to apply the limit to purchased PC services.

Second, CMS proposes to limit the ability to bill for all TC and PC services only to situations where the service is provided by a full time employee working 35 hours per week. However, CMS has not provided any evidence of abuse or over utilization where a reassignment arrangement exists with other than a full time employee to provide the services. In gastroenterology, the proposal would affect pathology services furnished to GI practices through contractual arrangements with laboratory technologists and/or pathologists or through a less than full time employment arrangement. Most gastroenterologist who enter into these arrangements for pathology services do so in order to achieve a higher quality of patient care through timely

diagnoses and utilization of pathology personnel who are experts in gastrointestinal and liver pathology. Where justified by workloads, a full time employment arrangement is used while in smaller practices, a part time employment or contract basis make much more sense.

We are unaware of any evidence of over utilization by gastroenterologists who have entered into these arrangements and note that the peer-reviewed literature provides guidance in terms of numbers of biopsies, lesion removal, etc. We are convinced that this proposal will have an adverse effect on practice efficiency and quality of patient care. In the absence of any evidence of abuse, we ask CMS to withdraw the proposal.

In-Office Ancillary Services Exception

CMS requested comments on whether changes are necessary for amending the in-office ancillary exception to the prohibition on physician self-referral. Specifically, CMS asks whether changes are needed in the following areas:

- Whether certain services that are not needed at the time of the office visit in order to assist the physician in his or her diagnosis or treatment should qualify for the exception.

- Whether non specialist physicians should be able to use the exception to refer patients for specialized services involving the use of equipment owned by the non-specialists.

We appreciate that CMS is seeking input before proposing any change in the in-office ancillary service exception. It is our judgment that this exception has generally served the program well and there is no need to make any changes at this time.

We think attempting to define what ancillary services a particular practitioner may provide "in-house" would be very unwise. There are legitimate differences in practice styles based on geographic location, the number and variety of physicians in the group, availability of specialized services in a particular community which would make a "one size fits all" rule inappropriate. Advances in medical technology continue to occur and it would be very difficult for CMS to have rules that are responsive to changing conditions. As Gastroenterologists have completed training in Internal Medicine and Gastroenterology, and may further subspecialize in fields such as Hepatology, Nutrition, Motility, Bariatrics, Transplant or other disciplines, this further complicates any effort to determine what equipment they might reasonably be expected to own.

However, out greatest concern is that any effort by CMS to prescribe what services are needed or are not needed at the time of an office visit, gets very close to CMS interfering with the practice of medicine. We mean that this may preempt the dialogue between the physician and the appropriately informed and insightful patient, as to what is the standard of care and best to optimize the potential therapeutic outcome. Such activities by CMS are not only prohibited by the statute but they are an affront to the lifelong dedication by physicians to doing what is right for their patients. Rather, if CMS suspects over utilization of ancillary services by certain physicians, CMS should concentrate on identifying and eliminating abuses through medical review policies, post payment audit, etc.

Thank you for the opportunity to submit these comments. If we may provide additional information, you may contact Anne Marie Bicha, AGA Director of Regulatory Affairs, at 240-482-3223, Bernard Patashnik, Consultant to ASGE at 202-833-0007, or Julie Cantor-Weinberg, ACG Vice President of National Affairs, at 301-263-9000.

Sincerely,

David A. Johnson, MD, FACG
President, American College of Gastroenterology

Mark Donowitz, MD, AGAF
Chair, American Gastroenterological Association

Grace H. Elta, MD, FASGE
President, American Society for Gastrointestinal Endoscopy

**Submitter :** **Ms. Barbara Marone** **Date: 08/23/2007**

**Organization :** **American College of Emergency Physicians**

**Category :** **Health Care Industry**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

August 20, 2007 Attention: CMS-1385-P

DRAFT

Herb B. Kuhn, Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1385-P: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for 2008

Dear Mr. Kuhn:

On behalf of the American College of Emergency Physicians (ACEP), I am pleased to submit comments on the proposed rule for Medicare physician payment for 2008 that was published in the Federal Register on July 12, 2007.
ACEP is a national medical specialty society with more than 25,000 members, dedicated to improving the quality of emergency care through continuing education, research, and public education. We appreciate the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with our comments on fee schedule payment policy and its effects on the practice of emergency medicine.

Impact

After seven years of reductions or updates significantly less than the rate of inflation or zero percent, physicians are now faced with the largest payment reduction ever (9.9%). Each year, ACEP works with the Administration and Congress to urge rescinding of the SGR and replacement with a formula that recognizes reasonable inflationary costs, using similar mechanisms that are employed in all of the other Medicare payment systems. This proposal has been repeatedly recommended by the Medicare Payment Advisory Commission (MedPAC) and other policy experts as well.

