Submitter : **Dr. Theodore Simon** **Date: 08/25/2007**

Organization : **Simon Clinics of Chioropractic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

As per the July 12 rule regarding Medicare reimbursement for x-ray taken by a non-treating provider and used by a Chiropractor for determination of subluxation, be eliminated. I am writing in strong opposition to this proposal.
The cost to US taxpayers to pay for an additional referral let alone extra time (for additional referrals) for a senior to be in pain or discomfort is terrible.
Comparing prices now, In my or most D.C. offices the billed cost is $90. . At our local hospital it is $450. Do we (taxpayers) let alone medicare/medicaid and their recipients need an additional expense?
I strongly urge you to oppose this proposal.
Respectfully,
Dr Theodore Simon

Submitter : **Dr. LIsa Caramico** **Date: 08/25/2007**

Organization : **Dr. LIsa Caramico**

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.

Lisa Caramico, MD
1566 Bronson Road
Fairfield, CT 06824

CMS-1385-P-7806

Submitter : **Dr. Ellen Matuszak** **Date: 08/25/2007**

Organization : **Dr. Ellen Matuszak**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Re: CMS-1385-P
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.

Submitter : **Date: 08/25/2007**

Organization :

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

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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.

Submitter : **Dr. Robert Kranz** **Date: 08/25/2007**

Organization : **Associated Anesthesiologists Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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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. Stephen Heimbach** **Date: 08/25/2007**

Organization : **OU Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

CMS-1385-P-7810

Submitter : **Dr. Lisa Morse** **Date: 08/25/2007**

Organization : **Dr. Lisa Morse**

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.

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Kevin Hook** **Date: 08/25/2007**

Organization : **OSA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Lcslic V. Norwalk, Esq.
Acting Administrator
Ccntcrs for Mcdicarc and Mcdicaid Services
Attcntion: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

Rc: CMS-1385-P

Ancsthcsia Coding (Part of 5-Ycar Rcview)

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Dennis Williams** **Date: 08/25/2007**

Organization : **Tahlequah City Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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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. REGINALD SCOTT** **Date: 08/25/2007**

Organization : **AAI**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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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. jonathan schaller** **Date: 08/25/2007**

Organization : **Dr. jonathan schaller**

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 ehoose 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 D. Schaller

Submitter : **Dr. Richard Whitten** **Date: 08/25/2007**

Organization : **Noridian Administrative Services**

Category : **Physician**

Issue Areas/Comments

Drug Compendia

Drug Compendia

Colleagues: Your summary at page 38178 of the NPRM is an accurate reflection of our March 30, 2006 MedCAC meeting, though several points may help strengthen both its record and your current task. It is understood that the bullets listed will become criteria to assess compendia, which is logical. Your current 2nd bullet reads Quick throughput from application for inclusion to listing. This is a correct reflection of the MedCAC discussion and is an appropriate criterion. A corollary, also discussed, is that with the large number of new drugs and indications coming forward, any useful compendium will have regular (probably at least monthly) updates throughout the year. It may help to make this more explicit. The seventh bullet reads Explicit Not recommended listing when validated evidence is appropriate. Printed as such this can be misinterpreted to mean no recommendation / no comment . It may therefore strengthen this wording to state as Explicit recommendation against listing when validated evidence is appropriate , which is what we discussed at MedCAC and was widely supported. The tenth bullet might preferably read Process for public identification and notification of potential conflicts of interest in each step of the compendium s process, for all participants, with an established procedure to manage any relevant conflicts. Lastly, an issue also discussed at the MedCAC, but that has become much more apparent since the attempted change from USP-DI to DrugDex, is that of Accessibility and cost of the compendium s materials to the public. A high-quality process and extensive materials will be of little value if their price and ease-of-access are such that they are not readily used. This has been a problem with the current compendia and a reason for the popularity of the (less accurate) summary on the ACCC s website and in its quarterly brochure as well as the NCCN s website. To be functional, a useful compendium needs a quality process, with frequent updates of the wide breadth of oncologic drugs, easily accessible (web-based) at reasonable cost. The reasonable cost needs to be a more explicit criterion, without which limited access to the information will preclude its usefulness. Thank you for this opportunity to comment. Richard W. Whitten, MD, MBA, FACP; Contractor Medical Director, Medicare B for AK, HI & WA.

