CMS-1385-P-8192

**Submitter :** **Dr. James Anton** **Date: 08/27/2007**

**Organization :** **Baylor College of Medicine Dept. of 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)

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-8193

**Submitter :** Mr. James Freymiller **Date:** 08/27/2007

**Organization :** Atlantic CardioLink

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**Resource-Based PE RVUs**

*Resource-Based PE RVUs*

See attachment

CMS-1385-P-8193-Attach-1.PDF

#8193

ATLANTIC CardioLink

1305 SOUTH HICKORY STREET
MELBOURNE, FLORIDA 32901
(321) 952-9009
FAX (321) 952-9005

August 28, 2007

Herb B. Kuhn, Deputy Administrator (Acting)
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: Proposed Revisions to Payment Policies Under the Physicians Fee Schedule, and Other Part B Payment Policies for CY 2008**

Dear Mr. Kuhn:

On behalf of Atlantic CardioLink and our 13 individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the ***"Resource-Based PE RVU's"*** section of the above referenced July 2, 2007 Proposed Rule. We are specifically concerned with the 2008-2010 PE RVU's established for non-facility outpatient cardiac catheterization procedure codes and the significant negative impact that could result for our practice and our patients if these values are finalized for the 2008 Physicians Fee Schedule.

Atlantic CardioLink is an IDTF located in Melbourne, Florida, which was established in 1999 for outpatient cardiac cath services. This facility has 13 physicians successfully utilizing its services. Atlantic CardioLink operates with just one cath lab suite in which we perform about 1,000 procedures per year.

Atlantic CardioLink is a founding member of the Cardiovascular Outpatient Center Alliance (COCA) and as such we have actively been involved in the work that COCA has accomplished this year to collect and submit direct and indirect cost data to the AMA's Practice Expense Review Committee (PERC) of the Relative Value Scale Update Committee (RUC). Unfortunately, this process did not allow all of COCA's data to be considered and resulted in PE RVU recommendations to CMS that severely undervalued the direct and indirect costs associated with providing these procedures to our patients.

It is apparent from the July 2, 2007 Proposed Rule that CMS has accepted the RUC recommendations without considering the detailed direct cost information that COCA provided to CMS in May 2007. The PE-RVU values set out in the July 2 Proposed Rule would result in a draconian cut in reimbursement for cardiac catheterizations performed in

practice or IDTF locations. For example, if the 2007 conversion factor is applied to the technical component of the primary three CPT codes for a Left Heart Cath (93510TC, 93555TC, and 93556TC) the reimbursement in 2008 would be cut by **32%** and when fully implemented the total reimbursement would be reduced by **49%**. These reductions would undoubtedly result in the closing of the majority of non-facility outpatient cardiac catheterization labs in the country forcing all patients who now benefit from improved access and lower costs into more acute hospital settings.

It has also come to my attention recently that reimbursement for outpatient hospital APC rates (code 0080) have been proposed to receive an increase of **11.19%** for 2008 while the equivalent procedure performed in an outpatient IDTF setting will receive a decrease in reimbursement by **32.18%**.

I am requesting that CMS review the additional cost data provided by COCA and establish PE RVU's for outpatient cardiac catheterization procedures that more reasonably reflect the direct and indirect costs of providing these procedures. If the proposed RVU's are allowed to stand, the outcome will inevitably that will cost the Medicare program more in direct APC payments **and** Medicare patients more in higher deductibles and co-insurance.

Thank you for this opportunity to comment on this important issue.

Sincerely,

James D. Freymiller, RCIS
Director

**Submitter :** Dr. David Lange **Date:** 08/27/2007

**Organization :** Anesthesia Company

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1385-P-8194-Attach-1.DOC

#8194

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:

As Treasurer of an all physicians ( ~34) anesthesia group in Annapolis, MD, I am writing to express support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. Thank you for recognizing this gross undervaluation of anesthesia services. Please consider my opinion to represent the opinion of all 34 anesthesiologists in our group.

