Submitter : **Dr. Amer Akmal** **Date: 08/23/2007**

Organization : **North Jersey Pathology, LLC**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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 Paterson, NJ as part of North Jersey pathology, LLC, a 4 member pathology practice providing pathology service at St. Joseph s Regional Medical Center.

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,

Amer Akmal, MD

North Jersey Pathology, LLC

703 Main Street
St. Joseph s Regional Medical Center
Paterson, NJ 07503

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

Organization :

Category : **Other Health Care Professional**

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:

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,

Albert E. Scates CRNA
7301 Bringle Ridge
Texarkana, Texas 75503

Submitter : Dr. Michael Brook **Date:** 08/23/2007

Organization : Dr. Michael Brook

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I would like to express my concern regarding the proposal that CPT 93325 be bundled as part of other CPT codes. In particular, I am concerned that this is not associated with a reasonable change in the RVU's associated with these codes. This issue affects my practice directly as a pediatric cardiologist.
Although I understand the logic behind the bundling, namely that this codes is performed in conjunction with the other codes, the lack of RVU accounting for this is inappropriate. The performance of color Doppler in pediatric cardiology practices is clearly an essential tool in the diagnosis and management of congenital heart disease. It is, however, also often quite a time-consuming addition to the standard 2-dimensional echo covered under the 93303/04 echocardiography code. To bundle these codes together without allowing for the increased work and time required by color Doppler flow mapping does not recognize this issue properly. Even when this code was established in 1997, it was recognized that in pediatrics the use of color Doppler was crucial. I quote "& even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." To now remove all reimbursement for this procedure is a significant step backwards. This will have the effect of markedly reducing reimbursement across all payor groups in pediatric cardiology, and significantly impact my ability to provide care to all of my patients, since over 60% either are covered by state Medicaid insurance or by no insurance at all.

I strongly urge CMS to withdraw this change until these issues can be reviewed and evaluated in an appropriate forum.

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

Organization : **University of Arizona Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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.

John Rapiejko D.O.

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

Organization : **Cardiology Associates**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

August 16, 2007

To Whom It May Concern:

I am a cardiologist practicing at Cardiology Associates, P.C., the largest and most comprehensive provider of cardiovascular care in the Nation s Capital and the adjacent Maryland suburbs. Our practice has been delivering state-of-the-art care since our founding in 1979, and we have continuously strived to provide the most technologically advanced diagnostics for our patients. I believe that the proposal to bundle reimbursement for color flow Doppler into the basic echocardiography examination is seriously misguided.

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

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

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

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

Sincerely,
Robert Alex Lager, M.D.

Submitter : Dr. James Kindscher **Date:** 08/23/2007

Organization : Kansas University

Category : Physician

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

We must increase the conversion factor for ANESTHESIOLOGY. This specialty lags behind the rest of all medical disciplines in fair reimbursement from medicare. Please follow the suggestion for increasing the anesthesiology reimbursement conversion factors.

Submitter : **Mr. David Pennington** **Date: 08/23/2007**

Organization : **Nurse Anesthesia**

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
Baltimore, MD 21244 8018

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

Submitter : Mrs. Anne Kindscher **Date:** 08/23/2007

Organization : Mrs. Anne Kindscher

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The proposal to increase anesthesiology conversion factors is a good idea. This medical specialty has been unfairly impacted by the low conversion factor from medicare. With more and more seniors needing anesthesiology services this specialty cannot survive unless you take action to increase this conversion factor.

Submitter : **Dr. Archie Magee** **Date: 08/23/2007**

Organization : **American Society of Anesthesiologist**

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.

Archie E. Magee, M.D.

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

Organization : **Hugh Cochran**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 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,
___Hugh Cochran, CRNA_____
Name & Credential
_____2111 Trinity Manor Lane_____
Address
____Richmond, TX 77469_____
City, State ZIP

Submitter : **Mrs. Ilissa Hecht Hecht** **Date: 08/23/2007**

Organization : **Mrs. Ilissa Hecht Hecht**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Close the Stark Referral for profit loophole! The patient should have the right to choose who provides services such as physical therapy and imaging. Having ambulatory services allows the benefit of competition in regard to cost and the ablility to have a choice.

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

Organization : Nancy Knape

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)
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.

Medicare patients and healthcare delivery in the U.S. depend on the services Certified Registered Nurse Anesthetists provide. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

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

Organization : **Anesthesia Consultants Limited**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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:

There are approximately 7,000 physicians practicing interventional pain management in the United States including myself. 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 did not relieve the continued underpayment of interventional pain services. 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 devastate our groups ability to provide interventional pain services to all patients. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries access.

The current practice expense methodology does not accurately reflect the practice expenses associated with providing 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.

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 and therefore have practice expenses that are similar to other physicians who perform both E/M services and surgical procedures in their offices.

