CMS-1385-P-7384

Submitter : Mr. Steven McGraw

Date: 08/23/2007

Organization : Anesthesiologists Associated, P.C.

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-7384-Attach-1.DOC

#7389

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.

Submitter : **Dr. Marcelino Alvarez** **Date: 08/23/2007**

Organization : **Dr. Marcelino Alvarez**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Marcelino Alvarez, MD FCAP
Medical Director, Integrated Regional Laboratories
5361 NW 33rd Avenue, Ft. Lauderdale, FL 33309
Phone: 954-717-0299 Fax: 1-800-866-386-1517

August 6, 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 in a group practice as part of a 5 member pathology group. Our group practices in Crystal River and Fort Lauderdale, Florida rendering pathology services for a Community Hospital and a large Core Laboratory.

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,

Marcelino Alvarez, M.D., F.C.A.P.

CMS-1385-P-7386-Attach-1.DOC

CMS-1385-P-7386-Attach-2.DOC

#7386

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Medical Director, Integrated Regional Laboratories
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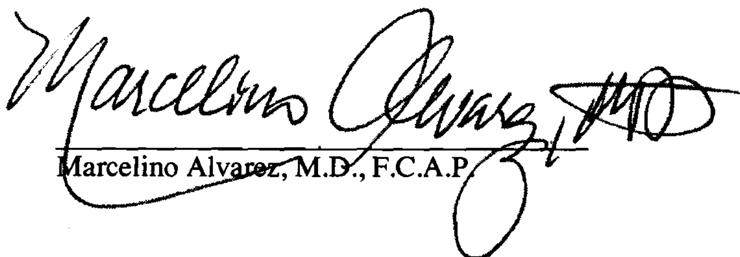

Marcelino Alvarez, M.D., F.C.A.P.

CMS-1385-P-7387

Submitter : **Dr. Kimberly Babiash** **Date: 08/23/2007**

Organization : **Wichita Anesthesia Chartered**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
C ..rs for Medicare and Medicaid Services
A. .ion: 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.

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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.

Dr. Kimberly Babiash

Submitter : **Dr. John Maxa** **Date: 08/23/2007**

Organization : **Dr. John Maxa**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Sincerely,
John Maxa MD

CMS-1385-P-7393

Submitter : Mrs. Allison Morgan **Date:** 08/23/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

P O Box 8018

RE: CMS-1385-P (BACKGROUND, IMPACT)
Baltimore, MD 21244-8018 ANESTHESIA SERVICES

Dear Administrator:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Allison M. Morgan, BSN, RN, nurse anesthetist student
2355 N State Hwy 360 #1026
Grand Prairie, TX 75050

CMS-1385-P-7394

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

Organization : Dr. Brian Chung

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Cent... or Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore , MD 21244-8018

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Sincerely,
Brian Chung, MD
Northwestern Memorial Hospital

Submitter : **Mr. Jose Soto** **Date: 08/23/2007**

Organization : **Mr. Jose Soto**

Category : **Other Technician**

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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Sincerely,
Jose Soto
Northwestern Memorial Hospital

Submitter : Mr. Peter Klimah **Date:** 08/23/2007
Organization : Mr. Peter Klimah
Category : Other Technician

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,
Peter Klimah
Northwestern Memorial Hospital

Submitter : **Dr. Robert Sullivan** **Date: 08/23/2007**

Organization : **Dr. Robert Sullivan**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore , MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Sincerely,
Robert Sullivan, MD
University of Mississippi Medical Center

Submitter : Ms. Jennifer Enriquez **Date:** 08/23/2007

Organization : Physiotherapy Associates

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have been a practicing PT in an outpatient setting for 12 years and I feel it is important that there remain signficiant checks and balances regarding referral sources. We can look to the past and see abuses of the system when such resources were not in place and due to those abuses we are in our current situation regarding insurance coverage. I feel that with more physician ownership of clinics the patients suffer as they lose the freedom to choose which clinic they go to for PT. Patients often feel intimidated when a physician refers to one and only one clinic and may feel they have to go to the clinic despite their desire to go to another clinic about which they have heard good recommendations. I feel that with more "POP"s there is less abiltity for PT clinics to be opened and managed by PTs and I feel that the best clinics are the ones that are owned/managed by PTs themselves. This is our area of expertise and I feel that PTs are the ones who are better aware of the balance between functional gains with therapy, need for continued skilled coverage and plateau in progress. In an environment where there are signficant financial gains for physician owners I do not feel these insurance constraints will be considered. Thank you for your consideration in this matter.

CMS-1385-P-7399

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

Organization : Laboratory Physicians Association

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 23, 2007

I appreciate the opportunity to submit comments on the Physicians Referral provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, for Year 2008 . I am a board certified pathologist practicing in Dallas, TX. I am part of a group of eight pathologists practicing mostly in a hospital-based setting, as well as a small outpatient laboratory. I am a member of the College of American Pathologists.

I enthusiastically support the initiative of CMS to end self-referral abuses for pathology services. These irregular billing arrangements are an attempt to bypass the Stark law which prohibits physician self-referrals. Clinicians have exploited a loophole that allows them to profit from pathology services which they did not perform. I am acutely aware of several abusive arrangements in my practice area here in Dallas-Fort Worth and around the state, especially in San Antonio, TX where many of these dubious billing practices originated. They are nothing more than a fee-splitting arrangement on self-referrals of a captive patient population.

I strongly support the expansion of the anti-markup rule to purchase pathology interpretations and the exclusion of anatomic pathology from 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-interest considerations in critical decisions and are in the best interests of the patient. I believe that physicians should not be able to profit from professional pathology services unless they have personally preformed or supervised the service.

Opponents of the proposed changes argue that these dubious arrangements actually enhance patient care. I agree that the Medicare Program should ensure the highest quality of care for their patients. Restrictions on physician self-referrals are necessary to safeguard and ensure that clinical decisions are determined solely on the basis of quality and not tainted by financial incentives. The proposed changes, contrary to what opponents may argue, do not impact the availability or delivery of pathology services. They simply remove the financial conflict of interest that compromises the integrity of the medicare program. Thank you again for addressing this issue.

