CMS-1385-P-8254

Submitter : **Mr. John T Hitchens** **Date: 08/27/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

? 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,

John T. Hitchens, CRNA
1715 Farmshire Court
Jarrettsville MD 21084

CMS-1385-P-8255

Submitter : Dr Gary Parsons **Date:** 08/27/2007

Organization : Dr Gary Parsons

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr Gary Parsons

CMS-1385-P-8256

Submitter : Dr. Hang Nguyen **Date:** 08/27/2007

Organization : The Center for Spine Pain

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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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,

Hang Nguyen

CMS-1385-P-8257

Submitter : Dr. Neil Clark **Date:** 08/27/2007

Organization : The Heart Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"CODING - ADDITIONAL CODES FROM 5-YEAR REVIEW

CMS-1385-P-8257-Attach-1.DOC

#8257

THE HEART GROUP

LANCASTER MEDICAL CENTER, SUITE 200
217 HARRISBURG AVENUE
LANCASTER, PA 17603-2962
(717).397-5484
FAX (717) 397-8407
www.theheartgroup.com

ROLF L. ANDERSEN, M.D., F.A.C.C.
PAUL N. CASALE, M.D., F.A.C.C., F.S.C.A.I.
GURPINDER K. CHATHA, M.D.
NEIL R. CLARK, M.D., F.A.C.C.
SCOTT J. DERON, D.O., F.A.C.C., F.S.C.A.I.
RUPAL P. DUMASIA, M.D., F.S.C.A.I.
MARK D. ETTER, M.D., F.A.C.C.
DOUGLAS C. GOHN, M.D., F.A.C.C.
JEFFREY M. HARDIN, M.D., F.A.C.C.

TINA DAVIS, C.R.N.P.
SHERRI DELGADO, C.R.N.P.
DEANNA DUKES-GRAVES, C.R.N.P.
JON ECHTERLING, C.R.N.P.
ANITA HOLZ, C.R.N.P.
JOETTE HUGHES, C.R.N.P.
CONNIE KISER, C.R.N.P.

JOSELUIS IBARRA, M.D., F.A.C.C.
DAVID M. LOSS, D.O., F.A.C.C.
AJAY R. MARWAHA, M.D.
MELISSA L. McKERNAN, M.D.
R. WARD PULLIAM, M.D.
JOHN P. SLOVAK, M.D., F.A.C.C.
ROY S. SMALL, M.D., F.A.C.C., F.S.C.A.I.
EDWARD W. SUPPLE, M.D., F.A.C.C., F.S.C.A.I.
SETH J. WORLEY, M.D., F.H.R.S., F.A.C.C.

LISA RATHMAN, C.R.N.P.
JILL REPOLEY, C.R.N.P.
KIMBERLY SHEA, C.R.N.P.
KELLY TRYNOSKY, C.R.N.P.
JENNIFER WARDLE, C.R.N.P.
ALEXANDRA WYANT, C.R.N.P.
BRENDA YOUNG, C.R.N.P.

To whom it may concern:

This letter is intended to address the proposed changes in reimbursement for Doppler and color flow imaging and how this change may affect our private practice and the hospital, in which we serve. I am a cardiologist in my 15th year of private practice in Lancaster, Pennsylvania. I am the director of the imaging center of our 18 physician private practice and the director of noninvasive cardiology at Lancaster General Hospital. In total, we perform over fifteen thousand echocardiograms annually. Both labs have been accredited in echocardiography. In this context, let me address the proposed changes and what it may mean to our practice and the care of our patients.

If color flow Doppler imaging is "bundled" with the other portions of the echo exam, it will, of course, decrease overall payment for echocardiograms. This particular component of the echo exam requires special skills and special time and should not be bundled as part of the basic 2-D exam. To make my point, consider the following:

1) To assume that a rather limited two dimensional echo to rule out pericardial fluid and assess left ventricular function is the same skill level, time and expertise as evaluating mitral regurgitation using newer techniques of quantification is naive, to say the least. Multi-valvular heart disease is common in our practice and requires considerable time to perform in the quality we expect. Your bundling color flow Doppler amounts to telling us that a complete and appropriate echo is not worth any more than a cursory echo.

2) We have employed state of the art care in our practice including Doppler evaluation of diastolic performance of the left ventricle, quantification of mitral regurgitation using PISA techniques and tissue Doppler to assess wall strain and synchrony of left ventricular function. These techniques not only improve patient care for timing for valve replacement, medication adjustments and treatment of congestive heart failure symptoms, but require considerable time and effort, which is not reimbursed currently over and above standard approaches to Doppler imaging. So, in essence, our diligence to provide superior care and to go beyond the standard techniques at our own cost of technologist's time and effort should be further rewarded with no reimbursement at all?