The utilization rates for interventional pain and pain management specialties are so low that they have a minimal effect on Medicare rate setting compared to the high utilization rates of anesthesiologists. This fact, with the low practice expense for anesthesiologists, drives the payment rate for the interventional pain procedures. These results in payment rates to physician payment that do not reflect 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 to reduce this inequity for physicians who have real practices expenses. Even this may not cover our expenses and force use to stop providing this service.

Please work with congress to fix the SGR formula. My collections continue to decrease, but my employees expect raises, my malpractice goes up and yes my cost for health insurance is going up. We have already decreased our staff by 40%. The next step is to close our office. This would result in this service not being provided for our patient area and the lost of jobs for our remaining employees.

Thank you for the opportunity to comment on the Proposed Rule. Underpayment for interventional pain and other physician services means that there will not be physicians willing to provide these services to Medicare beneficiaries when I need them.

Sincerely,

Steven Croy, MD
20 Endicott Lane
Highwood, IL 60040

Submitter : **Mr. Bikram Mohanty** **Date: 08/23/2007**

Organization : **Mr. Bikram Mohanty**

Category : **Occupational Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

My comment is about Physician self Referral of Therapy services.

1. Physicians should be prohibited from owning, renting or sharing Physical Therapy clinics. We have observed, that due to their own financial interest, they refer too many patients to the clinic, they own or rent or share office space with. This seriously undermines quality care. No one actually knows if the clinic has a licenced PT or a high school educated technician. Of course, the more patients the physician refers, the more money he makes.
2. Those rehab clinics owned by physicians treat more patients per day than they should , which is illegal.
3. This practice can only be stopped by prohibiting physicians to own , rent or have financial interest in Therapy clinic.
4. In one occasion, a Physician in my locality told me " we are locked in" with our own clinic, so we can not refer to any other clinic.

In conclusion, this undermines quality of care, encourages Medicare Frud, waste and abuse and should be stopped immediately.

Submitter : **Dr. Peter Kosek** **Date: 08/23/2007**

Organization : **Pain Consultants of Oregon**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

I wanted to provide the prespective of a physician practicing in Oregon to the issue of practice overhead expenses.

CMS-1385-P-7468-Attach-1.DOC

#7468

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.

I am one of the 7,000 physicians practicing interventional pain management in the United States I practice pain management in my office, in addition to two hospital outpatient departments and an ambulatory surgery center.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the "all physicians" crosswalk. Unfortunately, this 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 my 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.

In my community many physicians refuse to treat patients with chronic pain. These physicians understand that it takes a very organized (and expensive) office to be able to manage patients with chronic pain. I know most of the Pain Management physicians in Oregon, and all of these physicians have offices that are more expensive to run than those of primary care physicians. To be able to continue to treat pain, this increased overhead must be reimbursed.

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 (Non-Facility)	Interventional Pain Management Physicians - 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.

Sincerely,

Peter Kosek, MD

Submitter : **Mr. Jeffrey Rosa** **Date: 08/23/2007**

Organization : **Ohio Physical Therapy Board**

Category : **State Government**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

see attachment

CMS-1385-P-7469-Attach-1.DOC

#7469

Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board
77 South High Street, 16th Floor
Columbus, Ohio 43215-6108

Governor
Ted Strickland
Executive Director
Jeffrey M. Rosa

August 23, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-1850

Re: CMS-1385-P
THERAPY STANDARDS AND REQUIREMENTS

Dear Sir or Madam:

The Physical Therapy Section of the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board submits the following comments on the proposed rules changing the definition of "physical therapist" in Section 484, Title 42 of the Code of Federal Regulations. The proposed rules are part of the 2008 Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 2008, found in Volume 72 of the Federal Register, published on July 12, 2007.

Under subsection (i)(B) and (ii)(B) of the proposed definition of "physical therapist" an applicant would need to have "[p]assed the National Examination approved by the American Physical Therapy Association." We strongly suggest that CMS rely on state licensure and that the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist" be deleted from the final rule. At the very least, the Centers for Medicare and Medicaid Services ("CMS") should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We, along with all of the other state boards of physical therapy examiners, have already adopted a national qualifying exam for physical therapists, the National Physical Therapy Examination ("NPTE"). The Federation of State Boards of Physical Therapy ("FSBPT") develops and administers the NPTE in close collaboration with the state boards. Working together, we have developed a national passing score. The FSBPT has done an outstanding job of meeting our needs. Likewise, the NPTE has been a valuable tool in screening physical therapist applicants. Through the NPTE, we have been able to successfully filter applicants. In turn, we, as a policing body, have been able to protect the public by ensuring that only qualified therapists are licensed care for our citizens.

CMS should not usurp the states' function of licensing physical therapists and other professionals. Health care professional credentialing and licensing is a classically state function. Licensing and credentialing are the domain of the states. CMS' proposal would inappropriately transform a state function into a federal function. There is no justification for this action, and CMS should prevent it by removing the proposed rule.

