Submitter : Dr. David Orsinelli **Date:** 07/27/2007

Organization : The Ohio State ?University

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in at The Ohio State University and its affiliated clinical sites, 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 echocardiographic procedures. While color Doppler is frequently performed with 2D imaging, the information obtained from these two different ultrasound methods is unique to each technique.

Two-dimensional echocardiography provides anatomic information, while color Doppler provides physiologic (functional) information (such as valvular regurgitation and intracardiac shunting). It is useful for quantification of the severity of these lesions. Color Doppler information is critical to the decision-making process in patients with suspected or known valvular and congenital heart disease and for appropriate selection of patients for surgery or medical management. Color Doppler is important in the accurate diagnosis of many other cardiac conditions.

The proposal to bundle (thereby eliminating 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 in concert with the imaging component of an echo, the performance of color flow Doppler utilizes different ultrasound techniques / principles, different aspects of the ultrasound probe / system, increases sonographer time and equipment time required for a study and requires additional knowledge, expertise and time on the part of the physician who performs the final interpretation. Physician / sonographer time has increased, as color flow Doppler s role in the evaluation of valve disease and other conditions has become more complex. Neither the physician time (professional reimbursement) nor the sonographer, equipment time and associated overhead (technical component) required for the performance of color flow Doppler are included in the RVU s for any echocardiography base procedure. Thus, the proposal simply eliminates Medicare payment for a service that (as CMS acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

While it is true that color Doppler is performed in most echo studies in adults and children, CMS is incorrect in assuming that color flow Doppler is intrinsic to the 2 D imaging or to the provision of all echocardiography procedures in general. I understand that data 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. These data 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%. In my practice it is not uncommon to perform only an imaging study (no color Doppler) when the specific clinical question is one of anatomy (e.g. pericardial fluid) rather than physiology (e.g. murmur, dyspnea, valve disease, congenital disease).
Thus, 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.

Sincerely yours,

David A. Orsinelli, MD
Professor, Clinical Internal Medicine
The Ohio State University
Columbus, OH

Submitter : Dr. Tory McGrath **Date:** 07/27/2007

Organization : Cleveland Clinic Foundation

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I support the medicare reimbursement payment for anesthesia.

Submitter : **Dr. Vincent Cirella** **Date: 07/27/2007**

Organization : **RWJ/UMDNJ**

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.

Vincent N. Circlla,MD Assistant Prof Anesthesia/Anesthesia Residency Director RWJ/UMDNJ

Submitter : Mr. Robert Brazee **Date:** 07/27/2007

Organization : Spokane Cardiology

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As physicians and sonographers who provide echocardiography services to Medicare patients and others in eastern Washington and northern Idaho, we are 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 (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decision making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color 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,

Physicians and Sonographers of Spokane Cardiology
Spokane Cardiology, P.S.C.

Submitter : Dr. mark mumford **Date:** 07/27/2007

Organization : AMAET

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the proposal to inerease anesthesia payments under 2008 Physician fee schedule. CMS has recognized thc unfair undervaluation of anesthesia services and I appreciate your efforts to rectify this. Sinee its inception, RBRVS has undervalued anesthesia work compared to other MDs. A decade later we are paid a paltry $16.19 per unit and dropping because of proposed cuts. This fee can not cover basic services to the senior population who needs them most. The RUC recommends to CMS to increase the conversion factor by 32% to $4 per anesthesia unit. This would be a necessary first step to ensure competent care for the senior citizens. Sincerely Mark Mumford MD

Submitter : **Dr. Charles Pollick** **Date: 07/27/2007**

Organization : **Los Angeles Cardiology Associates**

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 CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As an MD who provides echocardiography services to Medicare patients and others in Los Angeles, 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 proccdurcs.

In conjunction with two-dimcnsional echocardiography, color Doppler typically is uscd for idcntifying cardiac malfunction (such 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 valvc discase and appropriate selection of patients for valve surgery or medical management. In addition, color flow Dopplcr is important in thc accuratc 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, thc 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 morc 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 Medicarc payment for a servicc 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 indcpcndcnt consultant and submitted by the American College of Cardiology and thc American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT codc 93307. Howcvcr, thcsc data, which were previously submitted to CMS, also indicate that an cstimatcd 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 thc 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,

Charles Pollick MD

Los Angeles Cardiology Associates

Submitter : **Dr. David Cannom** **Date: 07/27/2007**

Organization : **Los Angeles Cardiology Associates**

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 CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As an MD who provides echocardiography services to Medicare patients and others in Los Angeles, 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 (such 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 selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

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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.