CMS-1385-P-7815-Attach-1.DOC

#- 7815

Colleagues:

Your summary at page 38178 of the NPRM is an accurate reflection of our March 30, 2006 MedCAC meeting, though several points may help strengthen both its record and your current task. It is understood that the bullets listed will become criteria to assess compendia, which is logical.

Your current 2nd bullet reads "Quick throughput from application for inclusion to listing." This is a correct reflection of the MedCAC discussion and is an appropriate criterion. A corollary, also discussed, is that with the large number of new drugs and indications coming forward, any useful compendium will have regular (probably at least monthly) updates throughout the year. It may help to make this more explicit.

The seventh bullet reads "Explicit 'Not recommended' listing when validated evidence is appropriate." Printed as such this can be misinterpreted to mean "no recommendation"/"no comment". It may therefore strengthen this wording to state as "Explicit 'recommendation against' listing when validated evidence is appropriate", which is what we discussed at MedCAC and was widely supported.

The tenth bullet might preferably read "Process for public identification and notification of potential conflicts of interest in each step of the compendium's process, for all participants, with an established procedure to manage any relevant conflicts."

Lastly, an issue also discussed at the MedCAC, but that has become much more apparent since the attempted change from USP-DI to DrugDex, is that of "Accessibility and cost of the compendium's materials to the public." A high-quality process and extensive materials will be of little value if their price and ease-of-access are such that they are not readily used. This has been a problem with the current compendia and a reason for the popularity of the (less accurate) summary on the ACCC's website and in its quarterly brochure as well as the NCCN's website. To be functional, a useful compendium needs a quality process, with frequent updates of the wide breadth of oncologic drugs, easily accessible (web-based) at reasonable cost. The "reasonable cost" needs to be a more explicit criterion, without which limited access to the information will preclude its usefulness.

Thank you for this opportunity to comment.

Richard W. Whitten, MD, MBA, FACP
Contractor Medical Director, Medicare B for AK, HI & WA.

Submitter : **Dr. mICHAEL fERGUSON** **Date: 08/25/2007**

Organization : **ANESTHESIA sCHEDULING**

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.

CMS-1385-P-7817

Submitter : Dr. Carmen Occhiuzzi **Date:** 08/25/2007

Organization : Dr. Carmen John Occhiuzzi

Category : Chiropractor

Issue Areas/Comments

Impact

Impact

I am strongly opposed to the proposed rule dated July 12 contained in the technical corrections section which would eliminate reimbursement by medicare for an x-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation. By eliminating a DC from referring for an X-ray study,the cost of patient care will rise drastically resulting from patient having to seek duplicative care from referrals to ortopedists, rheumatologists, etc., and treatment, further will be delayed. I stongly urge you to table t his proposal. These X-rays, if needed, are necessary to the overall treatment plan of Medicare patients, and it is ultimately the patients that wil suffer should this proposal become standing regulation. Thank you.

Submitter : **Dr. Michael Robinson** **Date: 08/25/2007**

Organization : **AAEdmond**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Dana Terrell** **Date: 08/25/2007**

Organization : **St.John Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter :

Date: 08/25/2007

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

This comment relates to CMS 1385-P I am an attending anesthesiologist in Illinois. My practice is located in the Chicagoland area. I care for hundreds of very sick patients on a consistent basis. These important members of our society need our help. Please support our work by increasing the reimbursements for our services. we need to keep strong, committed, well trained practioners in our system. Thank You

Submitter : **Dr. Dennis Rehrig** **Date: 08/25/2007**

Organization : **ACA**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to ask you oppose the proposal dated July 12th related to the elimination of X-rays taken by non-treating providers and used by Doctors of Chiropractic.

For a senior citizen, this would burden them physically and financially having to travel to another provider (GP, ortho, rheumatalogist, etc.) to again be evaluated before potentially being sent to a radialogist for X-rays.

It would seem like a no-brainer that X-rays would be a required an integral aspect of any logical evaluation tool especially for the elderly. To create more barriers to getting a diagnositic tool that can rule out many conditions and locate potential problems would seem ridiculous.

Please at least table this proposal or even more appropiately, drop it.

Thank you!

Dennis T. Rehrig D.C.