CMS respects states' rights and state licensure for other health care professions, and it should continue to do so with respect to physical therapists. For example, CMS' regulations define a physician as a "doctor of medicine ... legally authorized to practice medicine and surgery by the State in which such function or action is performed." 42 C.F.R. § 484.4 (2006). Likewise, a registered nurse is defined as "[a] graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing." 42 C.F.R. § 484.4. Establishing requirements that are different than what the states require for licensing PTs would be inconsistent with not only the rights of the states, but also CMS' own standards.

Moreover, the federal government should not impose an additional burden on the states, particularly since its stated desire for a national examination already satisfied and its other stated goals would not be better met by the burden it

proposes to impose. The proposed unfunded mandate could result in the development of a second exam, which would create confusion and more work for the states, without benefit. Our resources are already limited and stretched.

In the preamble to the proposed regulations, CMS says that it is seeking uniformity. The fact of the matter is that uniformity and consistency across the nation and across provider settings already exists. State licensing requirements apply to physical therapists without regard to where they practice. All states accept CAPTE accreditation. All states accept the NPTE and have adopted the same passing score. No federal regulation is required.

In fact, the proposed regulations would likely defeat CMS' own goal of uniformity. If, for example, the APTA were to approve a different exam than the NPTE, which the regulations would permit it to do, physical therapists, patients, including Medicare and Medicaid beneficiaries and recipients, and others could face substantial confusion and interruption of service. As a state board of physical therapy examiners, we would continue to have authority to select an exam of our choice for licensing purposes. However, under the proposed rule, a physical therapist would have to pass a second exam approved by the APTA to qualify for Medicare reimbursement. Thus, patients might be forced to change physical therapists as they become Medicare or Medicaid eligible, and the current uniformity and continuity of standards across the country would be lost. Thus, the proposed rules undermine CMS' ambition for uniformity of standards.

CMS and the federal government should not empower an advocacy group, like the APTA, to establish an examination or any qualifications for professionals to provide healthcare services to patients. The APTA's mission is to advocate and promote the profession. As a licensing body, our mission is to ensure that physical therapists are qualified to provide physical therapy services and are authorized to do the work for which they are trained. The FSBPT, the organization to which we look for the national licensing exam, was created to eliminate, protect against and prevent the inherent conflict of interest that the APTA would have if it were to have authority over the examination and credentialing processes. Even the APTA recognized this conflict of interest problem two decades ago when it created the Federation of State Boards of Physical Therapy. CMS must not allow this conflict of interest to become a rule.

The Physical Therapy Section of the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board strongly urges CMS to require only state licensure. Most importantly, CMS should remove the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist." At a minimum, CMS should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We appreciate the opportunity to comment on the proposed rules regarding physical therapist and physical therapy assistant qualification requirements.

Respectfully yours,
The Physical Therapy Section
Ohio Occupational Therapy, Physical Therapy, & Athletic Trainers Board

Robert M. Frampton, PT, DHCE
Chairperson, Physical Therapy Section

Jeffrey M. Rosa
Executive Director

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To: Centers for Medicare and Medicaid Services (CMS)

Re: The Stark Referral for Profit Loophole

Few challenges facing physical therapists (PTs) and physical therapist assistants (PTAs) have been as frustrating and tough to deal with as those involving financially motivated practice arrangements in which physicians derive significant profit by using their own referrals to steer patients into physical therapy practices they own. I am writing this letter to ask you to remove physical therapy from the in-office ancillary services exception to the federal physician self-referral laws. I have several patients who have shared some of their personal therapy stories at other clinics that were physician owned clinics. I would like to share one situation in particular with you, federal and state policymakers in order to paint a picture of the myriad problems created by arrangements based on referral of physical therapy services for profit: A recent patient of mine was sent to our clinic after 4 weeks of therapy at a local physician owned physical therapy clinic where she was not making much progress for a minor, common injury. She complained that she did not know she could attend therapy at any clinic of her choice- she was not informed of her rights. Furthermore, she underwent treatment there for a month with very little time spent on one-on-one individual treatment with the pt noting how the staff was too busy to help due to the number of patients they were seeing at that clinic at the same time as my patient was attending therapy. As a result, she saw a specialist following no significant gains and after 3 weeks at our clinic is 75% functionally improved with no pain as compared to the initial treatment my patient received at the other clinic. My patient has commented several times on the amount of money that was wasted at the other clinic at insurance s expense. This is only one of several patient testimonials I have heard regarding patient experiences at physician owned physical therapy clinics. Again, I urge you to take action now and remove physical therapy from the in-office ancillary services exception to the Stark Referral for Profit Loophole. Please help us prevent referral of physical therapy services for profit for patient benefit, ethical standpoint, and fraud and abuse prevention.

Thank you for your time and consideration.