Submitter : Dr. Thomas Shook **Date:** 07/27/2007

Organization : Los Angeles Cardiology Associates

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 CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As an MD who provides echocardiography services to Medicare patients and others in Los Angeles, 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 (such 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 selection of patients for valve surgery or medical management. In addition, color 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.

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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.

Submitter : Dr. Anil Bhandari **Date:** 07/27/2007

Organization : Los Angeles Cardiology Associates

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 CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

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In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such 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 selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

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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.

Submitter : Dr. Steven Burstein **Date:** 07/27/2007

Organization : Los Angeles Cardiology Associates

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 CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As an MD who provides echocardiography services to Medicare patients and others in Los Angeles, 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.

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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.

Submitter : **Dr. Derek Booton** **Date: 07/27/2007**

Organization : **Dr. Derek Booton**

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.

Derek Booton M.D.

Submitter : **Dr. Armin Schubert** **Date: 07/27/2007**

Organization : **Dr. Armin Schubert**

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 support strongly the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. It is extremely gratifying, and a testimonial to your leadership, that CMS has recognized how severely undervalued anesthesia services are by Medicare. Many of my friends' practices have stopped providing anesthesia for Medicare patients or severely curtailed availability because they lose money on each patient.

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.

Armin Schubert, MD

Submitter : **Date: 07/27/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.
Dr Stephen Rubin

Submitter : Dr. Jeffrey Askew **Date:** 07/27/2007

Organization : Virginia Cardiovascular Consultants

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 CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Sir or Madam:

As a cardiologist who provides echocardiography services to Medicare patients and others with congestive heart failure, pulmonary hypertension and valvular failure in Virginia, 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 (such 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 selection of patients for valve surgery or medical management. In addition, color 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 professional expertise 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, expertise, 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 year. Referrals for echocardiograms from primary care providers for one diagnosis, often reveal another more serious diagnosis with the use of color doppler.

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,

Jeffrey Askew
Virginia Cardiovascular Consultants

Submitter : **Dr. Brian Richardson** **Date: 07/27/2007**

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Jay Erlebacher **Date:** 07/27/2007

Organization : Englewood Cardiology Consultants

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

July 27, 2007

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a cardiologist in private practice who provides echocardiography services to Medicare patients and others in Englewood, New Jersey, 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 valvular and congenital heart disease.

CMS s proposal to bundle and functionally eliminate payment for color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. Echocardiography is becoming more complex and time consuming as new Doppler methods become part of the examination. Furthermore, the advances in equipment design are forcing us to consider upgrades to new and more advanced equipment when we have just paid off our existing machines. A cut in reimbursement is just what we don t need when we are considering major expenditures on new equipment to improve patient care and keep up with advances in the field!

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,

Jay Erlebacher, MD, FACC
Englewood Cardiology Consultants

CMS-1385-P-4367-Attach-1.DOC

CMS-1385-P-4367-Attach-2.DOC

CMS-1385-P-4367-Attach-3.DOC

#4367

GEORGE B. LEBER, MD, FACC
JAY A. ERLEBACHER, MD, FACC
RICHARD S. GOLDWEIT, MD, FACC
CRAIG WILKENFELD, MD, FACC
DENNIS KATECHIS, DO, FACC

Englewood Cardiology Consultants

Suite 100
177 North Dean St.
Englewood, NJ 07631
Tel: (201) 569-4901
Fax: (201) 569-6111

July 27, 2007

Re: CMS—1385—P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008.
CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a cardiologist in private practice who provides echocardiography services to Medicare patients and others in Englewood, New Jersey, 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 valvular and congenital heart disease.

CMS's proposal to "bundle" and functionally eliminate payment for color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. Echocardiography is becoming more complex and time consuming as new Doppler methods become part of the examination. Furthermore, the advances in equipment design are forcing us to consider upgrades to new and more advanced equipment when we have just paid off our existing machines. A cut in reimbursement is just what we don't need when we are considering major expenditures on new equipment to improve patient care and keep up with advances in the field!

