CMS-1385-P-7987

Submitter : **Dr. Anil Desai** **Date: 08/26/2007**

Organization : **Indian River Pathology, P.A.**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 26, 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 Fort Pierce, Florida as part of Indian River Pathology as a solo practitioner and at Lawnwood 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,

Anil Desai, M.D.

CMS-1385-P-7988

Submitter : Dr. Sujatha Bhandary **Date:** 08/26/2007

Organization : The Cleveland Clinic

Category : Physician

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sujatha Bhandary

Submitter : **Dr. Michael Ho** **Date: 08/26/2007**

Organization : **Hospital for Special Surgery**

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.

CMS-1385-P-7990

Submitter : **Dr. Katherine Latimer** **Date: 08/26/2007**

Organization : **American Society of Anesthesiologist**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

KATHERINE LATIMER, MD

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.

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Thank you for your consideration of this serious matter.

Katherine Latimer, MD

236 BRIARPATCH CT., MOUNTAIN PINE, AR 71956
PHONE: 501-767-9302 " EMAIL KLTLAKEO@MAC.COM

Submitter : **Dr. John Walsh** **Date: 08/26/2007**

Organization : **Massachusetts General 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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Thank you for your consideration of this serious matter.

CMS-1385-P-7992

Submitter : **Ms. Lynn Stuteville** **Date: 08/26/2007**

Organization : **AANA**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

August 26, 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,

Lynn Stuteville, CRNA, MS
9412 Sunperch Court
Pearland, TX 77584

Submitter : **Dr. Fernando Arbona** **Date: 08/26/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.

-Fernando L. Arbona, M.D.

CMS-1385-P-7994

Submitter : **Dr. thomas campana** **Date: 08/26/2007**

Organization : **aca**

Category : **Physician**

Issue Areas/Comments

Technical Corrections

Technical Corrections

please consider what this means to the patients not your pocket book the gold standard of care for chiropractic is the x- ray . stop trying to destroy the chiorpractic profession.

Submitter : **Date: 08/26/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

CMS-1385-P-7996

Submitter : Rachelle Spiro

Date: 08/26/2007

Organization : R. Spiro Consulting

Category : Pharmacist

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-7996-Attach-1.DOC

#7996

August 27, 2007

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

Re: PROPOSED ELIMINATION OF EXEMPTION FOR COMPUTER-GENERATED FACSIMILES

To Whom It May Concern:

R. Spiro Consulting appreciates the opportunity to submit comments on the *Exemption to Foundation Standard Requirements for Computer-Generated Facsimiles* found starting on page 38194 of proposed rule CMS-1385-P dated July 12, 2007. R. Spiro Consulting is a consulting firm specializing in all aspects of long-term care pharmacy and information systems processes. As President of R. Spiro Consulting, my expertise in the long-term care industry especially in the area of health information technology is nationally known. I am the Co-Chair of the National Council for Prescription Drug Programs (NCPDP) Work Group 14 (the long-term care Work Group). I work with many long-term care pharmacy providers, facilities, intermediaries, software vendors and professional associations. I was a consultant on the Achieve Healthcare Information Technologies, LP "Long-term Care E-prescribing Standards Pilot Study. On May 4th, 2007, R. Spiro Consulting presented the 2007 National Committee on Vital Health Statistics (NCVHS) Subcommittee on Standards and Security a statement of the status of the NCPDP SCRIPT standards as it relates to the long-term care setting, requesting that the committee recommend that Health and Human Services (HHS) adopt NCPDP e-Prescribing standards for the long-term care setting.

Processes in the long-term care electronic prescribing (e-prescribing) pilot study in some instances utilized computer-generated faxes for medication orders (e.g. Controlled Substances) and in many long-term care setting computer generated faxes are the standard of practice. Adoption of e-prescribing in the long-term care setting is still very limited. Reasons for this include the costs of buying and installing a system, training involved, time and workflow impact, and lack of reimbursement for costs and resources. Historically long-term care facilities and in many cases even today receive computer-generated medical records (e.g. physician orders and medication administration records) from their long-term care pharmacy provider. Many independently-owned nursing facilities have yet to adopt technology other than the computers in their administrative and billing offices. The Center for Medicare and Medicaid Services (CMS) states in the November 7, 2005 final e-prescribing

rule that "less than 30 percent of nursing homes have computer access at the nursing station." The long-term care industry is still in its initial phases of adopting fully interoperable electronic health records and data exchange.