When the RBRVS was first 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, nation wide. 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. As the Treasurer of our group, it has been my pleasure to negotiate reimbursement rates with third party payers, not an easy task in the State of Maryland. The only tool at hand was to stop participating with the third party payers, and send a full non-discounted bill to the patient. With the planned decrease in Medicare reimbursements that had been promulgated before the recent announcement by the Relative Value Update Committee (RUC), I had anticipated telling our hospital and affiliated free standing surgery centers that we would no longer participate with Medicare/Medicaid products, and that we would be billing their facility directly for our services. The reason behind this stance is simple survival of our group. As the % of Medicare/Medicaid patients increase in our payer mix, our ability to attract physicians to our location in Maryland dramatically decreases. Prior to wrestling increases from our commercial products, we had 18 consecutive job applicants reject employment offers with our group, because our reimbursements were too low. The previously proposed downward spiral of Medicare reimbursements would rapidly return us to the days where we could not attract qualified physicians to our group.

As you know, 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 first 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 yours,

David G. Lange M.D., Ph.D.
Treasurer
Anesthesia Company
700 Melvin Ave.
Suite 7A
Annapolis, MD 21401

CMS-1385-P-8195

**Submitter :** Dr. Brad Bushong **Date:** 08/27/2007

**Organization :** Balanced Body Chiropractic Wellness

**Category :** Chiropractor

**Issue Areas/Comments**

GENERAL

GENERAL

The full scope and benefit package available to Medicare patients is already dismally limited for chiropractic care. The government's own research shows how effective chiropractic care can be for chronic ailments that afflict the elderly. Rather than block reimbursement further, and thereby choosing the over inflated medical model, Medicare should reimburse chiropractors for all they do as primary care physicians. This form of corrective care with continued pain management is less expensive, more responsive and highly efficacious in treating Medicare patients. Medical research demonstrates the necessity for chiropractic care, but it will take a brave Congress to trust the facts and turn away from lobbyist monies in order to provide the best care for our elderly. Please consider the ramifications of your actions for those who can't speak for themselves.

**Submitter :** **Dr. Jerrold Simon** **Date: 08/27/2007**

**Organization :** **ACA**

**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,

Jerrold Simon, DC

**Submitter :** **Roxanna Hall** **Date: 08/27/2007**

**Organization :** **OREGON IMAGING CENTER**

**Category :** **Health Plan or Association**

**Issue Areas/Comments**

**GENERAL**

GENERAL

The Physician Work RVU-CPT 77080 (DXA)
The Direct Practice Expense RVU for 77080 (DXA)
Indirect Practice Expense for DXA and VFA
Deficit Reduction Act
Dear Mr. Weems:
I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.
As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:
a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;
b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:
? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;
? the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.
c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and
d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

CMS-1385-P-8198

**Submitter :** Dr. David Charles **Date:** 08/27/2007

**Organization :** Alliance for Patient Access

**Category :** Physician

**Issue Areas/Comments**

**Drug Compendia**

Drug Compendia

See attachment.

CMS-1385-P-8198-Attach-1.RTF

#8198

THE ALLIANCE FOR PATIENT ACCESS

August 27, 2007

**Via Electronic Submission to: http://www.cms.hhs.gov/eRulemaking**
Kerry Weems
Administrator, Centers for Medicare and Medicaid Services-Designate
U.S. Department of Health and Human Services
Attn: CMS-1385-P
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Mr. Weems:

As chairman of the Alliance for Patient Access (AfPA), a national network of physicians whose mission is to ensure and protect patient access to approved medical treatments in the U.S., and as a neurologist who has been practicing in an academic setting for 13 years, I am pleased to submit comments on the Proposed Physician Fee Schedule Update for 2008, particularly on the agency's proposal concerning drug compendia and request for comments concerning CAP issues.