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,

Jay Erlebacher, MD, FACC

Submitter : **Dr. Wade Porterfield** **Date: 07/27/2007**

Organization : **Southern Tier Anesthesiologists, P.C.**

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.

Wade R. Porterfield, MD

Submitter : **Date: 07/27/2007**

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Sincerely,
Giac Vu, M.D.

Submitter : **Dr. Joseph Kisslo** **Date: 07/27/2007**

Organization : **Duke University**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

It is appropriate to bundle color flow Doppler (93325) into the standard echo examination.

Submitter : **Dr. Don Richter** **Date: 07/27/2007**

Organization : **Midwest 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
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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. George Hepler **Date:** 07/27/2007

Organization : Mayo Clinic

Category : Other Technician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

To whom it may concern, I have been performing echocardiograms for fifteen years and we do not use color flow doppler in all of our studies. We routinely perform follow up studies for Left ventricular Function(regional wall motion analysis), Pericardial effusion, Constriction/restriction studies, ejection fraction, LV and LA thrombus studies, etc. and color flow dopppler is not used. Color flow analysis often involves calculations to quantify regurgitant lesions such as PISA, Vena contracta, etc. This involves more time for the Physician to analyze the data to see if the numbers are reliable. Please reconsider making the color flow portion of exams a bundle charge. Sincerely, George N. Hepler

Lead Sonographer- Mayo Clinic Jacksonville

Submitter : **Dr. Krishna Rao** **Date: 07/27/2007**

Organization : **Pinnacle Partners in 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)

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Krishna Rao, MD

Submitter : Dr. Rachael Wyman **Date:** 07/27/2007

Organization : Dr. Rachael Wyman

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 CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in Washington state, 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.

Color Doppler information is critical to the decision making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color 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.

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,

Rachael A. Wyman, MD
Eastside Cardiology Associates

Submitter : **Dr. DAVID ELKINS** **Date: 07/27/2007**

Organization : **PINNACLE PARTNERS IN 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.

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

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

Thank you for your consideration of this serious matter.

Sincerely,

David Elkins, M.D.
Dallas, Texas 75252

Submitter : **Dr. Kent Swanson** **Date: 07/27/2007**

Organization : **Kent Swanson MD Inc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I would like 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.

Since the start of RBRVS, 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 reimbursment for anesthesia services stands at just $16.19 per unit. This does not cover the cost of caring for our medicare seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with moderate to high Medicare populations.

In an effort to rectify this terrible 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. This will serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. It is great that the Agency has accepted this recommendation in its proposed rule, and I fully support implementation of the RUC s recommendation.

To ensure that our Seniors 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.

Thanks for your attention to this serious matter.

Dr. Kent Swanson

Submitter : Dr. Gary Kauffman **Date:** 07/27/2007

Organization : North Phoenix Heart Center

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

5. CODING ADDITIONAL CODES FROM 5-YEAR REVIEW. The federal register citation is 72 Federal Register 38122 (July 12, 2007).

Echocardiographic imaging is a vital part of a Cardiologist's practice. These studies require a high tech machine costing in the range of $200,000, a highly qualified tech at $50-75 per study, and a physician to read the study. We are also now asked to have our Echo lab certified in order to maintain insurance contracts which will cost the practice $20,000. Now is not the time to start cutting reimbursement for Echo which is what this code change is all about. Color doppler is an important part of all echo studies. It adds to the price of the machine, the time for the tech to perform the study, and time for the doctor to read the study.

With all of the increased costs for physicians to remain in practice, it would be devestating to have another blow. We are already seeing our revenue taking major hits this year from decreased revenue for nuclear cardiology. Our overhead is up to over 60% because of all of the complexities in managing an office.

I represent an 11 doctor single specialty cardiology practice in Phoenix. We are all American trained, Multiboarded Cardiologists.
We cannot survive any more budgetary cuts and afford to stay in business.

Unless you want to start driving all of us out of business, I think you better rethink this proposal. If anything, reimbursement for echo should go up, not down!!