Submitter : **Mr. Benjamin Roberts** **Date: 08/25/2007**

Organization : **Mr. Benjamin Roberts**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 25, 2007

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

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

Dear Ms. Norwalk:

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,

Benjamin J. Roberts, RN, MSN, CRNA, CCRN
13713 Stringfellow Lane
Charlotte, NC 28278

Submitter : **Date: 08/25/2007**

Organization :

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,

Carrie Dixon,
current chiropractic student

Submitter : Ms. LUCY SUGG **Date:** 08/25/2007

Organization : Ms. LUCY SUGG

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

This increase in Medicare payment is important for several reasons.

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? 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).

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Submitter : **Dr. Donald Littlejohn** **Date: 08/25/2007**

Organization : **Dr. Donald Littlejohn**

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

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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,

Donald Littlejohn, DC

Submitter : Dr. Kerry Kasegian **Date:** 08/25/2007

Organization : Dr. Kerry Kasegian

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

Interfering with a Chiropractor's rights to refer a patient to have necessary x-rays also hinders the potential outcome of a patient's diagnostic and treatment results. Having been a chiropractor for 22 years, I would expect laws to be enacted to benefit the patient, not the opposite. I am strongly opposed to this revision.

Submitter : **Dr. Donn Gurske** **Date: 08/25/2007**

Organization : **Gurske Chiropractic Center**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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After 31 years of practice, I can tell you this proposed change will have an effect on our health care system. In the last ten years I have seen a substantial increase in the volume of Medicare patient's. These patients come with a uniqueness unlike any other patients that I see. Their medical history is complex with multiple past trauma, degenerative changes to muscle, tendons, ligaments, and nerves. These conditions bring about special concerns and certainly need to be addressed in order to properly treat the patient.

By limiting the ability of a doctor to refer patients for appropriated tests is malpractice. I cannot treat a patient with my form of care without a complete understanding of the patient's condition. I can tell you from personal experience that if I do not have the ability to refer directly to the radiologist, the alternative is to refer back to the primary who then refers to the specialist who then does further testing and x-rays and then may implement treatments in addition to chiropractic that may not be effective.

Why with all the laws in place to protect the public would you want to put at risk the senior population? Quality care comes from proficient and effective clinical procedures.

Submitter : **Mrs. Sandra Zanetti** **Date: 08/25/2007**

Organization : **The Hale Hand Center**

Category : **Occupational Therapist**

Issue Areas/Comments

TRHCA-- Section 201: Therapy CapS

TRHCA-- Section 201: Therapy CapS

The Hale Hand Center

747 Apollo Boulevard
Melbourne, FL, 32901
Tel: 321-674-5035 Fax 321-674-5039

August 24th, 2007

RE: CMS-1385-P

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

Dear CMS Representative,

I am writing this letter to express my deep concern regarding the proposed Medicare Physician Fee Schedule (MPFS) revision. I believe that this will dramatically affect the reimbursement of Occupational and Physical Therapy services provided to the elderly and the patients receiving Medicare benefits in my community, and throughout the Nation.

This proposed method of reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care. This will result in peoples loss of functional independence.

I understand that the AMA, the American Occupational Therapy Association and the American Physical Therapy Association, as well as other organizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these clients right to adequate and necessary medical care, and ultimately their function.

Sincerely,

Sandra Zanetti OTR/L, CHT

Submitter : **Dr. Richard Bohannon** **Date: 08/25/2007**

Organization : **Physical Therapy Consultants**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I strongly urge that physical therapy services should not qualify as an in-office ancillary services exception to the Stark law. I can think of no case where in-office therapy services are warranted and necessary for the public good.

Such services are anticompetetive and subject to abuse. Physicians should not be able to profit from self-referral when the services they are profiting from are freely available. Particularly in states where referral is necessary for therapy provision, physicians can essentially monopolize the market.

Let patients make their own choices about where to receive therapy.

I thank you for your consideration.

CMS-1385-P-7830

Submitter : **Dr. michael fiscella** **Date: 08/25/2007**

Organization : **wilmington clinic**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

there is a proposal before you "not allowing chiropractors to refer for xrays. i have been practicing since 1977. i treat many medicare citizens. this will have very negative effect on my ability to treat safely people over 65 because their spines are a more risky than 20 yr olds. by limiting my access to an inexpensive method to help the patient and my care for them is very disappointing. please reconsider this gross error in my humble opinion. thank you. dr fiscella