3) Color flow Doppler requires training and understanding of cardiac physiology and to not consider it separately is poor precedence for future technology. Can we expect that for new technology, for which we seek out additional training and expertise, we can expect it to be "assumed" into the old technology? This is not a venue for encouraging the progression of what we do. You are encouraging mediocre medicine. You are encouraging substandard care.

The current reimbursement of echocardiography has seen significant erosion over the past ten years. Let us not disguise a reduction of payment in any other form than which it is. By bundling Doppler with echocardiology, you are further undermining the quality of care for my patients and the future patients of this community. As overhead escalates and we try to treat not only our patients with respect and good care, you are making it impossible to provide adequate salaries and benefits to our staffs. In an environment in which a well trained echocardiography technologist becomes rare to find, how can we continue to give top notch care?

I'm working as hard as I can to provide outstanding care for our senior population, and in the future I hope to have access to similar excellent well-trained providers who can help me, my family and my community in times of health care need. However without adequate compensation, we Americans will lose future sub-specialists to non-medical fields, who will not be able to help our aging population as our health needs continue to grow. Our attempt to slow the cost of health care services might be better directed at requiring certification and quality for reimbursement instead of bundling this procedure. It is difficult to make this request without appearing self-serving, but I believe this particular initiative will be a true barrier to providing the care our seniors deserve. In Lancaster the Amish bundle, Medicare should not.

Neil R. Clark MD FACC
The Heart Group
Director, LGH Noninvasive Cardiology

CMS-1385-P-8258

Submitter : **Dr. Ann Babbitt** **Date: 08/27/2007**

Organization : **Greater Portland Bone and Joint Specialists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Organization : **Redding Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
REGARDING: PHYSICIAN SELF REFERRAL ISSUES

Dear Mr. Weems, I am writing to express my support for eliminating physical therapy as a DHS furnished under the in-office ancillary services exception. I am a physical therapist in Redding, CA and have been practicing for 8 years. Recently, a large orthopedic group opened their own physical therapy clinic which has negatively impacted many of the therapist owned facilities in our small town. This impacts us both economically and in terms of patient care. I have had several pt's of mine who went to these physicians, and were then referred to their physical therapy facility even when they had asked to be sent back our facility. There certainly appears to be an inherent conflict of interest when physicians are referring to a clinic in which they have a vested financial interest.

CMS would reduce a significant amount of problematic abuse, overutilization of therapy services, and enhance the quality of patient care by eliminating physical therapy as a designated health service furnished under the in-office ancillary services exception.

Thank you for your consideration of my comments.

Sincerely,

Mike Engbretson, MPT

CMS-1385-P-8260

Submitter : Dr. kyle ormsbee **Date:** 08/27/2007

Organization : ormsbee chiropractic

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

scc attachment

#8260

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 : **Mrs. Catherine Morris R.N.** **Date: 08/27/2007**

Organization : **Diomed, Inc**

Category : **Device Industry**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Resource based PE RVUs

We commend CMS for its work to establish a bottom up approach to physician payment and its clarity identifying the elements of practice expense.

I am concerned with the element of equipment expense. New technologies, including those that are office based, frequently require the purchase of capital equipment. This cost of capital, to be absorbed into the cost of doing business, must be compensated in a manner that is affordable to the provider (in all practice settings) and reasonable to the payor.

I have reviewed the PE RVUs for 2008, especially in regard to CPT code 36478. Based on the CMS utilization formula for equipment cost per minute, I am finding a discrepancy in the equipment expense.

The Federal Register, Volume 72, July 12, 2007 identifies equipment expense for all physicians at 4.08. Based on the CMS equation:

(1/(minutes/yr * usage)) * price * ((interest rate/(1-(1/(1 + interest rate) * life of equipment)))) + Maintenance)

The allowed equipment expense is 4.08. When calculated using the ASP for the equipment used, the calculation is 4.75. Compare this to CPT code 36475, a similar, but less expensive technology that has a calculated equipment cost of 3.28.

CPT 36475 has a RE RVU of 43.52 for 2008, while CPT 36478 has a PE RVU of 36.69 for 2008. We are requesting that you reconsider the RVU for 36478 and provide RVUs that more reasonably equate to the actual equipment cost.