Submitter : **Dr. David D'Agate** **Date: 07/27/2007**

Organization : **Suffolk Heart Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam,

It is becoming very difficult to practice cardiology with the impending medicare regulations.

Please note I do not use color flow Doppler with all echo procedures, and the additional sonographer and physician time needed will be too costly.

Please do not bundling color flow Doppler into all the other echo base codes, without providing any additional payment for those base codes.

Sincerely,
Dr. D'Agate

Submitter : **Dr. William Hayes** **Date: 07/27/2007**

Organization : **Pinnacle Partners**

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.

W. Brendan Hayes, MD
4617 Briarhaven Road
Fort Worth, TX 76109

Submitter : **Mr. Elton Aguilar** **Date: 07/27/2007**

Organization : **Willamette Valley Society of Echocardiography**

Category : **Other Health Care Professional**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Congressman or Representative,

My name is Elton Aguilar, BS RDCS, and have been working in the field of Cardiology and Echocardiography for nearly 20 years. Furthermore, I am acting President of the Willamette Valley Society of Echocardiography. All in all, I am a cardiac sonographer who provides echocardiography services to Medicare patients and others in the Oregon and SW Washington regions. My plea to you is that you refraining from passing CMS 1385 s proposal which bundles the color flow Doppler Medical payment (CPT Code 93325) into all other echocardiography services. This in turn reduces medicare reimbursment for echocardiographic services.

The argument that color flow Doppler has become intrinsic to the performance of all echocardiography procedures may or may not be true. However, the truth is that performing color flow Doppler is a time intensive procedure that requires skill and patients to perform properly. Color flow Doppler is not simply a flip-the-switch-on procedure and you get results. The physics of ultrasound and Doppler imaging require proper probe positioning, system tweaking, and technical finesse. A test such as this requires much knowledgebase and time intensity by the sonographer. Color flow Doppler may be intrinsic to what we do because it is a huge part of what we do. It is a necessary and valuable technology that is available in today s medicine.

In summary, 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.

Elton Aguilar, BS RDCS
T2 Imaging, Inc. -Vice President
The Willamette Valley Society of Echocardiography
608 NE 147th Circle
Vancouver, WA 98685

Submitter : **Dr. Asad Hussain** **Date: 07/27/2007**

Organization : **Dr. Asad Hussain**

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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Dear Ms. Norwalk:

I am writing to request you to support 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. We are also being unable to support our Nurse Anesthetists due to the fact that their hourly pay is more than Medicare reimburses for typical hour. It is in reality a financial loss to us to provide care to a Medicare patient aside from the loss of time and its associated risks. Any increase, however modest it may be, will help offset our losses and at least bring us to a break even point.

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 time.

Sincerely,

Asad Hussain

Submitter : **Dr. Steven Hybarger** **Date: 07/27/2007**

Organization : **Pinnacle**

Category : **Physician**

Issue Areas/Comments

GENERAL

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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.

Steven Hybarger MD
Arlington Texas

Submitter : **Dr. Timothy Lorenz** **Date: 07/27/2007**

Organization : **Dr. Timothy Lorenz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Submitter : Dr. Patrick Anonick **Date:** 07/27/2007

Organization : Heart Group of the Carolinas

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am writing as a practicing cardiologist in North Carolina to strongly protest the concept of bundling echo Doppler codes as part of a routine echocardiogram codes. I have several points I would like to make.

First, echocardiography is changing all of the time. The concept of echo Doppler is ever expanding and is being used to diagnose and treat patients non-invasively for problems that could only previously be diagnosed invasively by cardiac catheterization. This extends not just from valvular heart disease but also to diastolic heart failure and to pulmonary hypertension. These techniques are ever evolving and much more complicated as time goes on. These procedures are NOT done on every echocardiogram. They are limited to those patients with certain diagnoses and with certain findings during the exam. They add considerable time and expense (technician and physician time) to these exams. To "bundle" them with a regular echocardiogram would imply that they are unnecessary AND routine. This will lead to less non-invasive diagnoses and eventually more doctors resorting back to cardiac catheterization to make these diagnoses. This will be MORE costly and result in higher risk to patient care.