CMS has recognized the differences between the long-term care and ambulatory settings in the e-prescribing final rule. In the final rule, CMS states:

> "We agree that the nursing home industry standard practice is not conducive to early application of e-prescribing standards. The foundation standards that have been adequately tested in the ambulatory setting may not be directly transferable to the LONG-TERM CARE setting for several reasons... The current practice is for written orders to be faxed to the pharmacist as well as transcribed onto the Plan of Care at the nursing station. These intermediate steps would need to be developed separately in an e-prescribing system."

Medication management in the long-term care setting is very different from the ambulatory-retail setting. The long-term care setting requires planning, coordination and a unique timeline for widespread implementation. It is for these reasons that CMS, in the final rule, did not require application of the foundation e-prescribing standards in the long-term care setting:

> "...we exempt from the requirement to use NCPDP SCRIPT Standard prescription transactions between prescribers and dispensers where a non-prescribing provider is required by law to be a part of the overall transaction process."

Since CMS exempted the long-term care setting from the e-prescribing final rules, does it mean that the long-term care setting is exempt from any proposed changes to the computer-generated fax portion of the rule? The long-term care e-prescribing pilot found that e-prescribing worked in the long-term setting with modifications to the NCPDP SCRIPT standards, if CMS changes the e-prescribing regulations to include e-prescribing in the long-term care setting with a modified SCRIPT version, will the proposed changes to the computer-generated fax portion of the rule affect the long-term care setting?

The long-term care industry is very interested in fully adopting e-prescribing using the SCRIPT standard. In all reality it is going to take longer for the long-term care setting to reach this goal. The long-term care e-prescribing pilot has identified necessary additions to the SCRIPT standard, Version 8, Release 1 (8.1), in order to account for the nuances of the long-term care setting. Through the NCPDP, Work Group 14, the long-term care work group, has already forwarded and championed several modifications to the NCPDP SCRIPT Standard. Thus far, four Data Element Request Forms (DERFs) have been submitted for American National Standards Institute (ANSI) accreditation with more pending final NCPDP approval and ANSI submission:

DERF 743 – This DERF identified a specific unit, room and bed for medication delivery to the NCPDP SCRIPT Version 10.0 Patient Segment. This NCPDP SCRIPT Version was available for use in October 2006.

DERF 779 – This DERF will create a new Census Update Transaction. This new CENSUS SCRIPT is used to inform the pharmacy when a resident is admitted, discharged, or has a demographic change (e.g. a change in U/R/B or payer) that is not related to an order. Until this CENSUS DERF is available, the pharmacy system should review each NEWRX to see if any resident changes have occurred to insure that the pharmacy system is updated when the NEWRX is processed.

DERF 784- This DERF creates a new prescription modification process to link the current order cancel/DC with the new order to indicate to the pharmacy that this was a change to an existing order. This change was how an order modification was addressed in the pilot.

DERF 795 – This DERF creates a way to send a refill request from the facility to the pharmacy. This new RESUPPLY SCRIPT DERF is designed for use in the LONG-TERM CARE environment to allow nursing facilities to request a new supply/refill from a pharmacy.

The DERFs 779, 784 and 795 were recently balloted and approved as part of the NCPDP SCRIPT Standard Implementation Guide Version 10 Release 1 (10.1).

As an industry representative my firm recommends the adoption of the SCRIPT 10.1 standard as the e-prescribing standard within long-term care by August 2009, the expected completion date of the final long-term care electronic health record certification by the Certification Commission for Health Information Technology (CCHIT). It is important for the long-term care industry to adopt e-prescribing following the CCHIT roadmap and not be hindered by regulations counter to the certification process.

It is important to discuss the impact of the proposed computer-generated fax exemption elimination on the prescribing of controlled substances medication orders or any other situation that a computer-generated fax is needed in the long-term care setting. It is currently illegal to issue prescriptions for controlled substances using e-prescribing systems because those prescriptions must be written and "manually signed" by the prescriber. There are exceptions, such as when a Schedule II prescription is intended for a resident of a long-term care facility or a patient in a Medicare-covered hospice program, in which case a copy of the prescription may be transmitted entirely via fax without requiring the pharmacy to obtain an original, manually signed copy of the prescription. However, DEA controlled substance prescription regulations do not specifically prohibit a computer-generated fax transmission of a "manually signed" prescription. If the computer-generated fax

exemption were removed completely, a prescriber or facility using a paperless system that involved computer-generated faxes would be required to add an additional step to the prescribing process for controlled substances. This could be very detrimental to the long-term care setting and would have a potential to negatively impact implementation of health information technology – which is contrary to CMS's intended goal with the proposed exemption elimination. R. Spiro Consulting specifically recommends exempting controlled substances from the elimination of computer-generated faxed prescriptions.