This discrepancy is carried over into the APC payment as well. CPT 36475 with an equipment cost of 3.28 is in APC 0091, with an unadjusted payment of $2,780.89 while 36478, with an equipment value of 4.75 is in APC 0092, with an unadjusted payment of $1,684.02. Could these codes have been inadvertently reversed? We are requesting that you move CPT code 36478 from APC 0092 to APC 0091.

CPT code 36478 has been moved form ASC group 9 to ASC group 8. We are requesting that CPT code 36478 be placed back into group 9.

Minutes/yr = 150,000 Usage = 0.5 Life of equipment = 3yrs
Interest rate = 11% Maintenance = 0.05
Cost of equipment: 478 = $32,000 36476 = $22,000

Submitter : **Dr. Susan Cole** **Date: 08/27/2007**

Organization : **Dr. Susan Cole**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

Re: TECHNICAL CORRECTIONS

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

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,

Submitter : **Dr. Traci Nelson Hassel** **Date: 08/27/2007**

Organization : **Nelson Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

I am writing to strongly oppose the proposal regarding 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.

X-rays are conservative, diagnostic toos used to rule out any pathology or fracture or to 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. Patients would have to go through a lot of red tape and numerous appointments for the same information from the film that we can provide. It often takes weeks to get an appointment with specialists like these. Our office can see patients in the same day or minimum 48 hours. 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,

Traci Nelson Hassel, D.C., D.I.C.C.P.

Submitter : **Mrs. Joyce Schomberg** **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.

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-8265

Submitter : Mr. Wes Tomlinson **Date:** 08/27/2007

Organization : Mr. Wes Tomlinson

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems,

I hope that you will consider not supporting Physician self-referral, specifically "in office ancillary services." Studies have shown that there is a tendency for over utilization of PT when the physician has a financial interest involved. Please help stop this self-referral pattern which is just driving up healthcare costs.

Respectfully,

Wes Tomlinson, PT

CMS-1385-P-8266

Submitter : Dr. Michelle Dougherty **Date:** 08/27/2007

Organization : Dougherty Family Chiropractic

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1385-P-8266-Attach-1.DOC

8266

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. Michelle S. Dougherty
Dougherty Family Chiropractic, PC
23915 W Main Street, Suite D
Plainfield, IL 60544

Submitter : **Dr. Web Smith** **Date: 08/27/2007**

Organization : **Gulfcoast Pathologists / Community Hospital**

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 New Port Richey, FL, 34652 as part of a 3 person pathology Group that provides pathology services to Community Hospital and North Bay Hospital, and also has an active outpatient practice.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

Weber Lee Smith, MD

CMS-1385-P-8268

Submitter :

Date: 08/27/2007

Organization :

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

This is a conflict of interest. Physicians are referring to themselves and profiting from it. This is outrageous and has been banned in other states. I'm disappointed that Iowa hasn't followed suit. The patient's best interest should be the focus not padding the pockets of the physicians.

CMS-1385-P-8269

Submitter : Dr. ANDREW MANCINI II **Date:** 08/27/2007

Organization : Dr. ANDREW MANCINI II

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

PLEASE ALLOW THE REIMBURSEMENT FOR X-RAYS THAT ARE USED BY CHIROPRACTORS. X-RAYS ARE AN INTEGRAL PART OF CHIROPRACTIC ANALYSIS AND BENEFICIAL FOR PROPER ADJUSTMENT FOR YOUR INSURED.

Submitter : **Dr. Clint Dickason** **Date: 08/27/2007**

Organization : **Dickason Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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Sincerely,

Dr. Clint Dickason, D.C.

Submitter : Dr. JERSEY WULSTER **Date:** 08/27/2007

Organization : MORRIS COUNTY COMMUNITY CHIROPRACTIC CENTER

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

CMS 1385 P: IT IS ABSOLUTELY RIDICULOUS AND UNETHICAL FOR A DOCTOR OF CHIROPRACTIC NOT BE ALLOWED TO REFER PATIENTS FOR A XRAY IF CLINICALLY WARRANTED. MEDICARE/CMS ARE PUTTING OUR SENIORS AT GREAT RISK AND COSTING THEM MORE MONEY OUT OF THEIR POCKET.

IT IS BAD ENOUGH THAT WE CANNOT EVEN TAKE THE XRAYS OURSELF, EVEN THOUGH CHIROPRACTORS ARE TRAINED AND HAVE A DEGREE WITH THE REQUIRED QUALIFICATIONS TO INTERPRET XRAYS.