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a practicing physical therapist of 13 years and manager of a not for profit hospital based orthopedic outpatient department. I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in office ancillary physician owned physical therapy services exception.

There are 3 large orthopedic surgical groups in this suburban town in which I practice. In 2002, my manager left our clinic to manage a physician owned clinic. My manager at the time told me that the physicians had been very pleased with the care that our hospital based clinic had given the patients, and that this acquirement of their own physical therapy department was strictly based on financial gains. Our referrals from that clinic decreased drastically as was expected. Three hospital employees left to work at the physician owned clinic and 2 have returned to work for the hospital this year citing they received a bonus the first year based on how many units of service that were billed. The following years, that benchmark was set even higher, so high, in fact that they did not receive the bonus. They also cited that they were being required to see up to 8 patients at one time and were billing each patient as if they were receiving one-on-one care. They were also strongly encouraged to use as many modalities as possible (electrical stimulation and ultrasound) even when the patient no longer needed these passive modalities in order to increase the billed units of service. We have in fact had numerous patients that were bold enough to discontinue their therapy at that physician owned clinic stating that they were just left to do exercises on their own while their therapist yelled across the room telling them what to do next. I know this because these were the testimonies of numerous patients that came to our clinic where they stated that the care was much better because the therapist only saw one patient at a time. I know that many of my former patients that I have come in contact with later were told to now go to the physician owned clinic when they needed physical therapy. The patients stated that they did not know that they could go where they wanted and stated that the doctor wanted them to go to his clinic where he could keep a close eye on them . Many patients are intimidated by the physician and sincerely believe that the doctor has his or her best interest in mind. They do not consider that the financial gains are many times the driving factor. The former employees of this physician owned clinic stated that the physicians never set foot in the physical therapy clinics that they owned.

When therapists are encouraged to see as many patients as possible, even the very best therapist cannot provide quality care. The patient suffers, the profession suffers, and we all suffer financially as a result of abuse of the insurance companies.

I am strongly opposed to the continuing existence and growth of these physician owned clinics. I believe that even the best and most morally strong individuals do not need to have the temptation of monetary gains based on self referral, abuse of billed units of service and abuse of patients by not giving them the individualized care that they deserve.

Thank you for your consideration of my comments.

Submitter : **Mr. Joshua Brettingen** **Date: 08/23/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

Please support the increase in proposed fee schedule increase for anesthesia services.
Thank you for your attention to this matter

Submitter : **Dr. Lars Van Etten** **Date: 08/23/2007**

Organization : **UNMH Dept of Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Ms. Norwalk:

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

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

Our specialty has been overlooked and undervalued for over a decade. This is primarily due to the occult nature of our work. One cannot overtly observe the physiology we have such an intricate understanding of. No one notices that the only aspect of most surgeries which can result in death are those services which render the patients non-breathing, by us. Furthermore, the surgery itself has become so much more safe not due to any change in surgical techniques, but due to the constant vigilance focused on our patients honed over four years of post medical school training, and years in the practice.

Anesthesiology services are increasingly being rendered by undertrained mid-level staff CRNA s and AA s. Although providing minimally adequate care to healthy patients, actual medical training is necessary to thouroughly understand the pathology of an aging population. Without maintaining adequate numbers of our best going into the field, our aging population will suffer.

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. Regina Lantin **Date:** 08/23/2007

Organization : Texas Childrens Hospital

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

RE: the proposed change to bundle CPT 93325 with other CPT codes when performed together. I believe 93325, Doppler Color Flow mapping, is distinct from the other CPT codes as the information it provides is critical to patient management and not obtainable from other modalities. 93325 should be recognized as separate from the other codes as it is a unique medical service provided to patients, requiring specialized skill and training for interpretation. Bundling 93325 with other codes is improper, as it will not take into consideration the additional work, time, training, and expense associated with obtaining the information 93325 provides. This is particularly true in congenital heart disease and fetal echocardiography. The surveys used to determine RVUs for the echo codes used by pedi cardiologists are out-dated, and bundling 93325 will not account for the extra time, effort and costs necessary to perform 93325 in a child or a fetus.

Submitter : Dr. Lisa Caplan **Date:** 08/23/2007

Organization : UT Houston

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am in favor of increasing the RVU.

Submitter : **Mrs. Mary DuBose** **Date: 08/23/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

I am writing to support The Centers for Medicare & Medicaid Services 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 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,
Mary C. DuBose, CRNA
Po Box 150256
Lufkin, TX 75915

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

Organization : **Joe Liu**

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.

Joe Liu

Submitter : Dr. swarup varaday **Date:** 08/23/2007

Organization : Barnes Jewish Hospital(Washington Universtiy,Stl)

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS must analyse the UNDERFUNDING of Medicare payments for anesthesia services and raise the fees it pays anesthesia providers.