## DRUG COMPENDIA

AfPA thanks CMS for recognizing and proposing solutions to resolve the problems that could arise if Medicare contractors are left with only one compendium on which to make off-label use coverage determinations. Although AfPA recognizes that Medicare law refers to the compendia specifically for coverage of Part B cancer chemotherapy drugs, we likewise recognize that Medicare contractors generally refer to these same compendia when making off-label determinations for most Part B drugs.

While we generally applaud CMS for developing a process to permit listing of additional compendia, we are nonetheless concerned that the process CMS is proposing may be overly restrictive to allow timely adoption of new compendia. The process outlined by CMS likely would take applicants more than a year to clear, and may actually be too high a hurdle for some useful compendia. Patients need access to drugs that treat their conditions. If there are too few compendia covering the drugs most commonly used by patients, and those that are available are not updated quickly enough as new therapies are approved or as new uses of existing therapies are reported in the clinical literature, access could be impacted. We urge CMS to develop a process for adoption of new compendia that is flexible and that focuses on adoption of new compendia that are accurate and timely in their updates.

Additionally, we urge CMS to immediately recognize *DrugPoints*® as the successor publication to the USP-DI, so that Medicare contractors have at least two compendia available to support coverage decisions while CMS reviews requests to adopt additional compendia.

**CAP ISSUES**

As physicians who frequently administer complex biologicals, we are concerned that CMS may be considering loosening CAP regulations in a manner that might permit CAP vendors to repackage complex biologicals that require special handling. Many complex biologicals require special handling, such as constant refrigeration at specified temperatures, utilization within a specified period after reconstituting and special refrigeration after reconstituting. Unless CAP vendors are specifically trained in these handling techniques, and abide by them, the safety and efficacy of the product furnished could compromised. Even if CAP vendors are specially trained, we as physicians could not vouch for the safety and efficacy of a product that has been opened and manipulated after leaving the manufacturer.

AfPA encourages CMS to consider carefully any changes that would allow CAP vendors to offer compounded *drugs*. AfPA strongly discourages CMS from allowing CAP vendors to compound or open in any manner complex biologicals. AfPA specifically recommends that CMS continue to require that CAP vendors ship complex biologicals only in "unopened vials or other original containers as supplied by the manufacture."

Thank you for your consideration of our comments.

Sincerely yours,

David Charles, MD
Chairman

**Submitter :** **Mr. Kevin Coit** **Date: 08/27/2007**

**Organization :** **Mr. Kevin Coit**

**Category :** **Device Industry**

**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. Hannah Coit** **Date: 08/27/2007**

**Organization :** **Mrs. Hannah Coit**

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

Thank you for your consideration of this serious matter.

**Submitter :** **Mr. David Freeman** **Date: 08/27/2007**

**Organization :** **Texas Association of Nurse Anesthetists**

**Category :** **Other Practitioner**

**Issue Areas/Comments**

**Background**

Background

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

Name & Credential

Address

City, State ZIP

CMS-1385-P-8202

**Submitter :** Dr. David Charles **Date:** 08/27/2007

**Organization :** Alliance for Patient Access

**Category :** Physician

**Issue Areas/Comments**

**CAP Issues**

CAP Issues

See attachment.

CMS-1385-P-8202-Attach-1.RTF

#8202

THE ALLIANCE FOR PATIENT ACCESS

August 27, 2007

**Via Electronic Submission to: http://www.cms.hhs.gov/eRulemaking**
Kerry Weems
Administrator, Centers for Medicare and Medicaid Services-Designate
U.S. Department of Health and Human Services
Attn: CMS-1385-P
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Mr. Weems:

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## DRUG COMPENDIA

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Additionally, we urge CMS to immediately recognize *DrugPoints*® as the successor publication to the USP-DI, so that Medicare contractors have at least two compendia available to support coverage decisions while CMS reviews requests to adopt additional compendia.

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Thank you for your consideration of our comments.