TO PASS THIS CHANGE WOULD BE DETRIMENTAL TO OUR PATIENTS. WERE IS THE CARE IN THIS WORLD GOING?

Impact

Impact

CMS 1385 P: IT IS ABSOLUTELY RIDICULOUS AND UNETHICAL FOR A DOCTOR OF CHIROPRACTIC NOT BE ALLOWED TO REFER PATIENTS FOR A XRAY IF CLINICALLY WARRANTED. MEDICARE/CMS ARE PUTTING OUR SENIORS AT GREAT RISK AND COSTING THEM MORE MONEY OUT OF THEIR POCKET. IT IS BAD ENOUGH THAT WE CANNOT EVEN TAKE THE XRAYS OURSELF, EVEN THOUGH CHIROPRACTORS ARE TRAINED AND HAVE A DEGREE WITH THE REQUIRED QUALIFICATIONS TO INTERPRET XRAYS. TO PASS THIS CHANGE WOULD BE DETRIMENTAL TO OUR PATIENTS. WERE IS THE CARE IN THIS WORLD GOING?

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems
Administrator-Designate
Cntrs. for Medicare and Medicaid Svcs.
U.S. Dept. of Health & Human Services
Attention: CMS-1385-P
RE: Phsyician Self-referral Issues

CMS-1385-P-8272-Attach-1.DOC

#8272

Mr. Kerry N. Weems
Administrator-Designate
Cntrs. for Medicare and Medicaid Svcs.
U.S. Dept. of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
RE: Physician Self-referral issues

FREEDOM
PHYSICAL THERAPY
SERVICES, S.C.

Dear Mr. Weems:

I am a newly graduated physical therapist who has working in private practice in Milwaukee, Wisconsin. I would like to comment on the July 12th proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception.

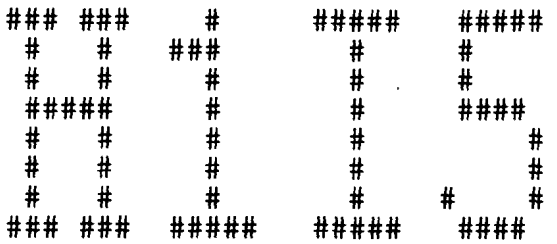
The company for which I work takes pride in seeking out and hiring very well-educated, experienced therapists who provide exceptional care. With declining reimbursement and limited visits with both Medicare and other insurers it has become increasingly difficult financially, for us to provide the high level of patient care our patients are used to. To compound the problem, we have physician groups reaping the financial rewards of referring patients to therapy practices they own instead of therapy practices that may provide superior and more cost-effective care. This is possible due to the "in-office ancillary services exception" to the Stark Law, as physical therapy is currently considered a "designated health service (DHS)". In some cases, these patients are not even being seen by PT's, but instead by PTA's and ATC's under the physician's direction. This is illegal under Physical Therapy laws and needs to stop. Physical therapists are uniquely educated to evaluate and develop appropriate care plans for individuals afflicted with neuromusculoskeletal dysfunction.

Physical therapy services are generally provided on a repetitive basis. That said, it is no more convenient for the patient to receive PT services 2-3 times per week in the physician's office than to attend an independent physical therapy location. Furthermore, physician-direct supervision is not necessary to administer physical therapy services. In fact, an increasing number of physician-owned physical therapy clinics are using the reassignment of benefits laws to collect payment in order to circumvent "incident-to" requirements.

Thank you for your consideration of my comments. I hope these comments have helped to highlight the abusive-nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

Sincerely,

A Concerned Physical Therapist in zip code 53213



Job : 1369
Date: 9/6/2007
Time: 9:03:56 AM

August 27, 2007

My name is Michelle Padgett and I am a certified athletic trainer who works for a physical therapy clinic and provides outreach services to a local high school.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the physician self-referral provisions proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As a certified athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam insure that my patients receive quality healthcare. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The current standards of staffing in hospitals and other rehabilitation facilities flexibility are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day healthcare needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B rehabilitation facility.

Sincerely,

Michelle Padgett MS ATC

Michelle Padgett, MS ATC LAT

Submitter : Dr. Andrew Heib **Date:** 08/27/2007

Organization : Heib Chiropractic Clinic, P.C.