Submitter : Ms. Susan Brienza Gordon **Date:** 08/23/2007

Organization : New York Pain Management PLLC

Category : Nurse

Issue Areas/Comments

ASP Issues

ASP Issues

CMS-1385-P

There are approximately 7,000 physicians practicing interventional pain management in the United States we are included in this statistic. While I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the all physicians crosswalk. This,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. This will have a devastating affect on my and all physicians ability to provide interventional pain services to Medicare beneficiaries.
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 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.

Please reconsider these revision

CMS-1385-P-7479-Attach-1.DOC

Re: CMS-1385-P

There are approximately 7,000 physicians practicing interventional pain management in the United States we are 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, did not relieve the continued underpayment of interventional pain services. 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. This will have a devastating affect on 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.

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

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& 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 (Non-Facility)**	**Interventional Pain Management Physicians - 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.

CMS should 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.

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.

Susan Brienza Gordon RN, BSN, MBA
Director of Operations
New York Pain Management PLLC
Latham, NY

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

Organization :

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)

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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.

Submitter : **Dr. Michael McMannis** **Date: 08/23/2007**

Organization : **Associates in Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

As Noted in the 2007 report entitled "Review of Physician and CRNA Recruiting Incentives" Every specialty tracked showed increases in average salary over the prior year except anesthesiologists which declined by $6,000 and there was a decline in the number of professionals receiving income guarantees over the prior year (32 percent in 2005/2006, 21 percent in 2006/2007).

Thank you for your consideration of this serious matter.

Submitter : Dr. Frank G **Date:** 08/23/2007

Organization : Dr. Frank G

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Hello, I would like to call on CMS to remove physical therapy from the in-office ancillary services exception to the federal physician self-referral laws. I am a Physical Therapist and own an independent outpatient facility. Since the in office exception this has taken some of the choice away from patients on whom they use for their PT. Patients are a "captive" audience for physicians that can steer these patients back to their own PT for a financial gain. This unfair advantage has certainly hurt my practice and the practices of my colleagues around the country. A very good example of this steering for financial gain occurred last month. We have a specialty practice of balance and vestibular rehabilitation and had in the past seen this particular patient. This patient went to her doctor because of dizziness and he ordered PT. She said she had good success in the past with my facility and would like to return. The physician refused to write the script for PT unless she went to his PT facility. It was blatantly obvious for dizziness we were the appropriate provider to render care but that did not matter to the physician. The only reason I have knowledge of this is the patient called me and apologized that she would not be able to come back to see us..Apologize??? Why should a patient have to apologize for seeking appropriate care with the most qualified provider. I urge members of congress to stop this source of ancillary income to physicians, Physical Therapists are highly educated professionals that should not be uses as sources of revenue for physicians. Patients should have the right to seek the care they choose not be forced to go where it is financially beneficial to their physician. I strongly urge CMS to remove physical therapy from the in-office ancillary services exception to the federal physician self-referral laws. Thank you.
Sincerely,
Frank Gargano DPT
Solon Ohio

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist who has been practicing in the Memphis area at a privately owned outpatient clinic for about a month-and-a-half. I am writing in regard to the in-office ancillary services which at this time includes physical therapy. I feel that physical therapy should be removed from this list due to the possibility of fraud and abuse with regard to referral for profit as it pertains to the current law. I have met many patients who did not know that they could seek physical therapy treatment at any clinic or with a therapist of their choosing. Rather, they are made an appointment to see a therapist employed by the doctor without being asked where they would prefer to have therapy, or if they have a preferred therapist. This is fraudulent and unethical and should be stopped immediately for the protection of patient rights and an individual s autonomy to make their own decisions rather than told what to do in order for a physician to increase his or her income.

Submitter : **Dr. travis hiles** **Date: 08/23/2007**

Organization : **Ozark Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Travis Hiles,MD

Submitter : **Dr. Bradley Woodle** **Date: 08/23/2007**

Organization : **Dr. Bradley Woodle**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Bradley M. Woodle and my patients

Submitter : Mr. Adam Hosmann **Date:** 08/23/2007

Organization : Mr. Adam Hosmann

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The new radiograph proposal is an outrage and must be reconsidered by your department. please ban the new xray policy that will hamper the chiropractic profession.

Submitter : Dr. Thomas H. Rynalski **Date:** 08/23/2007

Organization : Dr. Thomas H. Rynalski

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Naples, FL as part of a 10-member clinical and anatomic pathology practice group that serves two local hospitals and maintains a private laboratory for anatomic pathology.

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

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

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

Sincerely,

Thomas H. Rynalski, M.D.

Submitter : **Dr. Jonathan Schnelle** **Date: 08/23/2007**

Organization : **Dr. Jonathan Schnelle**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Jonathan Schnelle, D.C.