Second, the only goal of such a move would be to reduce reimbursement to physicians. Often times, the physicians reading these tests are NOT the ordering doctors. To effectively punish echocardiographers by cutting our reimbursement for a test which we must spend considerable time in performing, interpreting, working with technicians to ensure high quality, and continue to meet requirements of data storage, documentation, and HIPPA compliance will result in fewer and fewer doctors willing to take care of patients. These tests have become an extremely important part of patient care. To try to cut them to obivion is simply wrong.

Third, considerable expertise is required to perform proper Doppler exams (both color and spectral). The majority of the time I spend as the director of the echo lab is in teaching our technicians about cardiac hemodynamics so that they can understand how to perform a proper Doppler exam. One of my principles is teaching them when a Doppler exam is necessary and when it is not. Not all studies require these more advanced techniques, but when they are necessary the technicians need the expertice to recognize it and do the exam. To try to cut the coding for the extra time and expense put into performing such a high quality exam is highly irresponsible. It will be bad for our patients eventually leading to missed diagnoses because we will no longer be able to afford to spend the time in training these individuals.

My last comment is more univeral. I have been in the medical field for over a decade now. I have a dismal view of the future. There is no way physicians can continue to survive with increasing costs every year and decreased reimbursement every year. Will there be physicians here to take care of patients at 2 in the morning during their heart attacks 10 years from now? 20 years from now? I really wonder because the capable and dedicated people that were drawn into this field are being beaten down by the economics and politics of practicing in it. When that happens, costs may be down but the quality of medical care in this country will follow soon thereafter.

Sincerely,
Patrick K. Anonick, MD, PhD
President, Heart Group of the Carolinas
Medical Director of Echocardiography at Carolinas Medical Center Northeast
100 Medical Park Drive Suite 201
Concord, NC 28025
704-856-6100

Submitter : **Dr. Frederick Browder** **Date: 07/27/2007**

Organization : **Apex 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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Reed Saunders** **Date: 07/27/2007**

Organization : **Rancho Mirage Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

Impact

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

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Thank you for your consideration of this serious matter.

Reed M. Saunders MD

Submitter : Dr. M. Gregory Katos **Date:** 07/27/2007

Organization : Penn St / Hershey Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

(Please see attached)

CMS-1385-P-4387-Attach-1.PDF

-4387

PENNSTATE
Milton S. Hershey Medical Center
College of Medicine

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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Sincerely,

M. Gregory Katos, MD

Submitter : **Date: 07/27/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. David Beebe** **Date: 07/27/2007**

Organization : **Dr. David Beebe**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **steven carlton** **Date: 07/27/2007**

Organization : **oregon anesthesiology group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Dr. Carlos Marinelli **Date:** 07/27/2007

Organization : Tampa Heart Center

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear CMS Representative,

As a physician who provides echocardiography services to Medicare patients and others in the Tampa Bay area in Florida, 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 (such 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 selection of patients for valve surgery or medical management. In addition, color 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.

Respectfully submitted,

Carlos C. Marinelli, M.D.
Tampa Heart Center
2727 W M.L. King Blvd, Ste 800
Tampa, Florida 33607

Submitter : **Dr. Mikhail Rondel** **Date: 07/27/2007**

Organization : **Anesthesia Consultants of New Jersey**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

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

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er.

Thank you for your consideration of this serious matter.

Mikhail Rondel, MD
Co-chief of Vascular Anesthesiology Section
Director of QI Committee
Anesthesia Consultants Of New Jersey, LLC.
Saint Peter's University Hospital
New Brunswick, NJ

Submitter : Arley Peter **Date:** 07/27/2007

Organization : Arley Peter

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I do not use color flow Doppler with all echo procedures, and It ios important to emphasizing the additional sonographer and physician time needed to perform those procedures. Not performing them would reduce the scanning time on 30%, and the need of a well trainned sonographer. So it is very important to consider the need to dedicate time for this additional exam.

Submitter : **Dr. william adcock** **Date: 07/27/2007**

Organization : **Dr. william adcock**

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
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William R. Adcock, MD

Submitter : **Dr. Douglas Solomon** **Date: 07/27/2007**

Organization : **Dr. Douglas Solomon**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Dr. Andrew Koropey** **Date: 07/27/2007**

Organization : **Anaesthesia Associates of Massachusetts**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,
Andrew J. Koropey, M.D.