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

File Code CMS-1385-P, Technical Corrections

To whom it may concern;

Since I began practice I have experienced all matters of reimbursement limitation and discrimination at the hands of Medicare policies and regulations. First, we were forced to x-ray our patients on a yearly basis whether we felt it necessary or not despite the fact Medicare would not provide reimbursement for radiological services. Then, after that requirement was lifted we are forced to maintain Medicare Waiver and ABN forms in addition to tedious micromanaging documentation that increases the cost of doing business and does nothing to enhance the quality of care for the patient, and I would argue it actually detracts from the quality of care. Now, in an effort to ease the financial burden on patients requiring x-rays we at times work with other "allowed" providers to obtain x-rays that may enhance and or protect patient care and provide the patient with a reimbursement benefit. I obviously don't care who gets paid for the service I just care that the patient receives the care and benefit for that care if it is clinically indicated and an allowed Medicare benefit. I see the only reason behind eliminating the access of Medicare patients to medical x-rays when used for chiropractic purposes as a blatant attempt to eliminate access to quality chiropractic care. Your institution is constantly implementing one roadblock after another to patients seeking chiropractic care and this last attempt will not be tolerated if implemented!! Recent rulings against insurance companies who will pay for medical services and not the same service performed by a chiropractor within the scope of practice should apply to Medicare benefits as well. If you will pay an M.D. or D.O. for an x-ray and exams you should pay the D.C. as well. I have remained silent and inactive for too long and this latest attempt is the last straw. Your organization will ignite a wave of activism within our profession and many "silents" like myself will be provoked to immeasurable grassroots activism against these blatant discriminatory practices! As a flag of the Revolutionary War proclamed "Don't tread on me!" This has now gone too far to be tolerated any longer and I hope you end this charade and put a stop to any further deterioration and corruption of your policies against the chiropractic profession and the patients who deserve and demand fair access to quality and cost effective healthcare.

Sincerely,

Andrew J. Heib, DC
Certified Chiropractic Sports Physician

CMS-1385-P-8274

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

Organization : Albert Einstein Medical Center

Category : Physician

Issue Areas/Comments

Impact

Impact

Physicians will stop stop taking on new seniors

CMS-1385-P-8275

Submitter : Dr. Debra White **Date:** 08/27/2007

Organization : Advanced Chiropractic Center

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

In reference to CMS 1385-P
A direct referral to a radiologist from the chiropractor saves Medicare significantly by cutting out the middle man (the M.D..
X-rays are necessary to rule out pathology that would be life threatening.

CMS-1385-P-8276

Submitter : Mrs. NANCY FREEMAN **Date:** 08/27/2007

Organization : AANA

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

1

CMS-1385-P-8277

Submitter : Dr. Jon-Eirik Holm-Johansen **Date:** 08/27/2007

Organization : Thompson Valley Chiropractic, P.C.

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

This proposal must be abolished for the sake of future medicare participants and their health.

Submitter : Ms. Michelle Padgett **Date:** 08/27/2007

Organization : PRORehab

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-8278-Attach-1.DOC

CMS-1385-P-8278-Attach-2.DOC

#8278

August 27, 2007

My name is Michelle Padgett and I am a certified athletic trainer who works for a physical therapy clinic and provides outreach services to a local high school.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the physician self-referral provisions proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As a certified athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam insure that my patients receive quality healthcare. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The current standards of staffing in hospitals and other rehabilitation facilities flexibility are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day healthcare needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B rehabilitation facility.

Sincerely,

Michelle Padgett MS ATC

Michelle Padgett, MS ATC LAT

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Referral for profit kills our business. As a free-standing Physical Therapy practice, we rely on Physicians to refer patients to us. While Washington is a direct-access state (patients can come to PT without a referral from a doctor), insurance companies may not cover a patient without a referral from a Physician. Since most patients can not afford to self-pay for medical services and rely on their insurance, we in turn rely on referrals from Physicians. Referral for profit also hurts the patient as it prevents them from having the right to choose where they go for therapy.

CMS-1385-P-8280

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

Organization : **Cardiovascular Services of America**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

August 27, 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 Cardiovascular Services of America, the Outpatient Cath Lab Company and our 20 partnered but independently 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.
Cardiovascular Services of America , based in Nashville, TN., is a founding member of the Cardiovaseular 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.

We request 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.

Cardiovascular Services of America was founded on the premise of providing cost-effective care in the most convenient environment for our patients. We have accomplished these goals by keeping costs lower than hospitals while giving our patients and physicians an easily accessible and friendly outpatient setting. If these cuts are implemented, our company, and perhaps this entire segment of the outpatient delivery system, will be driven out of business.