Sincerely yours,

David Charles, MD
Chairman

CMS-1385-P-8203

**Submitter :** Mr. Paul Dierks **Date:** 08/27/2007

**Organization :** Mr. Paul Dierks

**Category :** Individual

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

I am writing in support of the propsed changes to CMS-1385-P, particularly in regards to 411.357(a)(5) and (b)(4), Exceptions to the referral prohibition to compensation arrangements. The proposed regulations are a good start, however they do not go quite far enough. The intent of the changes is sound, however while it is nice to state that rental charges 'are not to be determined in a manner that takes into account the volume or value of referrals or other business generated between the two parties,' in practice, this is still too vague. If a physician owns a share of a company that supplies equipment to a facility, even if the arrangement is based on market value and set in advance, the physician owner benefits by his/her referrals, since any contract entered into between the physician's entity and the facility will be based upon expected referrals.

With that in mind, while it would be nice to carve out a niche for physicians to participate in the market using arms length transactions in order to protect against referral abuse, particularly in areas that are underserved geographically, in practice, as long as physicians own ANY piece of an 'entity' (other than publically traded equities) that provides products or services to a facility, he/she benefits financially through that ownership through referrals.

While I support CMS's attempt to clearly define an 'Entity' in regards to these propsed changes, 411.351 Definitions, perhaps a better way to define the term, would be in fact, to define 'Entity' as ANY business arrangement, and instead define the one exception, that being a shareholder of a large publically traded corporation. That way, the impact of any physician shareholder referral is for all intents and purposes, insignificant.

Thank you.

**Submitter :** **Mr. Robert Rainey** **Date: 08/27/2007**

**Organization :** **Mr. Robert Rainey**

**Category :** **Attorney/Law Firm**

**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.

**CMS-1385-P-8205**

**Submitter :** **Mrs. Carolyn Rainey** **Date: 08/27/2007**

**Organization :** **Mrs. Carolyn Rainey**

**Category :** **Attorney/Law Firm**

**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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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-8206

**Submitter :** **Dr. Rodrick Phillips** **Date: 08/27/2007**

**Organization :** **Dr. Rodrick Phillips**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** **Mrs. Karen DiGregorio** **Date: 08/27/2007**

**Organization :** **Mrs. Karen DiGregorio**

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

**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.

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,

Karen DiGregorio

**Submitter :** **Dr. Byron Tsusaki** **Date: 08/27/2007**

**Organization :** **Baylor college of Medicine**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Byron Tsusaki D.O.
Houston, Texas

**Submitter :** **Dr. Rick DiGregorio** **Date: 08/27/2007**

**Organization :** **Dr. Rick DiGregorio**

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

**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.

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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,
Dr Rick DiGregorio

CMS-1385-P-8210

**Submitter :** **Dr. Ramon Alberto Vargas** **Date: 08/27/2007**

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

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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.

R. Alberto Vargas, M. D.
Board Certified Anesthesiologist
3483 Dovecote Meadow Lane
Davie, FL 33328-7312
nica53@aol.com

**Submitter :** Dr. Eric Hartman **Date:** 08/27/2007

**Organization :** Michigan Association of Chiropractors

**Category :** Chiropractor

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

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

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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,

Dr. Eric R Hartman
Sports/Family Chiropractor & Therapeutic Massage
7610 Cottonwood Dr. Ste 101
Jenison, MI 49428

**CMS-1385-P-8212**

**Submitter :** **Veronica Krussell** **Date: 08/27/2007**

**Organization :** **Anesthesia Medical Consultants**

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

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

See Attachment

#8212



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.