Submitter : Dr. Theodore Saylor **Date:** 08/23/2007

Organization : Dr. Theodore Saylor

Category : Pharmacist

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

It is considered "best practice" when physical examination indicates possible pathology that would be best diagnosed by x-ray. In addition, determining precise juxtaposition of skeletal joints is only possible through x-ray visualiztion. Let one not sacrifice safety, accuracy, and a best practice approach by eliminating diagnostic x-ray from the repetoir of chiropractic physicians. And, by the way, let's pay them for the excellent services they perform, including their evaluation, managment and radiology fees.
Theodore H. Saylor, B.Sc., R.Ph., D.C.

Submitter : Dr. Jason Eichacker **Date:** 08/23/2007

Organization : ABLE Chiropractic/American Chiropractic Assoc.

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I am writing to comment regarding CMS-1385-P that would eliminate reimbursement for chiropractic referral to a non-treating physician (such as a radiologist) for X-rays. As a DC in solo practice in a small office, it is highly ineffective from a cost standpoint to have imaging equipment on-site. Thus, I must rely upon a nearby imaging center for any radiography necessary.

Eliminating this reimbursement would drive overall health care costs up because a patient would be required to make an extra visit--to DC and then PCP--in order to have the same procedure performed. By maintaining the status quo, the system is efficient for patients (minimizing their number of visits), physicians (ensuring effective use of time and services provided) and CMS (in terms of sheer paperwork, but also repayment).

Thank you for taking the time to consider my comments.

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

Organization : **Carver Chiropractic Center**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Dr. Daniel S. Behe, Jr.

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

Organization : Central Plains Radiologic Services,P.A.

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

I am not infavor of the proposed change to 410.32 on the x-ray payment for x-rays order by a non-physician provider. The current status of chiropractors as non-physicians is unjust in the system. However, to continue to further limit the ability of chiropractors to make diagnosis and rule out contra-indications for treatment by making yet another barrier for patients to obtain radiographs is not fair to the patients that have medicare coverage. We commonly referr patients back to their primary medical doctor or to a facility with a cooperative radiologist to have x-rays performed. This saves a step in the referral process, as the patient can be appropriately diagnosed in our office with the help of imaging. If the patients cannot have access to imaging the way it is done know and they are forced to see their pcp or a medical specialist to have their x-rays performed, then this will greatly increase the cost of care for these patients. The real cost saver would be to cover the x-rays taken in chiropractic offices for initial examinations and if follow-up exam was needed for special situations. There is no justification for re-xray to demonstrate biomechanical changes, but if a patient is having issues of new trauma, non-response to care, or developes "red flag" signs and symptoms, then follow-up may be warranted.

I believe the proposed x-ray payment changes will result in more costly patient care.

Thank you,
Steven J. Gould, D.C., D.A.C.B.R.
chiropractic radiologist.
316-542-3400

Submitter : **Mr. william donovan** **Date: 08/23/2007**

Organization : **CRNA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

? 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.

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

Organization : **Orville Rickard**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

CMS:
RE:CMS-1385-P (Background,Impact)Anesthesia Services
I am member of AANA working in rural America. The hospitals struggle to survive, not from poor management, but from inadequate re-imbursement for services rendered.
I support the proposal by CMS to increase the value of anesthesia work by 32% and to increase the conversion factor by 15%.
The value of this proposal will help ensure survival of small hospitals who struggle with providing essential healthcare in our communities.
Sincerely,
Orville Rickard, CRNA
Putnam General Hospital
101 Lake Oconee Parkway
Eatonton, GA
31024

Submitter : Dr. JANICE GELLIS **Date:** 08/23/2007

Organization : JEGELLISMDPLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1385-P-7496-Attach-1.DOC

#7496

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 (Non-Facility)	Interventional Pain Management Physicians - 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.

***

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,

Janice E.Gellis, MD

1565 Barry Rd
Fairfield, VT 05455

Submitter : Dr. Sherry Woodhouse **Date:** 08/23/2007

Organization : Memorial Hospital Miramar

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 23, 2007Thank 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 Miramar, Florida as part of a 22 member pathology group contracted to provide pathology services to the South Broward Hospital District, Memorial Healthcare System in Broward County, Floridal 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, Sherry Woodhouse, MD, FCAP, FASCPChief of PathologyMemorial Hospital Miramar

Submitter : Dr. Don Handley **Date:** 08/23/2007

Organization : Dr. Don Handley

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

I am against revision 410.32, non-treating physicians should be paid for taking x-rays for chiropractors because this is the only way some patients are x-rayed to determine contraindications for spinal manipulation. These are patients on fixed incomes and can not afford out of pocket expenses. If a patients is required to go to a treating physician this will add to the total cost of medical care because of the added expense that the treating physician charges for extra exams to justify taking x-rays of the spine. They are not concerned with subluxations and the contraindications that might be found by spinal x-rays.