Sincerely,

Karen S. Roush, MD
3400 Hidalgo St.
Irving, TX 75062
214-974-3584
karenroush@mhd.com

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

Organization :

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 23, 2007

Cent- -- for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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Sincerely,

Randolph C. Lester, M.D.

Submitter : **Dr. Jay Williams** **Date: 08/23/2007**

Organization : **Bay Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Jay J Wiliams, MD-PhD
Managing Partner
Bay Anesthesia Assc
Dover, DE

Submitter : **Dr. Mila Mogilevsky**

Organization : **Dr. Mila Mogilevsky**

Category : **Physician**

Date: 08/23/2007

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

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Thank you for your consideration of this serious matter.

Sincerely,
Mila Mogilevsky
Rehabilitation Institute of Chicago

CMS-1385-P-7403

Submitter : Ms. Antoinette M. Ritchey

Date: 08/23/2007

Organization : Ms. Antoinette M. Ritchey

Category : Physician Assistant

Issue Areas/Comments

GENERAL

GENERAL

Scc Attachment

CMS-1385-P-7403-Attach-1.DOC

CMS-1385-P-7403-Attach-2.DOC

CMS-1385-P-7403-Attach-3.PDF

#7403

August 23, 2007

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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To ensure that all of 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 very much for your consideration of this serious matter.

Sincerely,

Antoinette M. Ritchey
5800 Colonial Blvd.
Willoughby, Ohio 44094

CMS-1385-P-7404

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

Organization : **American Academy of PM&R**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

CMS-1385-P-7404-Attach-1.DOC

#7404

American Academy of Physical Medicine and Rehabilitation

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Chicago, Illinois 60611-7617
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info@aapmr.org

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Deborah A. Venesy, MD

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Thomas E. Stautzenbach, CAE

August 23, 2008

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1385-P
P.O. Box 8015
Baltimore, MD 21244-8015

Re: Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for 2008; CMS-1385-P; Reassignment and Self-Referral

Dear Ms. Norwalk:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates this opportunity to comment on the *Proposed Revisions to Payment Policies Under the Physician Fee Schedule* as published in the July 12, 2007 *Federal Register*.

AAPM&R is the national medical specialty society of more than 7,000 board certified physical medicine and rehabilitation physicians, also called physiatrists. Approximately 90% of all physiatrists practicing in the United States are members of AAPM&R. Physical medicine and rehabilitation (PM&R), recognized as a board-certified medical specialty in 1947, focuses on restoring function to people with problems ranging from simple physical mobility issues to those with complex cognitive involvement. Physiatrists also treat patients with acute and chronic pain and musculoskeletal disorders, neurological disorders and those in need of prostheses, orthoses and mobility devices.

A. Anti-Markup and Reassignment Proposals

CMS' proposal to extend the anti-markup rule to the professional component of diagnostic tests and expand the definition of outside supplier to encompass anyone who is a less than full-time employee of the billing practice violates the Medicare statute and, as such, constitutes illegal agency rulemaking. In addition, the proposal is so broadly conceived that it would result in the elimination of many legitimate group practice arrangements and cause loss of access to care for Medicare beneficiaries.

1. Extension of the Anti-Markup Rule to the Professional Component of Diagnostic Tests

We find no legal authority for expanding the anti-markup rule to physician professional services. Section 1848 of the Social Security Act mandates that physician services be paid the lesser of the billing physician's actual charge or the physician fee schedule amount. CMS cannot, through regulation, impose a different methodology for determining payment for physician services.

Nor is there anything in Section 1842(n) which would permit the anti-markup rule to be applied to services other than diagnostic tests. That law specifically states that the policy applies to billing for a "diagnostic test described in section 1861(s) (3). The physician interpretation of a diagnostic test is NOT a service described in 1861(s)(3). Physician services are described in section 1861(s)(1). [1]). Congress, in enacting section 1842(n), specifically limited the applicability of the anti-markup provision to diagnostic tests. CMS cannot, through rulemaking, expand the scope of Section 1842(n) to include physician services. The proposal to do so is inconsistent with the plain meaning of the law and contrary to the clear intent of Congress.

2. Applicability of the Anti-Markup rule to Services Provided by Employees and Contractors

CMS also proposes to redefine outside supplier under the purchased diagnostic test rule and the reassignment rules to include anyone who is not a full-time employee of the billing physician or medical group. The agency's authority for the purchased diagnostic test rule comes from section 1842(n) of the Act. That section limits the applicability of the anti-

[1] CMS has specifically addressed this issue in a previous fee schedule notice in which the agency stated: [d]iagnostic services that have physician work RVUs are not "other diagnostic tests" covered under section 1861(s)(3) of the Act but physician services and services incident to a physician's services covered under sections 1861(s)(1) and 1861(s)(2)(A) of the Act. See Final 1998 Physician Fee Schedule Rule at 62 Fed. Reg. 59048, 59059 (October 31, 1997).

markup rule to charges for diagnostic tests "for which the bill or request for payment does not indicate that the billing physician personally performed or supervised the performance of the test or that another physician with whom the physician who (sic) shares a practice personally performed or supervised the performance of the test. . . ." Thus, the anti-markup rule does not apply where the services are provided by a physician who "shares a practice" with the billing physician or group. The clear intent of this section is to limit the prohibition on markups to services actually purchased from a third party or entity and not to interfere with services provided directly by the billing group.

Consequently, CMS' definition of "outside supplier" to include employees of a group practice is inconsistent with the plain meaning of the statute. Section 1842(n) is clear that the anti-markup rule does not apply if the diagnostic test is performed or supervised by either the billing physician or another physician with whom that physician "shares a practice." A physician who is an employee of a professional corporation, whether or not he is also an owner of the practice, clearly "shares a practice" with other physicians in the group. This relationship does not change simply because the physician might work part-time. For this reason, we believe the proposed definition of outside supplier in section 414.50 is inconsistent with section 1842(n).