**CMS-1385-P-8213**

**Submitter :** **Dr. David MacLennan** **Date: 08/27/2007**

**Organization :** **Dr. David MacLennan**

**Category :** **Health Care Provider/Association**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am opposed to the non reimbursement by a non treating physician for radiographs performed on patients whose insurance is medicare. This is in reference to CMS- 1385-P. I am opposed in that as a Chiropractor, it is important for Patients usually of medicare age to have an x-ray performed not just for evaluating a subluxation because that is what the PART portion of the examination is for. But, there are many organic and other causes of problems particularly for a patient of medicare age that would warrant an x-ray to be taken with regards to contraindications, such as Cancer, fractures and severity or arthritis. Please understand that if this is passed that medical costs would surely go even higher because radiographs would be ordered by an Orthopedist, Rheumotologist and then increased medication costs etc. I also feel that this would limit an avenue for a patient who is on medicare to recieve Chiropractic care and would force them to recieve other care in the form of injections which would also increase the cost to a medicare participant as well as to the system itself.

Sincerely,

D.A. MacLennan, D.C.

CMS-1385-P-8214

**Submitter :** Mr. Trevor Connell **Date:** 08/27/2007

**Organization :** AANA

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**Background**

Background

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the CMS proposal to boost the value of anesthesia work by 32%. If adopted, CMS' proposal would ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

America's 36,000 CRNAs provide some 27 million anesthetetics annually, in every setting requiring anesthesia services , and are the predominant providers in rural and medically underserved America.
Medicare patients and healtheare delivery in the U.S. depend on our sevices. The availability of anesthesia services depend in part on fair Medicare payment for them. I support the Agency's acknowlegement 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,

Trevor Connell, CRNA

4833 Saratoga Blvd.
Corpus Christi, TX 78413

CMS-1385-P-8215

**Submitter :** **Date: 08/27/2007**

**Organization :**

**Category :** **Chiropractor**

**Issue Areas/Comments**

**GENERAL**

GENERAL

The biggest loser here is the patients. DC's don't get paid for x-rays. MD's upon a referral won't get paid and the patient probably won't receive proper care.

**Submitter :** **Dr. William Martin** **Date: 08/27/2007**

**Organization :** **MCC**

**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,
William O. Martin, DC

CMS-1385-P-8216-Attach-1.DOC

#8216

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 MD or DO and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

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Sincerely,

CMS-1385-P-8217

**Submitter :** Mrs. VALERIE RUSSELL **Date:** 08/27/2007

**Organization :** WOMEN'S HEALTH CARE P.C.

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:

a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;

b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:

? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;

? the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.

c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and

d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,

As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:

a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;

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d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,

**Submitter :** **Dr. Gerald Roth** **Date: 08/27/2007**

**Organization :** **Dr. Gerald Roth**

**Category :** **Chiropractor**

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

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,
Gerald Roth, DC,CST,CCN

**Submitter :** **Dr. Edward Fritsch** **Date: 08/27/2007**

**Organization :** **Diagnostic Radiology of Houston**

**Category :** **Physician**

**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 MD or DO and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

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**Submitter :** **Date: 08/27/2007**

**Organization :** **Oregon Imaging Centers**

**Category :** **Other Technician**

**Issue Areas/Comments**

**Coding--Reduction In TC For Imaging Services**

Coding--Reduction In TC For Imaging Services

The Physician Work RVU-CPT 77080 (DXA)
The Direct Practice Expense RVU for 77080 (DXA)
Indirect Practice Expense for DXA and VFA
Deficit Reduction Act
Dear Mr. Weems:
I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.
As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:
a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;
b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:
? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;
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**Submitter :** **Dr. Eric DeLamielleure** **Date: 08/27/2007**

**Organization :** **Michigan Association of Chirotprators**

**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, Maryland 21244-8018

Re: TECHNICAL CORRECTIONS

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Sincerely,

Eric DeLamielleure

**Submitter :** **Denise D'Harlingue** **Date: 08/27/2007**

**Organization :** **Denise D'Harlingue**

**Category :** **Chiropractor**

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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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. Denise D Harlingue

CMS-1385-P-8223

**Submitter :** **Mrs. Susie Phillips** **Date: 08/27/2007**

**Organization :** **Mrs. Susie Phillips**

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

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to inerease 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 :** **Mr. Michael Fleming** **Date: 08/27/2007**

**Organization :** **Mr. Michael Fleming**

**Category :** **Individual**

**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 MD or DO and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

While 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.