Submitter : Dr. George Mark **Date:** 07/27/2007

Organization : Cardiovascular Associates of the Delaware Valley

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Policy Specialists:

I'm a cardiologist in my 1st year in private practice. I am board certified in cardiology, internal medicine and board eligible in clinical cardiac electrophysiology. I understand that Doppler imaging is being considered for bundling and felt it necessary to voice my concerns. The information derived from the 2-D imaging portion of the cardiac echocardiogram and that from doppler ultrasound are distinctly different entitities. While 2-D imaging provides the clues to regional wall motional abnormalities, the presence of pericardial fluid or gross valvular abnormalities, the use of doppler ultrasound adds the mechanistic understanding of the flow of blood throughout the heart. The information derived is raw and basic, expressed in terms of jet velocities and pressure gradients. It is up to the echo reader to interpret this information in the correct clinical context. Time is required to determine the diagnostic implications based on the context of the findings on the entire cardiac ultrasound. Since this particular component of the Echo exam requires special skills and special time, it should not be bundled as part of the basic 2-D exam.

For example, when I'm performing stress echocardiogram or am looking for a problem, which is not involve the flow of blood to the heart, the special services of color flow Doppler imaging are not provided and therefore are not billed. However, if I'm closely evaluating a cardiac valve, or there is a complex congenital heart problem, color flow technology, requiring the special skills and additional overhead of technologist time and equipment add-ons, gives me data crucial for accurate diagnosis.

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.

Submitter : **Richard Rerimer** **Date: 07/28/2007**

Organization : **Westchester Cardiology Associates**

Category : **Other Technician**

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 CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a cardiac sonographer who provides echocardiography services to Medicare patients and others in Westchester County, NY, 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 cchocardiography procedurcs.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such 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 selection of patients for valve surgery or medical management. In addition, color 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. [Include additional examples from your practice of CPT codes that are rarely billed with color flow Doppler.]

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,

Richard Reimer, RDCS, RDMS, RVT, FASE
Technical Director
Westchaester Cardiology Associates, PC

Submitter : **Dr. Ross Frohn** **Date: 07/28/2007**

Organization : **Northwest Hospital, Seattle, WA**

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.

Ross H. Frohn, MD, MSPH

Submitter : **Date: 07/28/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a physician who provides echocardiography services to Medicare patients and others in Las vegas, NV, 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 cchocardiography procedures.

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

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Sincerely yours,

Submitter : **Dr. Levick Bagdasarian** **Date: 07/28/2007**

Organization : **Dr. Levick Bagdasarian**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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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. Leah Paige Priddy** **Date: 07/28/2007**

Organization : **Pinnacle Anesthesiology Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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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.
Leah Paige Priddy, MD

Submitter : **Dr. Steven Lee** **Date: 07/28/2007**

Organization : **Dr. Steven Lee**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Eswar Sundar** **Date: 07/28/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

Ambulance Services

Ambulance Services

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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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. Guilllermo Garcia** **Date: 07/28/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please support CMS-1385-P.

As an Anesthesiologist, I am experiencing more and more difficulties sustaining a practice in Miami, Florida. CMS-1385-P will provide a helpful step in the right direction. As you know, reimbursements for Anesthesia services have been decreased consistently for years. I believe that the pendulum has swung too far. In order to provide quality anesthesia to all patients, reimbursement for services need to go up.

I hope that you all have the foresight and wisdom to accept this suggestion. Please pass CMS-1385-P.

Thank you.

Submitter : **Dr. Bruce Holmblad** **Date: 07/28/2007**

Organization : **President, Anesthesia Med Group of Riverside**

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.

Bruce Holmblad M.D.
President
Anesthesia Medical Group Of Riverside Inc.

Submitter : **Dr. Fred Fefer** **Date: 07/28/2007**

Organization : **Nassau Cardiology, PC**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re: 72 Federal Register 38122 (July 12, 2007)

CMS proposed bundling of color flow doppler services into other echo base codes without adjustment of the reimbursement rates ignores the added expense and time required to perform such services, and may jeaporize all physicians abilities to perform these tests. As it is there has been a steady decline in overall reimbursement and further decreases will likely cause this modality to be eliminated from the routine examination. This clearly would be detrimental to our ability to assess for cardiology maladies.