Submitter : **Dr. Barry Hughes** **Date: 08/23/2007**

Organization : **Hughes Chiropractic, P.C.**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

The preceding was the "canned" response letter from ACA and has many cogent points, however, I would like to make two (2) further points:
1: Who does this proposal, if enacted, ultimately benefit? The short answer is NO ONE AT ALL. By limiting chiropractic patients' access to ragiological services it places the patient at risk, as well as the doctor of chiropractic (most likely the actual intended victim). Chiropractic is the ONLY HEALTHCARE SERVICE in this country intentinally discriminated against. This proposal simply solidifies that discrimitatory bent. If this proposal were approved for blacks only, or hispanics or, God forbid, illegal aliens, a cry of official oppression would ring out from every corner... and should. The truth is this rule benefits no one and is only proposed to denegrate and limit a part of the health care chain that already performs valiantly and effectively under a cloud of official oppression... there I said it.
2) Cost-effectiveness: Let's be real - in order to properly police this proposed order every radiological facility, every hospital and every medical and osteopathic physician's office in the country will have to undergo intense scrutiny. This means increased inspectors, increased inspections, increased invasion of the patients' privacy; and for what? What overall benefit will be derived from this proposed rule? As I stated earlier, none.

In closeing, I would like to reiterate my strongest opposition to this proposal. It does nothing and accomplishes only one thing: wasting tax dollars on the petty biases of the few to limit the access of good people to effective and affordable healthcare. This money could be better spent limiting access to our country from those who hate us and our way of life... that includes chiropractic.

Sincerely,

Barry L. Hughes, D.C.

Submitter : **Mr. Donald Savidge** **Date: 08/23/2007**

Organization : **Memorial Hospital of York, PA**

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)
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,

Donald L. Savidge, MS, CRNA
192 Wilcox Drive
New Cumberland, PA 17070

Submitter : **Dr. Richard Buchanan** **Date: 08/23/2007**

Organization : **Dr. Richard Buchanan**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

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

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

Sincerely,

Dr Richard D Buchanan
Stockbridge, GA

Submitter : Dr. Tyler Pertree **Date:** 08/23/2007

Organization : South OKC Chiropractic Clinic

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I am in strong opposition of the proposed change of disallowing a Chiropractic physician from referring for an X-ray study on a Medicare patient. This is basically stating that Medicare does not see us as diagnostic physicians but rather as some form of therapist with no diagnostic ability. Since Chiropractors take as much or more diagnostic classes in their medical training as MD's, I cannot fathom how this can be allowed.

The threat to the patient is twofold. First, there is a threat to their lifestyle since many of the medicare patients are on fixed or limited incomes and cannot typically afford the cost of paying for the added cost. Secondly, without x-ray, the doctor of chiropractic cannot rule out many conditions with are contraindications for treatment.

Basically, Medicare is expecting us to treat their patients with the highest level of care, but is unwilling to allow us to do so. This is unreasonable at best.

Submitter : Dr. Steven Gould, D.C., DACBR **Date:** 08/23/2007

Organization : Central Plains Radiologic Services, P.A.

Category : Radiologist

Issue Areas/Comments

Technical Corrections

Technical Corrections

Technical Corrections

I am writing to express my concern over the proposal to do away with x-ray payments when x-rays are taken by a "non-treating" provider on order of a chiropractor. "410.32 " We (chiropractors) can currently send a patient to a cooperative radiology center and have x-rays taken for the patient and the medical or osteopath radiologist can sign for the order, as long as they agree with the indications for imaging. This is a good practice, as it saves the patients time and money. If this proposal goes through and cuts out payment for x-rays ordered in this manner it will cost the system much more money and delay diagnosis and treatment of patients. The patients will have to go back to their primary doctor or maybe even get sent to a specialist from the primary doctor to have x-rays performed. Now we are paying for 1 or 2 more office visits and the x-rays. Medical facilities and hospitals commonly charge more for x-rays than do private offices. Additionally chiropractors are trained in differential diagnosis (especially musculoskeletal diagnosis) and have been shown to have higher testing scores when compared to medical providers when tested on their musculoskeletal diagnosis skills. Therefore we are forced to send patients back to providers that are less knowledgeable about the patients condition than we are. Medicare would probably save more money by allowing chiropractors to practice as the physicians we are and licensed to be in our states. We order and read x-rays, MRI, and ultrasound for musculoskeletal conditions on a regular basis. Medicare should not stop payment for x-rays order by the chiropractor and taken by another "non-treating" provider. Medicare should allow full scope of practice for chiropractors and cover the x-ray procedures that we perform, according to our scope of practice in our states.

Thank you,

Steven J. Gould, D.C., D.A.C.B.R.
Residency trained chiropractic radiologist. Board certified by the American Chiropractic Board of Radiology.
316-542-3400

Submitter : **Mrs. Anita French** **Date: 08/23/2007**

Organization : **Atlantic Anesthesia**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
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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,

Anita French, CRNA
309 B 26th Street
Virginia Beach, Va 23451

Submitter : **Dr. Patrick Goodman** **Date: 08/23/2007**

Organization : **ASA**

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.