For similar reasons, we do not believe the anti-markup rule can or should be applied to services performed by physicians who have a contractual rather than employment relationship with a physician practice. This would be particularly true where the physician provides services on the premises of the billing practice and shares office space, overhead, clinical and administrative personnel and equipment with the billing practice. In such a situation, we believe the independent contractor is "sharing a practice" within the meaning of section 1842(n). Prohibiting a mark-up of the charge does not allow the billing practice to be paid for its legitimate overhead costs.

If implemented, the proposed rule would result in the elimination of a number of legitimate arrangements and would also reduce access to care for Medicare beneficiaries.

3. Impact of Proposal on Employed Physiatrists and Their Practices

Physiatrists perform nerve conduction studies (NCS) and electromyography (EMGs) to diagnose musculoskeletal conditions or disease. Both tests have a separate TC and PC. The TC of an NCS is occasionally done by a technician. However, the TC of an EMG is usually performed by the physician, who then also performs the professional interpretation. In fact, Medicare will only cover the TC of an EMG if it is performed personally by a physician or a physical therapist certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist and only if state law permits the therapist to perform such tests. The overwhelming majority (over 99%) of EMGs performed on Medicare beneficiaries are performed by physicians (primarily physiatrists and neurologists).

Under the proposed rule, CMS would require that a practice charge Medicare for the TC and PC of an EMG the same amount the practice is charged by the performing physician if that physician is not a full-time employee of the practice. Failure to include the "charge" of the performing physician on the claim would result in denial of the claim.

The proposed rule reflects a fundamental misunderstanding of physician group practice compensation. Employed physicians are not paid by the service and do not "charge" their own practices - they are typically paid on a salary basis which might be adjusted based on individual productivity. This is unlikely to be any different just because the employee is part-time. It will therefore be impossible to determine what the "charge" is for the TC or PC of an EMG or the PC of a NCS performed by a part-time employed physiatrist. Yet, if such a "charge" is not reflected on the claim, CMS is proposing that payment would be denied. However, including a "charge" on the claim when there is no identifiable charge or means of calculating a charge would subject a

practice to liability under the False Claims Act. Thus, the proposed rule puts practices in an entirely untenable position with respect to their part-time employees. The only way to avoid this dilemma would be for the part-time physician to bill Medicare him or herself for diagnostic test services, rather than reassign to his or her group (even though the group bills, under a reassignment arrangement for that physician's other services). This would create compliance problems under the physician-self-referral laws as well as substantial billing and administrative headaches for both the physician practice and the Medicare program without any apparent countervailing benefit. In addition, the proposed rule penalizes physicians who, for whatever reason, have elected to work on a part-time basis.

4. Impact on Physiatrists with Independent Contractor Arrangements

Many physiatrists have independent contract relationships with other specialty groups such as orthopedic surgery to provide specialized services such as nerve blocks or epidural injections or EMGs and NCS on a part-time basis (e.g. one half-day a week). These arrangements serve to increase patient access to services especially in rural or other areas where there may be a shortage of physicians able to provide these highly specialized services. Such services are furnished on the premises of the billing practice (i.e. not in a centralized building) and utilize the billing practice's overhead, clinical and administrative personnel and supplies. The physiatrist may be paid a per diem or may be paid per test. If payment is on a per diem basis, there is no assigned "charge" for the contract physician's services and thus, for the same reasons as discussed above, with respect to employees, practices are forced to come up with a "charge" and risk False Claims Liability or not be paid for the procedure.

Certainly if payment is on a per test basis, then a charge can be determined. However, that charge reflects the fact that the billing practices incurs practice expenses such as overhead, clinical and administrative labor costs, supplies and equipment. Thus, for example, a contract physician might be paid $100 for a service for which the practice charges

and is paid $200. Under the proposed expansion of the anti-markup policy, Medicare would only pay $100 for the service and the billing practice would receive no payment for its significant practice expense costs - costs that are otherwise recognized by CMS as appropriate and paid for under the physician fee schedule. It would be tantamount to paying for the work RVUs but not PE RVUs.

We understand that there are abuses that CMS is attempting to eliminate and we do not disagree that certain arrangements such as those involving so-called "pod laboratories" should be curtailed. However, the proposed solution has such a broad brush, that a great many legitimate non-abusive arrangements such as those discussed above would also be eliminated. We believe these abuses could be more appropriately addressed through changes to the Stark law definition of "centralized building."

5. Prohibition on Reassignment of the TC if Billing Practice Does Not "Directly Perform" the PC

We oppose the changes to the reassignment rule (section 484.40(d)(3)) for the same reasons we oppose the changes in the anti-markup regulation, as set forth above. We are also concerned about the particular impact of the proposed new 424.80(d)(3)(iii) on EMGs which are somewhat unique among diagnostic tests because the physician generally performs both the TC and the PC. That section states that if a group is billing under a reassignment from a physician who performs the technical or professional component of the service and is not a full-time employee of the practice, then:

> *To bill for the technical component of the service, the physician or medical group must directly perform the professional component of the service.*

As explained above, a physician performs <u>both</u> the TC and the PC of an EMG on the premises of the billing practice. If that physician is not a full-time employee of the billing group, then this provision would have the effect of entirely prohibiting the reassignment of the TC of EMGs since

the billing group would also not have performed the "professional component" of the service. This creates the odd situation that the group could bill for the PC of an EMG performed by a part-time employed or contractor physiatrist, under the reassignment rules, but could not bill for the TC since it was also performed by the same part-time employee. We do not believe CMS intended such an absurd result.

We recommend that CMS clarify that this provision would not apply where the physician performs both the TC and the PC of a diagnostic test such as is typically the case with EMGs.