In conclusion, R. Spiro Consulting would like to thank CMS for taking steps towards the advancement of health information technology. While at this point in time, the long-term care industry is still quite dependent on faxing medication orders, progress is definitely being made towards the adoption of health information technology, including e-prescribing. The industry is at a critical time and needs the help of the health care community to allow the industry to move toward technology solutions that will work within the long-term care setting and not being forced to follow ambulatory practices. It is important for the industry to receive CMS clarification on the applicability of the proposed changes of the proposed elimination of the exemption for computer-generated fax prescriptions on the long-term care setting. In addition, we are encouraging adoption of the NCPDP SCRIPT standard, version 10.1, prior to CCHIT certification of long-term care electronic health records so that e-prescribing and interoperability will be successful when implemented in this setting. Although controlled substance prescriptions cannot yet be electronically transmitted, we encourage the exemption of controlled substances from the proposed rule to eliminate at least some barriers for those currently using paperless systems.

Sincerely,

Rachelle F. Spiro, BPharm, FASCP
President
R. Spiro Consulting
1200 First St. Suite 1632
Alexandria, VA 22314
(703) 599-5051
E-mail: shellyspiro@yahoo.com

CMS-1385-P-7997

Submitter : **Dr. James McMichael** **Date: 08/26/2007**

Organization : **Capitol Anesthesiology Association**

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 strong support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I greatly appreciate that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation. As a long time memeber and former Chair of the American Society of Anesthesiologists Committee on Economics, I am very familiar with the processes that led to the RUC recommedation, and again, I appreciate and support the decision of CMS to implement the recommendation.

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

Thank you for your consideration of this serious matter.

Sincerely,

James P. McMichael, MD

CMS-1385-P-7998

Submitter : Lesley Boyko **Date:** 08/26/2007

Organization : Lesley Boyko

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-7998-Attach-1.DOC

CMS-1385-P-7999

Submitter : Dr. Bennett Fuller **Date:** 08/26/2007

Organization : Dr. Bennett Fuller

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Thank you for agreeing to hear arguements in support of increased RVU reimbursment rates for anesthesia services. After 18 years of dismal reimbursment it is nice to get a fair hearing!

For all these years it has become increasingly difficult to recruit,hire and keep well qualifies anesthesiologists in groups seving the public good in full service community hospitals.Over this same 18 years I personally have paid various contractors (plumbers, phone company employees, etc)more than I receive for the anesthetic care of medicare insureds. Why go to school for so long, incur that much debt and pay huge sums in malpractice insurance premiums for the reimbursment?

If it weren't for our sence of duty to our country's elderly and most needy I think most anesthesiologists would have stopped caring for the medicare insured. Many less patriotic colleagues have already run away from community hospitals precisely to avoid the low reimbursment of medicare for anesthesia services.

Finally, I'm not asking for any catch up monies for 18 years of underfunded care, because I know our government can not afford it, but from now on the correction in anesthesia services reimbursment is fair and just. Thanks for considering this very reasonable correction of a longstanding mistake. Bennett E Fuller, MD

CMS-1385-P-8000

Submitter : **Dr. Steven Pearce** **Date: 08/26/2007**

Organization : **Anesthesia Associates of York 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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Thank you very much!

Steven Pearce MD

CMS-1385-P-8001

Submitter : **Dr. ron rawlings** **Date: 08/26/2007**

Organization : **Dr. ron rawlings**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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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-8002

Submitter : **Dr. Barry Moody** **Date: 08/26/2007**

Organization : **Dr. Barry Moody**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I write to express my support for the CMS-1385-P Anesthesia Coding(Part of 5-year review) under which CMS proposes to increase substantially the reimbursement for anesthesiology services. These services have been grossly undervalued in previous years. This change will make it possible to continue to provide the care our senior citizens deserve, especially in a small rural area such as Florence,Alabama where I practice. Thanks you for your work in trying to right this long endured discrepancy in valuation of the services I provide daily for our sensior.

Barry J. Moody, MD
216 Marengo Street
Suite C
Florence, Alabama 35630

CMS-1385-P-8003

Submitter : **Dr. Donald Galligan** **Date: 08/26/2007**

Organization : **Fullerton Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Nowalk, Esq.
Acting Administrator
CMS
ATTN: CMS-1385-P
P.O. Box 8018
Baltimore, MD

Dear Ms. Norwalk:

I am writing to express my support for the proposal to increase anesthesia payments under the 2008 fee schedule. When I become a Medicare beneficiary I hope there are anesthesiologists willing to provide services to me. With the downward spiral ahead I am not sure there will be. It is gratifying to have CMS review the situation and take a proactive stance for anesthesia providers.

Thanks very much for your consideration of this very important matter.