Patrick Goodman, M.D.
Medical College of Georgia

Submitter : **Mr. Raymond Edwards** **Date: 08/23/2007**

Organization : **AANA**

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
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Sincerely,

Name & Credential

Address

City, State ZIP

Submitter : Mr. Matthew O'Connor **Date:** 08/23/2007

Organization : MTSA

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
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Sincerely,

Matthew A. O'Connor
CRNA, MSN
642 Tyree Springs Road
White House, TN 37188

Submitter : Ms. Lynn Fant-Burke **Date:** 08/23/2007

Organization : Tapestry Medical

Category : Nurse

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

I am writing to offer my opinion as an RN/ Health Care Provider in relation to the proposed CMS-1385-P Medicare Program Revisions to payment as it relates to the provision of Home INR Monitoring services (G-0248 and G-0249). I am a Registered Nurse, responsible for training patients to monitor their anticoagulation testing and communicating the results to their health Care provider along with how to translate results to monitoring facility and follow correct instructions.

I am writing today to express my concerns related to the payment for G0248 and G0249 services and a need to ensure that all G0248 (training) services be performed on a face to face basis (rather then by telephone) to ensure that procedures are followed and that the person /patient is performing the test correctly. This is vital to patient health and should be taught by a medical professional.

In my professional opinion I do not believe that it is possible to properly train patients in Home INR Monitoring safely with any other method other then face-to-face.

For this reason, I recommend that CMS ensure that the resource-based RVU's be based on face-to-face training and that the supporting procedures clearly stipulate that payment for G0248 services will only be made for face-to-face trainings.

Sincerely

Lynn Fant-Burke RN

Submitter : Dr. Lee Portnoff **Date:** 08/23/2007

Organization : Lee S. Portnoff, M.D., P.C.

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I wish to comment on the proposed elimination of the exemption of Mohs CPT codes from the multiple procedure payment reduction rule. You stated in the federal register (7/12/2007) that "Because
the RVUs for these services do not take into account the efficiencies that occur when multiple procedures are performed in one session, we do not believe that these codes should continue to be exempt from the multiple procedure payment reduction."

However, I strongly disagree that performing two or more Mohs surgeries on any one patient on a given day gives rise to any efficiencies. The work involved in one Mohs procedure does not overlap with the work involved in the other Mohs procedures. There is still a separate work effort involved in marking the location of the skin cancer, a separate work effort involved in sterilizing and anesthetizing an additional tissue site, a separate work effort involved in excising the tissue, a separate work effort involved in preparing the specimen for frozen sections, a separate work effort involved in making the frozen sections, a separate work effort involved in reading the slides, and a separate work effort involved in wound management. In addition, there is a separate work effort involved in performing any repair procedure, which can only take place after all the Mohs surgery steps have been completed.

I fail to see any "efficiencies" in performing multiple Mohs procedures on any patient. I don't believe this proposed rule change can be supported by any factual analysis of performing Mohs surgery. Therefore, this proposed rule change should be discarded, and the multiple procedure payment reduction exemption for the Mohs codes should be continued.

CMS-1385-P-7509-Attach-1.DOC

7509

LEE S. PORTNOFF, M.D., P.C.
DERMATOLOGIC SURGERY

MISSOURI BAPTIST MEDICAL CENTER
3009 NORTH BALLAS RD., SUITE 235A
ST. LOUIS, MISSOURI 63131-2308
TELEPHONE (314) 993-2909
FAX (314) 993-0693

August 23, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850.

Re: CODING—MULTIPLE PROCEDURE PAYMENT REDUCTION FOR MOHS SURGERY

Dear Sirs:

I wish to comment on the proposed elimination of the exemption of Mohs CPT codes from the multiple procedure payment reduction rule. You stated in the federal register (7/12/2007) that "Because the RVUs for these services do not take into account the efficiencies that occur when multiple procedures are performed in one session, we do not believe that these codes should continue to be exempt from the multiple procedure payment reduction."

However, I strongly disagree that performing two or more Mohs surgeries on any one patient on a given day gives rise to any efficiencies. The work involved in one Mohs procedure does not overlap with the work involved in the other Mohs procedures. There is still a separate work effort involved in marking the location of the skin cancer, a separate work effort involved in sterilizing and anesthetizing an additional tissue site, a separate work effort involved in excising the tissue, a separate work effort involved in preparing the specimens for frozen sections, a separate work effort involved in making the frozen sections, a separate work effort involved in reading the slides, and a separate work effort involved in wound management. In addition, there is a separate work effort involved in performing any repair procedure, which can only take place after all the Mohs surgery steps have been completed.

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Sincerely,

Lee S. Portnoff MD

Lee S. Portnoff, M.D.