B. Physician Self-Referral Issues

CMS states that it is considering whether it should narrow the scope of the in-office ancillary services and specifically mentions physical and occupational therapy services as an area of concern. CMS notes that it has received "hundreds of letters from physical therapists and occupational therapists stating that the in-office ancillary services exception encourages physicians to create physical and occupational therapy practices." Many physiatrists practicing in out-patient settings include a physical therapy or occupational therapy component to their practice. AAPM&R believes such this multi-disciplinary approach to treatment permits better coordination of care and can result in more effective use of therapy. Physiatrists are specifically trained in physical and occupational therapy and to work closely with and supervise therapists. Including therapy services as part of a PM&R practice allows Medicare beneficiaries to receive the benefit of this team approach to the provision of therapy. Medicare specifically recognizes the importance of this approach in the provision of inpatient rehabilitation. We believe this approach is also effective in the delivery of rehabilitation services to outpatients. It would be a disservice to Medicare beneficiaries to limit these types of multi-disciplinary models of health care delivery.

To the extent that CMS is concerned about potential over utilization of therapy services, the existing caps on the therapy services should be more than adequate to address such concerns. Moreover, even without therapy caps, we

do not believe there is any evidence of abuse or over utilization of therapy services in physiatry practices. To the extent that this is a concern in other specialties, we suggest that any restriction on physician self-referrals related to therapy be narrowly targeted to address only those areas where there is documented evidence of abuse. It is essential that physiatrists, who are specifically trained to provide a multi-disciplinary approach to rehabilitation, be permitted to continue to provide services in this manner.

C. Physician Work Adjuster

AAPM&R opposes the use of an 11% work adjuster and believes that budget neutrality changes should be made through adjustments to the conversion factor. AAPM&R supports the position taken by the RUC in its comment letter to CMS in connection with this rulemaking.

AAPM&R appreciates the opportunity to comment on these important issues. If you have any questions please contact Rebecca Burke, JD, at (202) 872-6751 or Rebecca.Burke@ppsv.com.

Sincerely,

Joel M. Press, MD
President

c: Thomas E. Stautzenbach, CAE, Executive Director
Lisa J. Kaplan, JD, Director, Health Policy and Practice Services
Wendy Chill, Manager, Reimbursement and Practice Management

CMS-1385-P-7405

Submitter : **Mr. Marcel Valenta** **Date: 08/23/2007**

Organization : **Mr. Marcel Valenta**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Marcel Valenta, Esq.
Wilson Sonsini Goodrich Rosati
Palo Alto, CA

CMS-1385-P-7406

Submitter : Dr. Tony Garcia **Date:** 08/23/2007

Organization : Dr. Tony Garcia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The time during direct patient care involves focus and expertise on the part of the physician. The knowledge and skills that make up our practice optimizes the care and eventual outcome. There are many distractions from this focus that we manage in addition to the medical decisions making we make. The medical care to patients and their families is our priority and placing value on this practice would be very appropriate.

Submitter : **Dr. Jake Krisik** **Date: 08/23/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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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.

Jake Krisik

CMS-1385-P-7408

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

Organization : **Carroll Anesthesia Services, Ltd.**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 23, 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-ANESTHESIA SERVICES)
Baltimore, MD 21244 8018
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to
ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.
First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for
Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.

Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.

Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Larry J. Carroll, CRNA, APN
President
Carroll Anesthesia Services, Ltd.
2630 East Fork Drive
Vandalia, IL 62471

CMS-1385-P-7409

Submitter : Dr. David Wheeler **Date:** 08/23/2007

Organization : Dr. David Wheeler

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

The workforce marketplace has long recognized that Medicare severely undercompensates anesthesia services. In my group practice, our unit reimbursement from Medicare is now less than one third of what we receive from the prominent commercial payers in our area. This disparity is well-known throughout the anesthesia workforce. The question what is your percentage of Medicare patients? is asked by all who interview for positions with us. The result of the dramatic undervaluation of anesthesia services by Medicare is straightforward and already apparent: the best applicants gravitate toward practices with low numbers of Medicare patients. This effect makes it difficult to retain and recruit anesthesiologists (and nurse anesthetists) in geographic locations with higher elderly populations and in clinical settings where older and sicker patients make up a greater fraction of the patient load.

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

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a physical therapist in Colorado I have seen ample abuse of referral for profit. I am part of a private practice (physical therapist owned) in the Boulder area that is within five minutes of a large surgical center/hospital that houses two large orthopedic surgery groups. Historically, these surgeons referred their patients to physical therapy clinics in the surrounding area, and in fact, our clinic was thought of well enough to have been the clinic of choice for treatment of the surgeons themselves. However, since these physician groups have been allowed to open their own in-house therapy services, the number of referrals to our clinic has dropped to nearly zero. Truthfully, the only time we see a patient from these surgeons is if the patient had formerly been seen in our clinic and specifically requested to be referred back to our care.
There have also been multiple instances of patient kidnapping'. Understanding our scope of care, we refer patients to orthopedists for additional treatment if appropriate. More than once, the patient has been explicitly told by the surgeon that they cannot return to our clinic and must be seen for therapy by the physician-owned group. Needless to say, this is overt action directed primarily at increasing their revenue, not acting in the best interest of the patient.
Additionally, physiatrists and osteopathic physicians have been opening in-house therapy clinics to where they refer the vast majority of their patients. This also is an advantageous abuse of the loophole in the Stark Law.
Private practice is not the only entity taking a hit from referral for profit practices. It has been demonstrated that the overall cost to the healthcare system is greater for referral-for-profit practices as compared to private practice.
The efforts of the American Physical Therapy Association, the legal structure of multiple state practice acts, and the true intent of the Stark Law are to prevent instances are described above from occurring. It would be in the best interest of the healthcare system and patients in general to close this loophole.

Submitter : **Mr. David N. Olsen** **Date: 08/23/2007**

Organization : **Star Valley Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

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

Dear Administrator:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

Submitter : Dr. Robert Start **Date: 08/23/2007**

Organization : Dr. Robert Start

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.