Don Galligan, D.O.
Anesthesiogist
Fullerton Anesthesia Associates
101 E. Valencia Mesa Dr.
Fullerton, CA

CMS-1385-P-8004

Submitter : **Mrs. Dianne Bayer** **Date: 08/26/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

Dear Administrator,

As a member of the 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 to the current levels. (72 FR 38122, 7/12/2007) If adopted, CMS' proposal would help to ensure that Certified 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 availbility 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 of 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America's 36,000 CRNA's provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant providers to rural and medically underserved America.

Im my own practice, my partner and I are the sole anesthesia providers for a center that does ~3000 anesthesia cases/year. Eighty-five percent of our patients are Medicare beneficiaries. We seem to be treating sicker patients as the age in America is older now. Our Liability Insurance is more expensive than ever before with our reimbursement lower than ever before. We feel that we are being punished for providing for Medicare beneficiaries. Our reimbursement is now below the cost of living in 1999.

Medicare patients and health care 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,

Dianne, Y. Bayer, CRNA
985 Carstairs Ct.
Tarpon Springs, FL 34688

Submitter : **Mary Billstrand** **Date: 08/26/2007**

Organization : **Mary Billstrand**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.
Sincerely,
Mary Billstrand

CMS-1385-P-8006

Submitter : **Dr. Larry Hopkins** **Date: 08/26/2007**

Organization : **Anesthesia Consultants of Indianapolis Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1385-P-8006-Attach-1.DOC

Submitter : **Dr. Paul Parker** **Date: 08/26/2007**

Organization : **Dr. Paul Parker**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I want to voice my opinion regarding the proposed increase anesthesia payments under the 2008 Physician Fee Schedule. Medicare has underpaid anesthesiologists relative to other physicians. While, as a specialty, we have been able to charge higher rates to private payers and thus make a competitive income, it has come at the cost of creating unequal playing fields in areas where there are large Medicare populations. This has led to the necessity of stipends from hospitals with large Medicare numbers and that creates disruptive forces in the market place. By raising the numbers to about $20/unit, anesthesia will still be undervalued relative to private payers, but the gap between private and Medicare will be brought in line with other physician specialties. It will be very helpful in areas with high Medicare populations. I hope you will approve the increase as proposed.

Sincerely

Paul Parker M.D.

CMS-1385-P-8008

Submitter : Mrs. Linda Hopkins

Date: 08/26/2007

Organization : Mrs. Linda Hopkins

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1385-P-8008-Attach-1.DOC

#8008

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.

Linda C. Hopkins

CMS-1385-P-8009

Submitter : **Dr. Craig Brener** **Date: 08/26/2007**

Organization : **Dr. Craig Brener**

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.

Craig Brener, MD

CMS-1385-P-8010

Submitter : **Mrs. Kathryn Smith** **Date: 08/26/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. In my own practice, my partners and I are the sole annesthesia providers for a center that does 4,000 anesthesia cases per year. Eighty-five percent of our patients are Medicare beneficiares. We seem to be treating sicker patients as the age in america is older now. Our Lability Insurance is more expensive than ever before with our reimbursement lower than ever before. Our reimbursement is now below the cost of living in 1999. We urge congress to make this injustice corrected. 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,
Kathryn E. Smith, C.R.N.A.
444 Winding Willow Drive
Palm Harbor, FL 34683

CMS-1385-P-8011

Submitter : **Dr. Philip Zitello** **Date: 08/26/2007**

Organization : **Dr. Philip Zitello**

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-8012

Submitter :

Date: 08/26/2007

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To whom it may concern:

I am writing because I think that the in-office ancillary services exception to the Stark law should include physical therapy. I have been a physical therapist for 24 years. I have seen first hand how physician referrals patterns can change with a physician owned practice. Suddenly a lot more patients need physical therapy and they need it in the physician owned PT clinic-even if there are other PT clinics closer to the patients home. I have had patients tell me they were bullied by their doctor or his staff to attend their PT even if they have had successful PT elsewhere in the past. It has disgusted me to hear physicians talk about how they are going to make lots of money by having their own physical therapy. The potential for abuse of the system by physicians having their own practice is huge and it is real. I hope the loophole can be closed to prevent physician from owning their own physical therapy practices.