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

there is a proposal before you "not allowing chiropractors to refer for xrays. i have been practicing since 1977. i treat many medicare citizens. this will have very negative effect on my ability to treat safely people over 65 because their spines are a more risky than 20 yr olds. by limiting my access to an inexpensive method to help the patient and my care for them is very disappointing. please reconsider this gross error in my humble opinion. thank you. dr fiscella

Submitter : **Mr. Gary Lewellen** **Date: 08/25/2007**

Organization : **The Indiana Orthopaedic Center**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

This proposal contains language that would constrict the physicians ability to employ occupational and physical therapists. Please consider the facts
While CMS refers to hundreds of letters from physical therapists and occupational therapists that the in-office ancillary services exception encourages physicians to create physical and occupational therapy practices. CMS does not elaborate any further on the harm of this activity. I m sure these letters quote some irrelevant 15 year old study; please delve into the integrity of the study. It is meaningless in this current context.
Realize that the patients are well served by the collegiality of working hand-in-hand in the same organization. Numerous studies show that handing-off the patient from one provider to next, is where break downs in the continuity of care occur. Our patients feel more comfortable knowing that their therapists and physicians are working together at the same location.
Outlawing in-house physical therapy simply reduces patient choice and constricts competition. It is proven time-and-time again than competition yields higher quality and lower costs. Think back over time about airline tickets, long distance phone calls and retail mark-up; all have become more economical and the quality has increased a result of competition.
Outlawing in-house therapy become an inconvenience to the patient. Now they have to find and travel to another provider. Frequently, this will be the hospital. Isn t one stop shopping better for the patient? Also, don t you pay the hospital more for the same service?
Please don t disturb the physician s latitude to provide in-office services to their patients. Further restrictions will do nothing but inconvenience the patient, constrict alternatives and competition, and drive up Medicare costs.

Submitter : **Barbara Sadler** **Date: 08/25/2007**

Organization : **Sadler Anesthesia, Inc.**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007 Ms. Leslie Norwalk, JD Acting Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT) Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Ms. Norwalk: As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services. This increase in Medicare payment is important for several reasons.

Submitter : Dr. Brian Karwowski, D.C. **Date:** 08/25/2007

Organization : Dr. Brian Karwowski, D.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

ocket: CMS-1385-P - Revisions to Payment Policies Under the Physician Fee Schedule
To Whom it may concern: X-ray ordered by a Chiropractic physician is an important tool in the diagnosing and treatment of many patients for purposes of ruling out more serious conditions and as a first line mode of testing that may lead to additional enhanced imaging and laboratory testing. As a recognized primary care physician in Illinois is question the reasoning behind these decisions and request that they be reconsidered.

Dr. Brian Karwowski
Chiropractic Physician

Submitter : **Abigail Caswell** **Date: 08/25/2007**

Organization : **Abigail Caswell**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for
Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates. Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B
providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule. Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments. Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

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

Submitter : **Dr. Thomas Klapp** **Date: 08/25/2007**

Organization : **Michigan Association of Chiropractors**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

It is outrageous that CMS would propose the denial of payment to radiologists and others for x-rays IF those x-rays are to be used by a doctor of chiropractic.

It is bad enough that Medicare doesn't reimburse DC's for x-rays, but to now deny reimbursement for anyone who takes x-rays to be used by a DC is pure discrimination. The worst part of this is that doctors of chiropractic are already the most cost-effective providers of health care by A LOT!

This provision must be eliminated for fairness to the patients who choose chiropractic and for the chiropractors themselves who labor under extreme discrimination already.

Submitter : **Dr. John Campbell** **Date: 08/25/2007**

Organization : **Midwest Physician Anesthesia Services**

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 D. Campbell, M.D.

Submitter : **Dr. Anthony Tamburello** **Date: 08/25/2007**

Organization : **ANJC**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

I am writing in strong opposition to the proposed rule dated July 12th under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by medicare for x-rays taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxtion , or contrainication to adjust, be eliminated. By eliminating a Chiropractor from refering for x-rays you are increasing the cost of care and restricting the Chiropractor's ability to diagnose and treat the patient. I strongly urge you to table this issue.
Sincerely,
Dr. Anthony Tamburello

Submitter :

Date: 08/25/2007

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator of CMS
Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Sincerely,

H.P. Reed MD
Ashland OH 44805

Submitter : **Paul Sinquefield** **Date: 08/25/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

I feel that cutting Medicare reimbursement for anesthesia services is not in the best interest of health care in the U.S. Particularly in rural America. There is already a tremendous shortage of anesthesia providers and cutting repayment will only shrink this valuable asset by making it harder for anesthesia providers to do business. This particularly affects CRNA's in that it is primarily the CRNA who is providing Anesthesia services in rural communities. In these communities the primary insurance people are relying on is Medicare. By cutting reimbursment, CRNA's in these communities will find it increasingly difficult to provide services. Groups that once could support multiple CRNA's will have to cut back on staffing thus reducing access to service. In Texas alone there are 270+ counties that have no anesthesiologist, these counties are serviced by CRNA's. Cutting reimbursement will hurt every one seeking surgical care in these counties.