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

Sincerely,

Mark Donati
Chief Operating Officer
Cardiovascular Services of America
320 Seven Springs Way
Nashville, TN 37027

Submitter : **Mrs. Teddi Ann Roy** **Date: 08/27/2007**

Organization : **Mrs. Teddi Ann Roy**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-8282

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

Organization : Alliance Urology Specialists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am deeply concerned about the proposed changes in the Stark legislation. As a physician I want to provide my patients with the most up to date therapy in an efficient, cost effective environment.

Legislation that hobbles physician groups from providing services in the office makes that goal difficult to achieve.

I can not in good conscience make a large capital equipment purchase knowing that payment regulations can change in an arbitrary and capricious fashion. You really don't want hospitals to be the only organizations that can afford to make the investment in new technologies. Any thing done in a hospital setting will be less efficient and more expensive than a similar procedure or service offered in an outpatient or office setting.

I know that financial arrangements can lead to the abuse of services, but I think the advantage in effiency and cost effectiveness can out weigh the abuse potential particularly if a proper oversite protocol is in place. Physicians, despite what some people may think, tend to have higher ethical standard that many businessmen and are less likely to abuse a service.

If anything, the government should find a way to encourage as many services as possible in the office setting. There has to be some financial incentive to provide these services otherwise no one will take on the added burden. Please reconsider drastic changes in the Stark legislation. I think medicine will be better for it in the long run.

CMS-1385-P-8283

Submitter : Dr. Richard Keuhn **Date:** 08/27/2007

Organization : Lakewood Health Partners

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Your proposed rule of July 12th contained an item under the technical corrections section calling for the eliminatin fo the long-standing provision 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. It is bad enough that Medicare already discriminates agaisnt chiropractic doctors by failing to pay for legimate and necessary services such as examinations, x-rays and physical modalities especially when they pay for these EXACT SAME services when performed by most any other medical professional. Implementing this additional restriction would only further demonstrate prejudice and descrimination in Medicare policies. I am writing in strong opposition to this proposal because it severely limits the ability of Medicare beneficiaries to receive appropriate and necessary chiropractic services.

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 properly determine diagnosis, treatment options, anticipated outcomes and complicating factors such as spinal degeneration. X-rays may also be required to help determine the need for further diagnostic testing, incliuding MRI or for a referral to the appropriate medical specialist.

By limiting a Doctor of Chiropractic from performing and now possibly referring for an X-ray study, the costs for patient care will go up due to the unnecessary referrals to specialists (neurologist, 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. Therefore, I strongly urge you to oppose this proposal. X-rays, when needed, are integral to the overall treatment plan of Medicare patients and it is ultimately the patient that will suffer from such poor public policy!

Sincerely,

Richard Keuhn, D.C.

CMS-1385-P-8284

Submitter : Dr. Cynthia Hatton **Date:** 08/27/2007

Organization : Bear Mt. Chiropractic & Healing Arts

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Please reconsider climinating patient reimbursement for x-rays taken by a radiologist or non-treating physician. This could drive up the costs of patient care. Often it is eritical to use x-rays to rule out contraindications to chiropractic care or to determine appropriate treatment options. X-rays may also be required to help determine the need for further diagnostic testing or referral to an appropriate healt care specialist.
Thank you

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a Physical Therapist with 9 years of experience. I work in an outpatient orthopedic setting which shares a suite with a couple of orthopedic surgeons. I am commenting on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. I support PT services removal from permitted services under the in-office ancillary exception. We need to establish ourselves as autonomous clinicians and avoid the possibiltiy of fraudulent use of our services by other healthcare providers.

Submitter : **Dr. Thomas Montgomery** **Date: 08/27/2007**

Organization : **Integrative Medical Centers Of Ohio**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

You are considering to stop reimbursement to x-ray facilities that take Chiropractic orders. Are you going to stop paying for x-rays ordered by Osteopaths? Medics? This is blatent discrimination against one medical provider.....WHY? You should reimburse the Chiropractic Physician for taking x-rays in their office as you do for the other physicians. This action will increase costs and decrease care to patients. Stop this silliness now...Thomas Montgomery DC,FACO,DABCC,DAAPM.

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

Organization : **John Roy**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Paul Banta** **Date: 08/27/2007**

Organization : **Dr. Paul Banta**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

Paul E. Banta, M.D.
Los Angeles, CA

Submitter : **Mr. Christopher L. Roy** **Date: 08/27/2007**

Organization : **Mr. Christopher L. Roy**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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