CMS-1385-P-8013

Submitter : Mr. HECTOR ACOSTA **Date:** 08/26/2007

Organization : ST GERMAIN CHIROPRACTIC,P.A.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

MY PARENTS HAVE TREATED WITH A CHIROPRACTOR FOR A LONG TIME, AND IT WOULD BE INCONSIDERATE, AT THEIR AGE (80YRS OLD)TO HAVE THEM TRAVEL TO GET X-RAYS AWAY FROM THE CHIRO CLINIC AS THEY HAVE THEIR DRIVING PRIVILEDGES RESTRAINED BY HEALTH ISSUES. PLEASE DO SOMETHING TO KEEP MEDICAID AUTHORIZED TO PAY FOR X-RAYS TAKEN AT THE CHIROPRACTIC CLINIC. THANK YOU.

CMS-1385-P-8014

Submitter : **Dr. Wayland Blikken** **Date: 08/26/2007**

Organization : **Dr. Wayland Blikken**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I appreciate your consideration in this important matter.

CMS-1385-P-8015

Submitter : Dr. Nancy Malin **Date:** 08/26/2007

Organization : Dr. Nancy Malin

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please see that this oversight in our anesthesiologists undervaluation is corrected now. Thank you for helping our seniors with access to this most important service.

CMS-1385-P-8016

Submitter : Dr. William Brotherton **Date:** 08/26/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The Anesthesia reimbersement schedule must be increased to account for past inequities. Medicare patients will receive suboptimal care because of an inability to recruit future M.D.s to the specialty if reimbursements are not increased.

Submitter : **Mr. Brad Koss** **Date: 08/26/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 27, 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,

Brad Koss, SRNA________________
Name & Credential
2132 Ponty Pool Drive____________
Address
Mount Juliet, TN 37122__________
City, State ZIP

Submitter : **Date: 08/26/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

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

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

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

Submitter : **Dr. David Harris** **Date: 08/26/2007**

Organization : **Capitol Anesthesiology Association**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Harold Bobb** **Date: 08/26/2007**

Organization : **Dr. Harold Bobb**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

It would be a definite descrimination against the Chiropractic profession and the patients they serve if x-ray referral and payment of that referral were declined. We arc the most inexpensive wasy to get a spinal opinion. We are the only docotrs out there that are trained when to x-ray, how to x-ray and how to read and anyalyzc spinal subluxations. This would be a great injusticc if allowed.

Submitter : **Dr. Salina Lucero** **Date: 08/26/2007**

Organization : **Univ. of Pittsburgh Medical Center**

Category : **Physician**

Issue Areas/Comments

CAP Issues

CAP Issues

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-eligible pathologist and a member of the College of American Pathologists and a member of Florida Society of Pathologists. I practice in Pittsburgh, PA as Surgical Pathology Fellow at the University of Pittsburgh 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 groups 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 as a Board-certified Pathologist.

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 and medical necessity. 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 physicians of other specialties utilize and compromises the integrity of the Medicare program.

Sincerely,

Salina D. Lucero MD
University of Pittsburgh Medical Center
Pathology Fellow

CMS-1385-P-8022

Submitter : **EILEEN BAKER** **Date: 08/26/2007**

Organization : **aana**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 26, 2007

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

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

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Additionally, if CMS proposed change is not enacted and it 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 thata third below 1992 payment levels (adjusted for inflation).

America s 36,000CRNAs 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 Mecicare payments 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,

Eileen T. Baker, CRNA
225 Park Drive
La Grange, TX 78945

Submitter : **Dr. Charles Gibbs** **Date: 08/26/2007**

Organization : **Adirondack Anesthesia Services, PC**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

See Attachment

#8023

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

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

Submitter : Dr. Mathai Kurien

Date: 08/26/2007

Organization : Anesthesia Associates of Abington

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.

Mathai Kurien, MD

Submitter : **Dr. xiuli zhang** **Date: 08/26/2007**

Organization : **SUNy Upstate Medical Univerisity**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Submitter : **Dr. Laura Hemmer** **Date: 08/26/2007**

Organization : **Dr. Laura Hemmer**

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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Submitter : **Dr. Ross Seibel** **Date: 08/26/2007**

Organization : **Southwest Medical Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Neil Stein** **Date: 08/26/2007**

Organization : **MetroUrology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a urologist in practice in Minneapolis, MN. I am part of a large single specialty practice and past president of the Minnesota Urological Association. Over the course of my career I have been an Air Force physician, a department head in an HMO (HealthPartners) and now is private practice. In no way am I against government involvement in health care with reasonable rules and regulations. I feel, however, the proposed rules and "Burden of Proof", "Per Click Payments", and physician ownership of technology to be poorly thought out, unreasonable, and grossly anti-physician. To not allow physicians to own equipment leased to a hosptial,ACS, or even their own office is anticompetetive. It will cause an increased number of physicians to leave the practice of medicine, form limited partnerships to circumvent the rules, or possible deny technology to geographical underserved areas.

Thank you.

Neil Stein, M.D.