Thank you for your time,

Paul J. Sinquefield, BSN, CRNA

Submitter : **Dr. Luiz Weksler** **Date: 08/25/2007**

Organization : **Hillcrest**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Falguni Modi** **Date: 08/25/2007**

Organization : **Mrs. Falguni Modi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Falguni Modi

CMS-1385-P-7844

Submitter : **Dr. Lynne Imhoff** **Date: 08/25/2007**

Organization : **Hillcrest**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Sameh Hanna** **Date: 08/25/2007**

Organization : **Lawton Indian Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Arvind Modi** **Date: 08/25/2007**

Organization : **Arvind Modi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Arvind Modi

Submitter : **Dr. Jay Wheeler** **Date: 08/25/2007**

Organization : **Hillcrest**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Mrs. Shakuntala Modi** **Date: 08/25/2007**

Organization : **Mrs. Shakuntala Modi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Shakuntala Modi

Submitter : **Dr. Ryan Hulver** **Date: 08/25/2007**

Organization : **Hillcrest**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Talin Modi** **Date: 08/25/2007**

Organization : **Mr. Talin Modi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Talin Modi

CMS-1385-P-7851

Submitter : **Miss. Kalyani Modi** **Date: 08/25/2007**

Organization : **Miss. Kalyani Modi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Kalyani Modi

Submitter : **Dr. Robert Blozen** **Date: 08/25/2007**

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

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.Robert A. Blozen Jr.

Submitter : **Dr. Paul Loubser** **Date: 08/25/2007**

Organization : **NCAC, PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Jay Cunningham** **Date: 08/25/2007**

Organization : **AAI**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Mrs. Teri Cunningham** **Date: 08/25/2007**

Organization : **Individual**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Tyler Cunningham** **Date: 08/25/2007**

Organization : **Individual**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Mr. JD Cunningham** **Date: 08/25/2007**

Organization : **Individual**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Submitter : **Date: 08/25/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1385 P
P.O. Box 8018
Baltimore, MD 21244 8018.
Dear Mr. Kuhn:
I am a urologist who practices in an academic facility, treating a wide range of patients with limited resources. I am writing to comment on the proposed changes to the physician fee schedule rules that
were published on July 12, 2007 that concern the Stark self-referral rule and the reassignment
and purchased diagnostic test rules.
The changes proposed in these rules will have a serious impact on the way urologists practice medicine and will not lead to the best medical practices. With respect
to the in-office ancillary services exception, the definition should not be limited in any way. It is
important for patient care for urologists to have the ability to provide pathology services in their
own offices. It is equally important to allow urologists to work with radiation oncologists in a
variety of ways to provide the best therapy to patients.
The proposed changes to the reassignment and purchased diagnostic test rules will make it
difficult, if not impossible for me to provide efficient care to our patients. For patients that already have limited resources, this will mean increased costs to the patient and disruption of the continuity of care which is so important for the types of diseases we treat.

The sweeping changes to the Stark regulations and the reassignment and purchased diagnostic
test rules go far beyond what is necessary to protect the Medicare program from fraud and abuse.
The rules should be revised to only prohibit those specific arrangements that are not beneficial to
patient care.
Thank you for your consideration,

Submitter : Dr. Robert Howell

Organization : Dr. Robert Howell

Date: 08/25/2007

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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.

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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,

Robert S. Howell, D.C.