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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,

Michael D. Fleming

CMS-1385-P-8225

**Submitter :** Mr. Joshua Phillips **Date:** 08/27/2007

**Organization :** Mr. Joshua Phillips

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia serviees, 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.

**CMS-1385-P-8226**

**Submitter :** **Tammy Vaca** **Date: 08/27/2007**

**Organization :** **Tammy Vaca**

**Category :** **Individual**

**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

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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,

Tammy Vaca

CMS-1385-P-8227

**Submitter :** Mr. Keith Brown **Date:** 08/27/2007

**Organization :** Core Physical Therapy

**Category :** Physical Therapist

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

CMS-1385-P-8227-Attach-1.DOC

# 8227

8/24/07

I am writing to ask CMS to please remove physical therapy from the allowed list of in-office ancillary services in physician offices. As a PT, I have worked in settings from hospital to home health care to private practice and even in a physician owned PT (POPTS) clinic. Without question, the only one of those settings where I ever felt uncomfortable practicing was the POPTS clinic. I saw concrete examples of patients being pushed by the physician into using his own therapists, even if the patient requested to go somewhere else. I've seen quotas that required therapists in a POPTS setting to see a certain number of patients per day or charge each patient a certain number of units per visit.

Patients are not always the savviest health care consumers, especially the elderly ones. They have a built-in trust in whatever their physicians tell them is in their best interests. If the physician tells a patient they need to drive an extra 30 minutes to come in to the POPTS clinic, even though they have a qualified PT three blocks from home, they believe their doctor. If the physician tells them that an outside PT is "not as qualified" to treat that patient as his POPTS therapists are, the patient believes the doctor.

Do these doctors tell their patients that they have a choice in where they get their therapy just like they have a choice in what pharmacy they use? Do these doctors tell their patients that two miles away there is a private PT practice with a board certified geriatric PT specialist who could give them the best treatment possible? Do these doctors tell their patients that every PT visit the doctor orders puts money right back into that same doctors pockets?

When a physician has such an easily accessible profit motive as a POPTS clinic, it takes away the doctor's incentive to do what is best for the patient in favor of padding his own bottom line. I saw one example just last week. A patient who is personal friends with another local physical therapist relayed this story to me. They went to see a local orthopedic surgeon. He recommended PT to the patient. The patient said he wanted to go see his friend for PT. The doctor told the patient, "No, you don't want to do that, that therapist is not qualified to do spine rehab like my PT staff is". If the allegation were not so damaging and patently false, it would be laughable. The therapist in question is known throughout the area as an outstanding clinician with advanced training in spine rehab.

Keeping PT on the list of in-house ancillary services hurts Medicare, it hurts private practice therapists and it hurts the entire health care system. Most importantly, it hurts the patient's right to choose and their right to get the best physical therapy possible. I strongly urge you to remove physical therapy from the list. That is the only way to make sure that every decision is made in the patient's best interest, not financial self-interest.

Sincerely,

Keith Brown, PT
Core Physical Therapy
301 Margie Drive
Warner Robins, GA 31088
478 953-5800 phone
478 953-5855 fax

**CMS-1385-P-8228**

**Submitter :** **Louis Vaca** **Date: 08/27/2007**

**Organization :** **Louis Vaca**

**Category :** **Individual**

**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 MD or DO and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

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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,