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Nisha Bhatt**

Date: 08/23/2007

Organization : **Mrs. Nisha Bhatt**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

scc attachmcnt

#7413

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

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

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

Submitter : **Mr. Bernard Kuzava** **Date: 08/23/2007**

Organization : **AANA**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

August 23, 2007

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

Dear Ms. Norwalk:

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This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Bernard A. Kuzava, CRNA
PO Box 382
Hastings, MI 49058

Submitter : **Dr. Lawrence Seigel** **Date: 08/23/2007**

Organization : **Suncoast Eye Center, P.A.**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

As a physician owner of a busy ophthalmology center that employs two CRNA's, providing care for approximately 200 patients a week, the Medicare reimbursement cut has affected us all. We are seeing and treating more patients than ever, yet have been punished with a reduction in reimbursement. I urge you to support the CMS proposal to boost the value of Anesthesia so we can continue to provide our patients with the highest quality of care that they are currently receiving. Thank you.

Submitter : Mrs. Kristen Brake **Date:** 08/23/2007

Organization : Thomas Jefferson University Hospital

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
' ;artment of Health and Human Services
I' C Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Ba..imore, 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,

Kristen Brake, RN, BSN, SRNA
318 Crestwood Avenue
Haddonfield, NJ 08033-2918

Submitter : **Dr. Alan Freedman** **Date: 08/23/2007**

Organization : **Suncoast Eye Center, P.A.**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

As a physician owner in practice at a busy surgery center that employs two CRNA's, and providing care for over 200 patients a week, the Medicare reimbursement cut has affected us all. We are seeing and treating more patients than ever, yet have been punished with a reduction in reimbursement. I urge you to support the CMS proposal to boost the value of Anesthesia, so we can continue to provide our patients with the highest quality of care. Thank you.

Submitter : **Dr. Michael M. Grubb** **Date: 08/23/2007**

Organization : **Dr. Michael M. Grubb**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Michael M. Grubb, M.D.
Methodist Hospital
Department of Anesthesiology
8303 Dodge Street
Omaha, Nebraska 68114

Submitter : **Dr. Robert Campagnone** **Date: 08/23/2007**

Organization : **Anesthesia Associates of Willimantic**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

After the recent reduction in reimbursement of our anesthesia conversion factor by $2 per unit, our group seriously considered no longer participating with Medicare. Although we feel that our seniors deserve the best care, the current rate is not sufficient in light of our increases in costs to provide our service. I hope that you will approve the increase in the conversion factor to $20 per unit as soon as possible. Furthermore, I would hope that this figure will be adjusted annually to take into account increases in cost of living and increases in our costs to provide the best service possible for our seniors.

Submitter : **Dr. Steve Wright** **Date: 08/23/2007**

Organization : **MedNet America**

Category : **Private Industry**

Issue Areas/Comments

GENERAL

GENERAL

August 23, 2007

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

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

Dear Ms. Norwalk:

This letter is to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. We are appreciative that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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 Medicare 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.

Sincerely,

J. Stephen Wright, Ph.D.
President
MedNet America

CMS-1385-P-7421

Submitter : Ms. Cathleen Sullivan **Date:** 08/23/2007

Organization : DePaul University/Evanston Northwestern Healthcare

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Office of the Administrator
Centers for Medicare & Medicaid Reimbursement
Department of Health and Human Services
P O Box 8018
Baltimore, MD 21244-8018

Dear Administrator:

I am currently a student member of the American Association of Nurse Anesthestists, and I am supporting the Centers for Medicare and Medicaid in the proposal to increase the value of anesthesia services by 32%. Currently, Certified Registered Nurse Anesthetists provide over half of anesthesia services to Medicare beneficiaries. The ability for CRNA's to provide anesthesia depends on the amount of Medicare reimbursement for their services. The reimbursement for CRNA's is currently below the level it should be according to inflation, and I support the proposal to increase the value of anesthesia services.

Sincerely,

Cathleen Sullivan
RN, SRNA
2442 W. Gunnison St. BSMT
Chicago, IL. 60625

CMS-1385-P-7422

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

Organization : Noı ιnwestern Health Sciecnes University

Category : Chiropractor

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

RE: CMS-1385-P

TECHNICAL CORRECTIONS

To Whom it May Concern:

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

While it is true that a subluxation does not need to be detected by an X-ray, they are vital to rule out serious (pathologic) causes of unresolved or recurring spinal pain syndromes. Radiographs are vital to determine diagnostic and treatment options. This proposed rule change will unfairly impact patients by forcing them to recieve duplicate services if X-rays or special tests are needed. Specifically, if X-rays are deemed necessary by a chiropractor, patients will need to schedule an additional examination by their MD in order to verify the need for for films or other tests. Furthermore, this process can result in delays in treatment or appropriate follow-up that could be potentially life threatening.

I strongly urge you to table this proposal. Appropriate X-rays are integral to the best case management of medicare patients and patients will suffer should this proposal become standing regulation.

If I can be of further assitance, please contact me.

Sincerely,

Paul J. Osterbauer,D.C., M.P.H
Associate Professor
College of Chiropractic
Northwestern Health Sciences University
2501 West 84th Street
Bloomington, MN 55431

Submitter : **Dr. Ahmed Bata** **Date: 08/23/2007**

Organization : **Lighthouse Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Deborah Hartley** **Date: 08/23/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

RE: CMS 1385 P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
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,
Deborah A. Hartley,CRNA, ARNP
650 E. Hiawatha Blvd.
Shelton, WA 98584

Submitter : **Dr. Christine Burns** **Date: 08/23/2007**

Organization : **Suncoast Eye Center, P.A.**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

As an eye surgeon in practice at a very busy surgery center that employees two CRNA's and cares for approximately 200 patients a week, the Medicare reimbursement cut has affected us all. We are seeing and treating more patients than ever and have been punished with a reduction in reimbursement. I urge you to support the CMS proposal to boost the value of anesthesia so we can continue to provide our patients with the highest quality of care. Thank you.