Submitter : **Dr. Diane Kramer** **Date: 08/25/2007**

Organization : **Dr. Diane Kramer**

Category : **Chiropractor**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, Md 21244-8018
Re: "Technical Corrections"

I am writing to you in regards to the proposed rule dated July 12.2007
calling for a current regulation that allows for a patient (beneficiary) to be reimbursed by Medicare for an xray taken by a radiologist and used by the Doctor of Chiropractic for the treatment and diagnosis of the medicare patient be eliminated. I am strongly opposed to this proposal.
This is extremely discriminatory for these medicare patients. In this time of attempting to save monies and cut costs why would CMS want to add another costly step in the medicare patients quest for an accurate health care assesment? Already by denying the rights of these patients of the Doctors of Chiropractic the ability to be reimbursed for xrays taken by the Doctor of Chiropractic CMS has forced these patients to go to a radiologist or other providers and CMS has had to pay additional monies. This newly proposed regulation further complicates the process of health care and will greatly increase the costs for an already overburdened CMS.
Xrays are an important part of the Doctor of Chiropractic 's patients evaluation, analysis and diagnostic procedure. The patient will suffer as a result of this newly proposed regulation.
Medicare patients deserve to recieve reimbursement for these medically necessary xrays. To force the patient to see additional healthcare providers which are more costly adds an unnecessry burden to the patient, delays proper treatment and increases the cost to the Medicare system.
I strongly urge you on behalf of these Medicare patients to table this proposal.

Sincerely,

Diane M. Kramer D.C.

Submitter : Dr. maia james **Date:** 08/25/2007

Organization : Dr. maia james

Category : Chiropractor

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I am a participating provider of Medicare with no X-ray services in my office. Making my patients go back to their Primary for Xrays would increase patient and systemwide costs while slowing efficiency. One of the reasons one might take Xrays, is being over fifty with a history that warrants it. Please do not add an undue burden on my patients. I need to be able to order Xrays from another facility with out requiring another evaluation from another provider with perhaps less musculoskeletal training and experience than myself.

I do not take routine Xrays, but only with yellow and red flags. This is not going to be an undue burden on the system, but will instead cause patients not to get the care they need because of fear or cost and hassle.

Sincerely,

Maia James

Submitter : **Dr. Andrew Smith** **Date: 08/25/2007**

Organization : **Dr. Andrew Smith**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Todd Sprang** **Date: 08/25/2007**

Organization : **Todd Sprang**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 25, 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,

Todd Sprang, CRNA
7703 W. 102nd St.
Overland Park, KS, 66212

Submitter : **Dr. Jay Srour** **Date: 08/25/2007**

Organization : **ASN**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Bhavika Patel** **Date: 08/25/2007**

Organization : **Mrs. Bhavika Patel**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Bhavika Patel, RN, BSN
Name & Credential
2134 Hill Canyon Ct
Address
SugarLand,Tx, 77479
City, State ZIP

Submitter : **Mrs. Shannon Hambrick** **Date: 08/25/2007**

Organization : **Mrs. Shannon Hambrick**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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Sincerely,
Shannon Hambrick RN, BSN, SRNA

Submitter : **Dr. gary Musgrave** **Date: 08/25/2007**

Organization : **Dr. gary Musgrave**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Another way that the ruling decision makers us strange logic to disable a Chiropractors ability to help seniors. After 20 plus years of education, congress still pretends Chiropractors are not real doctors, and ihibits our seniors from the care they seek, like they are ignorent children that don't know better. Every politition that votes to inhibit access to Chiropractors will be noted and reported to my over 10,000 patients.

Submitter : **Dr. David Graber** **Date: 08/25/2007**

Organization : **Dr. David Graber**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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.

Furthermore, allow freedom of choice for healthcare for senior Americans by expanding rather than limiting the services of Doctors of Chiropractic. Choice and competition for care of our seniors will lead to lower costs and healthier people.

Sincerely,

David Graber

Submitter : **Rebecca Hewitt** **Date: 08/25/2007**

Organization : **AANA**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

sec attachment

CMS-1385-P-7869-Attach-1.PDF

#7869

August 20, 2007

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

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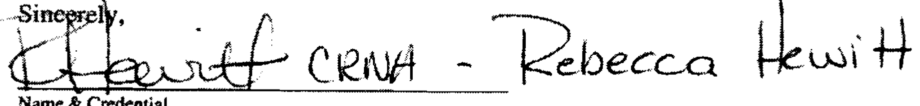

Name & Credential

Address Los Angeles, CA.

City, State ZIP

Submitter : **Dr. Paul Mouzakitis** **Date: 08/25/2007**

Organization : **Dr. Paul Mouzakitis**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Yours truly,

Paul U. Mouzakitis, M.D.