Louis Vaca

**CMS-1385-P-8229**

**Submitter :** **Dr. Michael Brown** **Date: 08/27/2007**

**Organization :** **Thoracic Cardiovascular Institute**

**Category :** **Physician**

**Issue Areas/Comments**

**Coding-- Additional Codes From 5-Year Review**

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

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

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

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

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

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

Sincerely yours,

T. Michael Brown, DO
Thoracic Cardiovascular Institute

CMS-1385-P-8230

**Submitter :** **Mr. Jordan Phillips** **Date: 08/27/2007**

**Organization :** **Mr. Jordan Phillips**

**Category :** **Individual**

**Issue Areas/Comments**

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-8231

**Submitter :** **Date: 08/27/2007**

**Organization :**

**Category :** **Physician**

**Issue Areas/Comments**

**CAP Issues**

CAP Issues

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Hollywood and Pembroke Pines, Florida as part of a 21 physician group.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of several arrangements in my practice area that give physician groups (particularly gastroenterology, urology and dermatology) 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. I believe the present situation leads to increased health care cost due to over utilization of tests.

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,

J. Victor Chancy, MD

CMS-1385-P-8232

**Submitter :** **Mr. Andrew Phillips** **Date: 08/27/2007**

**Organization :** **Mr. Andrew Phillips**

**Category :** **Individual**

**Issue Areas/Comments**

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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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. Kenneth Leung** **Date: 08/27/2007**

**Organization :** **Dr. Kenneth Leung**

**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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Thank you for your consideration of this serious matter.

Sincerely,

Kenneth Leung, M.D.

CMS-1385-P-8234

**Submitter :** **Mr. Jackson Phillips** **Date: 08/27/2007**

**Organization :** **Mr. Jackson Phillips**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

**Submitter :** **Patty Moore** **Date: 08/27/2007**

**Organization :** **Patty Moore**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

The Physician Work RVU-CPT 77080 (DXA)
The Direct Practice Expense RVU for 77080 (DXA)
Indirect Practice Expense for DXA and VFA
Deficit Reduction Act
Dear Mr. Weems:
I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.
As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:
a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;
b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:
? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;
? the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.
c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and
d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.
As I get closer to the medicare age, I pay more attention to what medicare is doing. I'm worried about the coverage of needed health care.
Thank you

CMS-1385-P-8236

**Submitter :** Dr. Jody Tenjeras **Date:** 08/27/2007

**Organization :** Lakes Area Family Chiropractic

**Category :** Chiropractor

**Issue Areas/Comments**

**GENERAL**

GENERAL

It has always been the standard of care to be able to take a radiograph of the area of chief complaint (minimum) and/or other areas as deemed necessary by examination. It makes no sense to prohibit insurance payment for this diagnostic tool. As a primary care physician, it would seem an unfair practice as well.

**Submitter :** RANDY KIRSHMAN **Date:** 08/27/2007

**Organization :** ANTHESIA MEDICAL CONSULTS

**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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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.

RANDY KIRSHMAN

CMS-1385-P-8238

**Submitter :** Mr. Gregory Pilcher **Date:** 08/27/2007

**Organization :** Mr. Gregory Pilcher

**Category :** Attorney/Law Firm

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

CMS-1385-P-8239

**Submitter :** **Dr. Robert Yood** **Date: 08/27/2007**

**Organization :** **Fallon Clinic**

**Category :** **Physician**

**Issue Areas/Comments**

**Coding--Reduction In TC For Imaging Services**

Coding--Reduction In TC For Imaging Services

Kerry Weems, Acting Administrator

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

Mail Stop C4-26-05

7500 Security Boulevard

Baltimore, Maryland 21244-1850

RE: CMS-1385-P Proposed Revisions to payment policies under the physician fee schedule and other Part B payment policies for CY 2008

Comments:

The Physician Work RVU-CPT 77080 (DXA)

The Direct Practice Expense RVU for 77080 (DXA)

Indirect Practice Expense for DXA and VFA

Deficit Reduction Act

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b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:

? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000 (note the I recently considered purchase of bone densitometry scanner from Hologic and was quoted $80,000);

? the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.