Submitter : **Dr. Joe Saad** **Date: 08/23/2007**

Organization : **Surgical Pathologists of Dallas**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 23, 2007

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

I appreciate the opportunity to submit comments on the Physicians Referral provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, for Year 2008 . I am a board certified pathologist practicing in Dallas, TX. I am part of a group of eight pathologists practicing mostly in a hospital-based setting with a small independent outpatient laboratory. I am a member of the College of American Pathologists and Texas Society of Pathologists.

I enthusiastically support the initiative of CMS to end self-referral abuses for pathology services. These irregular billing arrangements are an attempt to bypass the Stark law which prohibits physician self-referrals. Clinicians have exploited a loophole that allows them to profit from pathology services which they did not perform. I am acutely aware of several abusive arrangements in my practice area here in Dallas-Fort Worth and around the state, especially in San Antonio, TX where many of these dubious billing practices originated. They are nothing more than a fee-splitting arrangement on self-referrals of a captive patient population.

I strongly support the expansion of the anti-markup rule to purchase pathology interpretations and the exclusion of anatomic pathology from 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-interest considerations in critical decisions and are in the best interests of the patient. I believe that physicians should not be able to profit from professional pathology services unless they have personally preformed or supervised the service.

Opponents of the proposed changes argue that these dubious arrangements actually enhance patient care. I agree that the Medicare Program should ensure the highest quality of care for their patients. Restrictions on physician self-referrals are necessary to safeguard and ensure that clinical decisions are determined solely on the basis of quality and not tainted by financial incentives. The proposed changes, contrary to what opponents may argue, do not impact the availability or delivery of pathology services. They simply remove the financial conflict of interest that compromises the integrity of the medicare program. Thank you again for addressing this issue.

Sincerely,

A. Joe Saad

Submitter : Mr. William McKendrick III **Date:** 08/23/2007

Organization : MTSA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under
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Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of
private market rates.
Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
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Sincerely,
William McKendrick III

William C. McKendrick III, Student CRNA
617 Larking Springs Road
Madison, Tn 37115

Submitter : **Dr. Joni Summitt** **Date: 08/23/2007**

Organization : **Thoracic Cardiovascular Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

RE: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY2008.
Coding additional codes from 5-year review

Dear Mr. Kuhn:

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

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

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

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

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

Sincerely yours,

Joni R. Summitt, DO
Thoracic Cardiovascular Institute

Submitter : **Dr. Daniel Van Riper** **Date: 08/23/2007**

Organization : **Blair County Anesthesia, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 23, 2007
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Very truly yours,

BLAIR COUNTY ANESTHESIA, P.C.

Daniel Van Riper, M.D.

Submitter : **Jeremiah Flanigan, CRNA** **Date: 08/23/2007**

Organization : **Scott and White Hospital**

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:

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Sincerely,

Jeremiah J Flanigan, CRNA
8510 Sage Meadow Drive
Temple, Texas 76502

CMS-1385-P-7431

Submitter : Dr. Marc Mallis **Date:** 08/23/2007

Organization : Suncoast Eye Center, P.A.

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

As a retinal surgeon in practice at a busy ambulatory surgery center that employs two CRNA's and provides care for over 200 patients a week, the Medicare reimbursement cut has affected us all. We are seeing and treating more patients than ever and have been punished with a reduction in reimbursement. I urge you to support the CMS proposal to boost the value of Anesthesia so we can continue to provide our patients with the highest quality of eye care. Thank you.

CMS-1385-P-7432

Submitter : Dr. Marquerite Kohlhepp **Date: 08/23/2007**

Organization : Suncoast Eye Center, P.A.

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

As a retinal surgeon at a busy surgery center that employes two CRNA's and providing care for over 200 patients a week, the Medicare reimbursement cut has affected us all. We are seeing and treating more patients than ever, yet have been punished with a reduction in reimbursement. I urge you to support the CMS proposal to boost the value of Anesthesia so we can continue to provide our patients with the highest quality of care they are receiving. Thank you.

Submitter : Dr. Magda Barsoum Homsey **Date:** 08/23/2007

Organization : Suncoast Eye Center, P.A.

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

As an eye surgeon in practice at a busy ambulatory surgery center that employs two CRNA's and provides care for approximately 200 patients a week, the Medicare reimbursement cut has affected us all. We are seeing and treating more patients than ever and have been punished with a reduction in reimbursement. I urge you to support the CMS proposal to boost the value of Anesthesia so we can continue to provide our patients with the highest quality of eye care. Thank you.

Submitter : Dr. Hoon Choi

Organization : Dr. Hoon Choi

Category : Physician

Date: 08/23/2007

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-7435

Submitter : **Dr. John Becker** **Date: 08/23/2007**

Organization : **Dr. John Becker**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:
I am an anesthesiologist in Central Illinois. Our group serves a great number of rural and elderly patients. We are having a very difficult time recruiting and retaining physicians. I am very pleased to hear that CMS is considering an upward adjustment in the reimbursement for anesthesia services.
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. Our patients deserve the highest level of care. An increase in reimbusement will allow us to recruit and retain physicians of the highest caliber for the Medicare patients of Central Illinois.

Sincerely,

John A. Becker, M.D.

Submitter : **Mr. Chris Kelly** **Date: 08/23/2007**

Organization : **Martin Anesthesia Group**

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,
Chris Kelly, CRNA
325 Main Street
Martin, TN 38237

Submitter : Mr. BRET RICE

Date: 08/23/2007

Organization : FLEMING COUNTY HOSPITAL

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

WE NEED TO GET PAID TO MAINTAIN PATIENT CARE

CMS-1385-P-7438

Submitter : Dr. Marie Young **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

August 23, 2007

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 appreciate the fact that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking definitive steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, primarily 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 it 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.

CMS-1385-P-7439

Submitter : Dr. Asim Khan

Organization : Dr. Asim Khan

Category : Physician

Date: 08/23/2007

Issue Areas/Comments

GENERAL

GENERAL

Sce Attachmcnt

#7439.