TRHCA Section 101(d)

While the most salient challenge is on Congress to act, CMS has done nothing to ameliorate the growing cost of the SGR fix and has repeatedly refused to take drugs out of the SGR pool while continuing to under-estimate the costs of new Medicare benefits. This year, CMS proposes to take the $1.35 billion that Congress set aside in the TRHCA legislation of 2006 and use it for the physicians quality reporting initiative, rather than for an offset to the SGR which would benefit all physicians.

ACEP strongly supports use of these funds as a down payment for a longer term change in the reimbursement formula for physicians, as does MedPAC. CMS should overcome the legal and operational problems associated with applying the funds to the negative update, as the situation posed by the harmful cuts prevails over the potential obstacles. Use of these funds to offset a portion of the cost of replacing the SGR will have a more positive impact on all physicians than a reporting program whose value has not yet been demonstrated.

As you know, fee schedule cuts affect emergency physicians disproportionately. While physicians in other types of practice can limit their financial losses in ways considerably more subtle than dropping participation in the Medicare program, emergency physicians will continue to see everyone who comes to the emergency department, regardless of ability to pay. Emergency physicians provide care 24 hours per day, 7 days a week to an ever-growing population demanding their services.

According to the latest CDC survey data, emergency physicians provided care to over 115 million patients in 2005. Nearly 17 million visits represented Medicare patients and 51 out of every 100 Medicare patients had at least one visit to an emergency department that year. In response to shrinking practice revenues, physicians will generally not drop out of the Medicare program, they will explore other means to limit their exposure to continuing losses, which in turn forces more beneficiaries to seek care in the emergency department.

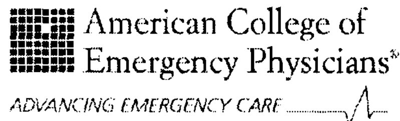
Budget Neutrality Adjustment

ACEP strongly objects to using physician work relative values as a mechanism to preserve budget neutrality and again urges CMS to make any budget neutrality adjustment for 2008 to the conversion factor. From 1998 to 2006, CMS achiev

CMS-1385-P-7377-Attach-1.DOC

CMS-1385-P-7377-Attach-2.DOC

#7377




August 20, 2007 **Attention: CMS-1385-P**

**DRAFT**

Herb B. Kuhn, Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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**TRHCA – Section 101(d)**

While the most salient challenge is on Congress to act, CMS has done nothing to ameliorate the growing cost of the SGR fix and has repeatedly refused to take drugs out of the SGR pool while continuing to under-estimate the costs of new Medicare benefits. This year, CMS proposes to take the $1.35 billion that Congress set aside in the TRHCA legislation of 2006 and use it for the physicians' quality reporting initiative, rather than for an offset to the SGR which would benefit all physicians.

**ACEP strongly supports use of these funds as a down payment for a longer term change in the reimbursement formula for physicians**, as does MedPAC. CMS should overcome the "legal and operational" problems associated with applying the funds to the negative update, as the situation posed by the harmful cuts prevails over the potential obstacles. Use of these funds to offset a portion of the cost of replacing the SGR will have a more positive impact on all physicians than a reporting program whose value has not yet been demonstrated.

WASHINGTON D.C. OFFICE
2121 K Street, NW
Suite 325
Washington, D.C. 20037-1801

202-728-0610
800-320-0610
202-728-0617 (FAX)
www.acep.org

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## Budget Neutrality Adjustment

**ACEP strongly objects to using physician work relative values as a mechanism to preserve budget neutrality and again urges CMS to make any budget neutrality adjustment for 2008 to the conversion factor.** From 1998 to 2006, CMS achieved budget neutrality requirements by adjusting the Medicare conversion factor, after rejecting adjustments to work as "undesirable policy". Therefore, we were shocked by CMS' decision to make the budget neutrality adjustment to the work values for 2007, particularly after an overwhelming majority of physician specialties asked CMS to make this adjustment to the conversion factor. During the course of this past year, CMS spokespersons publicly touted the increases given to primary care work values for evaluation and management services, without mentioning that a substantial portion of the increase was actually taken away by the budget neutrality adjustment. Given that CMS has never satisfactorily explained the policy rationale for this decision, a nearly -12 percent adjustment to the 2008 work values on top of a 10 percent cut will literally wipe out all of the E/M work gains that CMS accepted last year from the Relative Value Scale Update Committee (RUC). The conversion factor, as the monetary multiplier in the Medicare payment formula, is the most appropriate place to adjust for budget neutrality, and it would result in much more transparent payment mechanism for Medicare as well as other payers.