c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and

d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,

Robert Yood MD, FACP, FACR
Fallon Clinic
425 N. Lake Avenue
Worcester, MA 01605

**Submitter :** **Mrs. Tammy Skinner** **Date: 08/27/2007**

**Organization :** **Mrs. Tammy Skinner**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** **Dr. Bruno Dipasquale** **Date: 08/27/2007**

**Organization :** **Collier Pathology Services, PA**

**Category :** **Physician**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

August 27, 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 Naples, FL, and my group of three pathologists provides pathology at two Hospitals, Physicians Regional Medical Center, Pine Ridge and Collier Boulevard campuses, as Collier Pathology Services.

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,

Bruno Dipasquale, MD, Ph.D.

**Submitter :** **Mr. Ronald Mcafee** **Date: 08/27/2007**

**Organization :** **Mr. Ronald Mcafee**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Ms. Norwalk:

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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-8243

**Submitter :** Mr. Robert Perry **Date:** 08/27/2007

**Organization :** Mr. Robert Perry

**Category :** Other Practitioner

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am a CRNA in Arkansas and we are one of the lowest medicare rates in the country yet we have a high population of medicare patients. To be competetive we have to have a rate increase. Please help us take care of the medicare patients in our state

**Submitter :** **Mrs. Marilyn Mcafee** **Date: 08/27/2007**

**Organization :** **Mrs. Marilyn Mcafee**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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Thank you for your consideration of this serious matter.

CMS-1385-P-8245

**Submitter :** **Donald Mathews** **Date: 08/27/2007**

**Organization :** **Donald Mathews**

**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.

I have greatly enjoyed caring for patients in my 18 years as Anesthesiologist and would like to be fairly compensated for my skills and abilities.

Thank you for your consideration of this serious matter.

Respectfully,
Donald M Mathews, MD

CMS-1385-P-8246

**Submitter :** **Dr. Lisa Doan** **Date: 08/27/2007**

**Organization :** **Dr. Lisa Doan**

**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.

Lisa Doan

CMS-1385-P-8247

**Submitter :** **Dr. John Randolph** **Date: 08/27/2007**

**Organization :** **Dr. John Randolph**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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Thank you for your consideration of this serious matter.

CMS-1385-P-8248

**Submitter :** Mr. John Miles **Date:** 08/27/2007

**Organization :** Mr. John Miles

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

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Thank you for your consideration of this serious matter.

CMS-1385-P-8249

**Submitter :** Mr. Dennis Baltz **Date:** 08/27/2007

**Organization :** Mr. Dennis Baltz

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please help us overcome the 8.7% decrease in pay you started in 2007 by increasing the anesthesia medicare reimbursement rate for CRNA's in Arkansas. We have a lot of retired patients in our state and since we are already one of the lowest medicare reimbursement rates in the US we need this to pass. Thank you

CMS-1385-P-8250

**Submitter :** Mrs. Betty Miles **Date:** 08/27/2007

**Organization :** Mrs. Betty Miles

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

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Thank you for your consideration of this serious matter.

CMS-1385-P-8251

**Submitter :** Dr. Shawn Calvin **Date:** 08/27/2007

**Organization :** UT medical school dept of anesthesiology

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

CMS-1385-P-8252

**Submitter :** Dr. Monireh Moghaddam **Date:** 08/27/2007

**Organization :** Friendswood Family Chiropractic Clinic

**Category :** Chiropractor

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please see attachment

CMS-1385-P-8252-Attach-1.WPD

#8252

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 MD or DO and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

While 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 an X-ray the cost to the Medicare patient will go up significantly due to the necessity of a referral to an orthopedist or rheumatologist for evaluation prior to referral to the radiologist as it is now. With fixed incomes and limited resources, Medicare patients 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,

CMS-1385-P-8253

**Submitter :** Mrs. Margie Irvin **Date:** 08/27/2007

**Organization :** Bay Area Renal Stone Center

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Please see attached letter.

# 8253



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.