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

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

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

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Acting CMS Administrator: I am an independent physical therapist writing to express my concern over physician self referral for profit situations with the Medicare population. Medicare beneficiaries are being seen and billed for physical therapy in local physician offices or in clinics in which the referring physicians have at least a partial financial interest using the "in-office ancillary services" clause as a loophole. Sometimes the "physical therapy" is not provided by physical therapists. We have heard from patients that they received "treatment" from unsupervised physical therapy assistants, athletic trainers, physician's assistants and other persons, perhaps even office staff, applying modalities- thermal and ultrasound, setting them up for traction, etc. No physician supervision is required under the law in this setting. Not all physicians in our area are doing this, but some are, particularly those with known or suspected financial interest in a "POPTS", (physician owned physical therapy services) or in their office. There has been a proliferation of POPTS in our area over the last 5 years with the result of decreased Medicare referrals to independent private practices like mine and Medicare patients receiving substandard care at these locations. There is too much potential for fraud and abuse in these situations. It seems to me like a blatant attempt to get around the Stark protections passed by CMS. There is a growing body of evidence to support the existence of this problem, including the studies in Florida that showed treatments in POPTS were more expensive per visit and resulted in more visits than treatment in facilities with no physician financial interest. No surprise there. Most patients require multiple visits so convenience is no excuse. Please enforce the intended patient protections and close the loopholes available to unscrupulous physicians attempt to circumvent the current law. Removing physical therapy from the designated health service (DHS) list under the "in-office ancillary services" exception might go a long way in eliminating these situations. To maintain and enhance the quality of patient care, only licensed physical therapists should provide and be reimbursed for physical therapy services provided to Medicare beneficiaries. This will also help maintain Medicare viability by reducing the cost for PT (physical therapy) services. Thank you very much for your consideration.

PT, Contra Costa County California

CMS-1385-P-7441

Submitter : Mrs. Debra Dewig **Date:** 08/23/2007

Organization : Southern IL Univ. Edwardsville

Category : Nurse

Issue Areas/Comments

Background

Background

August 23, 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,

Debra Dewig, RN, BSN, Nurse Anesthesia Graduate Student
117 S. Weber Dr.
Haubstadt, IN 47639

Submitter : Dr. K. Reed Peters

Date: 08/23/2007

Organization : Dept. of Anesthesiology, Univ. of Nebraska

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit ($15.07 in Nebraska). 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. I am concerned in regards to this both as an anesthesiologist and a soon-to-be senior.

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Zenon Mercado** **Date: 08/23/2007**

Organization : **Huffman Anesthesia, PLLC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS' proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS' proposal would help to
ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services. This increase in Medicare payment is important for several reasons.
First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers' services had been reviewed and adjusted in previous years, effective January 2007.
However, the value of anesthesia work was not adjusted by this process until this proposed rule.
Third, CMS' proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS' proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America's 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency's acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Zenon Mercado III, CRNA

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

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **Advanced Health Care**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

72 Federal Register 38122 (July 12 , 2007)
Re: CMS -1385- P; Proposed Physcian Fee Schedule and other Part B Payment Policies for CY 2008.

Dear Mr Kuhn:
As a echocardiogaphy interpreting physician I am objecting to the CMS proposal to 'bundle' payment for color flow doppler (CPT code 93325) into echocardiography base services.

Color flow dopler is not routinely used for all echocardiograms but is used for quantification of severity of certain conditions such as valvular disease and intracardiac shunts. It is also needed and useful for evaluation of the timing (color tissue doppler) of myocardial contraction in those patients with poor ventricular function and congestive heart failure with regard for the possible need for biventricular pacing (cardiac resyncronization therapy). These applications require a great deal of study and time to properly interpret the echocardiogram for optimal patient care. These applications also require considerably more time for the echocardiography technician than routine echocardiograms with out color doppler.

The proposal to 'bundle' color flow doppler ignores the additional time and work load needed for doing and interpreting color flow doppler. There is considerably more sonographer and physician time needed for frame by frame analysis and proper evaluation of color flow doppler than needed for non-color flow doppler echocardiograms.

Color flow doppler is not intrinsic to all echocardiograms. Data submitted by the American Society of Echocardiography shows that many of the CPT codes submitted for echocardiograms do not include the CPT Code 93325 for color flow doppler (ie approximately 50% or less inclusion of the CPT 93325 in conjunction with 10 echocardiography codes other than 93307). In our practice the largest billing by far is CPT Code 93350 with no reimbursement for color doppler (CPT Code 93325).

For these reasons I urge you to reconsider the proposed 'bundling' of color flow doppler into other echocardiography procedures. I would urge you to work with the American Society of Echocardiography to address concerns regarding the appropriate use and billing of color flow doppler. I think they will be quit reasonable and responsive to the concerns about use of limited resources to achieve the best patient care for our citizens.

Steven Merry MD
Advanced Health Care
Menomonee Falls Wi

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

Organization : **FirstHealth Moore Regional Hospital**

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

These comments are intended to address the In-Office Ancillary services exception. This provision was originally intended to make it easier for patients to access routine services such as lab and simple imaging services in the physician's own office. However, practices, especially large group practices have begun taking this exception to the extreme installing not only routine x-ray equipment, lab equipment and providing some other ancillary services, but are now opening Physical Therapy Offices as a part of their practice, high end imaging such as MRI, PET, Nuclear Medicine Cameras or Multi-slice CT scanners. In small communities this move to capture the outpatient imaging market has made it almost impossible for the local hospitals to afford to provide the high end imaging for its in-patients and out-patients since the insured patients are largely being seen in the physician clinic setting leaving a disprportionate share of uninsured or self pay patients for which the hospital must provide care.

We are also aware of some instances where physician offices are coercing patients to have services provided by the physician's office over the patient's stated preference to have the service provided elsewhere.

It is the opinion of this responder that there is much opportunity for abuse in this area as the physician, or his office, have a considerable amount of influence on the patient's decisions about where services are provided.

If this practice is allowed to continue, consideration should be given to requiring the physician office to provide in writing to the patient the alternative providers of essentially the same service in the community similar to that notice required of other providers of wholly owned ancillary services.