## TRHCA -Section 101(b) Physician Quality Reporting Initiative (PQRI)

ACEP has been actively engaged in the development of physician-level performance measures at the American Medical Association's Physician Consortium for Performance Improvement (Consortium) since its inception, providing physician expertise to inform the development for emergency medicine as well as other specialty measures. ACEP has also been an active participant in the endorsement and adoption processes of the National Quality Forum and the Ambulatory Quality Alliance consensus bodies, working to ensure that measures for emergency medicine and other specialties were appropriate for inclusion in the 2007 PQRI. ACEP continues to work closely with external stakeholders to develop measures at the physician, hospital and system level that will help us continue to make quality improvements in a more systematic way while reducing redundancy of reporting.

We are concerned, however, that the process for developing the 2008 PQRI is advancing despite the 2007 PQRI having only just started July 1. This timeframe leaves scant opportunity to evaluate the most basic elements of the 2007 PQRI program, such as impact

on patient care, physician participation rates, and implementation costs before moving forward. While we understand that CMS is required by TRHCA to implement the 2008 program, we urge the agency to use its discretion to closely review the 2007 program before moving ahead, which is why we support S. 1519/ H.R. 2749, The Voluntary Medicare Quality Reporting Act which allows time for an evaluation of the effectiveness of the program that will help inform and improve the program as it evolves.

In addition, we believe that the requirement that measures for the 2008 program be developed "through the use of a consensus-based process" is too broad. For any reporting system to improve quality, the measures must be meaningful to clinical care and relevant to the specific specialty physicians. Therefore, direct physician involvement in the development, testing and implementation of quality measures is the only way to ensure measures are appropriate and clinically-relevant. While we appreciate that the proposed rule recognizes the Consortium as a source for the development of quality measures eligible for inclusion in PQRI 2008, we urge CMS to go further and consider the Consortium as the ***only*** entity appropriate for the development and updating of physician-level quality measures. The Consortium process is consensus-based and physician-led. This characteristic will ensure physician buy-in on measures which is essential for an effective quality reporting program. Further, tasking the Consortium as the only group for developing physician measures significantly reduces the risk of duplicative or contradictory measures.

Please do not hesitate to contact Barbara Marone, ACEP's Federal Affairs Director at (202) 728-0610 ext. 3017 if you have any questions about our comments and recommendations.

Best Wishes,

Brian F. Keaton, MD, FACEP
President

CMS-1385-P-7378

**Submitter :** **Ms. Barbara Browne** **Date: 08/23/2007**

**Organization :** **AANA**

**Category :** **Other Health Care Provider**

**Issue Areas/Comments**

**Background**

Background

Dear Administrator:

I am writing to support the Centers for Medicare & Medicaid Services proposal to increase the value of anesthesia work. If adopted the proposal would help CRNAs as Medicare providers continue to provide Medicaid beneficiaries with access to anesthesia services.

Americas Certified Registered Nurse Anesthetists provide millions of anesthetics in the U.S. yearly in every setting requiring anesthesia services. More importantly CRNAs are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. is depend on these services. The reimbursement for these services has slipped far below even the 1992 payment levels (adjusted for inflation).

I support the proposed increase in the valuation of anesthesia work in a manner that boosts Medicare anestheia payment.

Sincerely,

Barbara J. Browne CRNA
3078 Timberview Road
Saline, MI 48176
734-786-1517

**Submitter :** **Dr. Iva Chapple** **Date: 08/23/2007**

**Organization :** **Carolina Pain Specialists, LLC**

**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.

Iva T. Chapple, MD

Carolina Pain Specialists, LLC
421 Hulon Lane
West Columbia, SC 29169

**Submitter :** **Dr. Steven Jones** **Date: 08/23/2007**

**Organization :** **St. Anthony's Memorial Hospital**

**Category :** **Physician**

**Issue Areas/Comments**

GENERAL

GENERAL

Please help stop the so-called "POD labs" which I believe are a violation of Stark laws. They allow physicians to profit from ordering pathology services. Thank you very much. Dr. Jones

**Submitter :** **Dr. Brian Casement** **Date: 08/23/2007**

**Organization :** **Dr. Brian Casement**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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Thank you for your consideration of this serious matter.

**Submitter :** **Dr. Sasha Shillcutt** **Date: 08/23/2007**

**Organization :** **University of Nebraska Medical Center**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
A ' ntion: CMS-1385-P
P.O Box 8018
Bal.imore, MD 21244-8018

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Thank you for your consideration of this serious matter.

**Submitter :** **Ms. Elaine Ladich**

**Organization :** **American Association of Nurse Anesthetist**

**Date: 08/23/2007**

**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,
Elaine Ladich, CRNA

63 Sackarackin Ave.
Dover, Delaware 19901