Submitter : **Mrs. Carman Hogan** **Date: 08/23/2007**

Organization : **Medical Associates Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am a sonographer that uses color flow Doppler for some of my cardiac testing. Frequently we perform 2D/Mmode studies on patients for evaluation of left ventricular function, when color flow is not utilized, as well as pre testing for stress/echo. The additional time for performance of color flow when scanning and particularly for the physician reading the study must be taken into account. If doppler alone were utilized, a quick look at the tracings and measurements would be all that was necessary. However, it is more thorough, and more informative to have the colorflow, and that can lead to longer scanning time for peak optimization, as well as more physician reading time to sort through the additional information. Leaving this significant information out of the study would lead to less valuable information, and quite possibly a missed diagnosis.

Submitter : **Mr. Jerry Valentine** **Date: 08/23/2007**

Organization : **APTA**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Re: Physician Self-Referral Issues

Date: 8-23-07

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

Dear Mr. Weems;

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

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

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

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

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

Sincerely,

Jerry Valentine PT

Submitter : **Dr. Kenneth Bengtson** **Date: 08/23/2007**

Organization : **Dr. Kenneth Bengtson**

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 Port St. Lucie, Florida as a hospital based pathologist employed by
Ameripath, a large pathology group 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,

Kenneth L. Bengtson MD

6885 Cobia Circle
Boynton Beach, Fl. 33437

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

Organization : **Michael Ash**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

In 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.

Michael J. Ash, M.D.

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

Organization : Curtis Johnston

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a board-certified pathologist and a member of the College of American Pathologists. I practice in New London, Connecticut as part of a 4 member hospital-based group.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my state 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.

Sincerely,

Curtis A. Johnston, M.D.

Submitter : **Mr. Anthony Funke** **Date: 08/23/2007**

Organization : **Anesthesiology Group Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs,

I feel that anesthesia services are grossly undervalued with the current reimbursement rate. CMS is at or less than one-third of the commercial payors. The proposed rate increase would be a step to alleviate anesthesia undervaluation.

Sincerely,
Anthony Funke, M.D.

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

Organization : **Western Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Scc Attachmcnt.

CMS-1385-P-7453-Attach-1.DOC

#7453

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, "Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008" (the "Proposed Rule") published in the *Federal Register* on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.

There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the "all physicians" crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians' ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries' access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as "interventional pain physicians" for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to "all physicians" for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. Interventional pain is an inter-disciplinary practice that draws on various medical specialties of anesthesiology, neurology, medicine & rehabilitation, and psychiatry to diagnose and manage acute and chronic pain. Many interventional pain physicians received their medical training as anesthesiologists and, accordingly, clinically view themselves as anesthesiologists. While this may be appropriate from a clinically training perspective, their Medicare designation does not accurately reflect their actual physician practice and associated costs and expenses of providing interventional pain services.

This disconnect between the Medicare specialty and their practice expenses is made worse by the fact that anesthesiologists have the lowest practice expense of any specialty. Most anesthesiologists are hospital based and do not generally maintain an office for the purposes of rendering patient care. Interventional pain physicians are office based physicians who not only furnish evaluation and management (E/M) services but also perform a wide variety of interventional procedures such as nerve blocks, epidurals, intradiscal therapies, implant stimulators and infusion pumps, and therefore have practice expenses that are similar to other physicians who perform both E/M services and surgical procedures in their offices.

Furthermore, the utilization rates for interventional pain and pain management specialties are so low that they are excluded from Medicare rate-setting or have very minimal affect compared to the high utilization rates of anesthesiologists. CMS utilization files for calendar year 2007 overwhelming report anesthesiologists compared to interventional pain physicians and pain management physicians as being the primary specialty performing interventional pain procedures. The following table illustrates that anesthesiologists are reported as the primary specialty providing interventional pain services compared to interventional pain physicians

CPT Code	Anesthesiologists - 05	Interventional Pain Management Physicians

	(Non-Facility)	- 09 (Non-Facility)
64483 (Inj foramen epidural l/s)	59%	18%
64520 (N block, lumbar/thoracic)	68%	15%
64479 (Inj foramen epidural c/t)	58%	21%
62311 (Inject spine l/s (cd))	78%	8%

The high utilization rates of anesthesiologists (and their extremely low practice expenses) drive the payment rate for the interventional pain procedures, which does not accurately reflect the resource utilization associated with these services. This results in payment rates that are contrary to the intent of the Medicare system—physician payment reflects resources used in furnishing items and services to Medicare beneficiaries.

I urge CMS to make a modification to its practice expense methodology as it pertains to interventional pain services such that its methodology treats physicians who list anesthesiology as their primary specialty and list interventional pain as their secondary specialty designation as interventional pain physicians for rate-setting. This pool of physicians should be cross-walked to "all physicians" for practice expenses. This will result in a payment for interventional pain services that is more aligned with the resources and costs expended to provide these services to a complex patient population.

I urge CMS not to delay implementing our proposed recommendation to see if the updated practice expenses information from the Physician Practice Information Survey ("Physician Practice Survey") will alleviate the payment disparity. While I believe the Physician Practice Survey is critical to ensuring that physician services are appropriately paid, I do not believe that updated practice expense data will completely resolve the current underpayment for interventional pain services. The accurate practice expense information for interventional pain physicians will continue to be diluted by the high utilization rates and associated low practice expenses of anesthesiologists.

II. CMS Should Incorporate the Updated Practice Expenses Data from Physician Practice Survey in Future Rule-Making

I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

III. CMS Should Work Collaboratively with Congress to Fix the SGR Formula so that Patient Access will be preserved.

The sustainable growth rate ("SGR") formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing

reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

Because of the flawed formula, physicians and other practitioners disproportionately bear the cost of providing health care to Medicare beneficiaries. Accordingly, many physicians face clear financial hardship and will have to make painful choices as to whether they should continue to practice medicine and/or care for Medicare beneficiaries.

CMS should work collaboratively with Congress to create a formula that bases updates on the true cost of providing healthcare services to Medicare beneficiaries.

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Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

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