Submitter : **Dr. James Mathis** **Date: 07/28/2007**

Organization : **Reading Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Dear Sirs,

This is in regard to the proposed "bundling" of payment for color flow doppler interpretation into a more general payment for echocardiography services.

What this proposal amounts to is the elimination of reimbursement for the time, equipment and training needed to provide this invaluable imaging modality. One could with as much justification decide to eliminate reimbursement for chest xray interpretation or analysis of surgical pathology slides.

Color flow doppler imaging adds considerable value to the echocardiographic study of many cardiac and vascular conditions. There is no reason to selectively eliminate reimbursement for this added value.

I respectfully request that the proposal to "bundle" color flow doppler study reimbursement be dropped from CMS-1385-P.

Sincerely,

James G. Mathis M.D.
Director, Department of Anesthesia
Reading Hospital and Medical Center
Reading, PA 19610

Submitter : **Dr. John Abenstein** **Date: 07/28/2007**

Organization : **Mayo Clinic 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 add my voice in firm support for the proposaled increase in reimbursement for anesthesia services found in the proposed 2008 Physician Fee Schedule. I am gratified that CMS now recognizes that reimbursement for anesthesia care has been undervalued for many years, particularly when compared to other professional services, physician and nonphysician alike. I am thankful that the Agency is now taking steps to address this issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesiology services, secondary to the unexplained undervaluation as compared to other physician services. Ten years later Medicare payment for anesthesia services stands at just $16.19 per unit, as compared to more than $20 in the 1980's. This amount does not cover the cost of caring for those patients that are CMS's responsibility, our nation s seniors. This has created an unsustainable system forcing anesthesiologists away serving those communities with a disproportionately high Medicare populations.

As you know the RUC is recommending 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. Joseph Gunselman** **Date: 07/28/2007**

Organization : **Physician Anesthesia Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely yours,

Joseph G. Gunselman, D.O., M.B.A.

Submitter : **Dr. Nathan Williams** **Date: 07/28/2007**

Organization : **American Soc. of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

When I began practice of anesthesiology in southern NM in 1983 Medicare was accepting bills for $29.20. At the 2007 rate of $16, anesthesia for medicare patients in our area is primarily funded by cost shifting to commercial insurance providers and hospital corporations. If those surrogate payors lose interest, access problems are certain.

Thank you for your consideration of this serious matter,
Nathan L. Williams M.D.

Submitter : **Mrs. Rebecca Gunselman** **Date: 07/28/2007**

Organization : **Mrs. Rebecca Gunselman**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Sincerely yours,

Rebecca G. Gunselman

Submitter : **Dr. Donald Burke** **Date: 07/28/2007**

Organization : **Fountain Valley Regional Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Date: 07/28/2007**

Organization : **Mission Hospitals, Asheville, NC**

Category : **Other Technician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

As a cardiac sonographer at Mission Hospitals Echo lab, I represent the non-invasive area in a hospital system that has been awarded the honor of being one of the top 50 hospitals in the USA in cardiac services. I use color flow Doppler(CPT Code 93325) every day, but not necessarily in every echo exam. We have 5 Cardiac/thoracic surgeons who depend upon our expertise in using color flow Doppler to evaluate diseased heart valves prior, during and after open heart surgery. We have 12 cardiologists specialyzed in cardiac echo who must evaluate the color flow doppler used by us to quantify the severity of diseased heart valves. This is a VERY complex process and requires much additional knowledge and time on everyone's part in order to give our patient's the best medical service we can to insure the optimal outcome of their stay in our hospital system.

Color flow Doppler is also used in the diagnosis of congenital disease in our children and also for acquired disease, emergent situations such as Aortic dissections and gunshot wounds to the chest to name just a few. Having just any cardiologist not trained in echo would result in erroneous diagnoses. Bundling color flow doppler ignores the expertise needed by echo-trained cardiologists and cardiac sonographers, ignores the extra time needed by both cardiologists and cardiac sonographers for accurate information aquisition and evaluation, and in fact would ENCOURAGE less optimal performances and diagnoses.
I would hope that everyone would want the BEST medical care for yourself and your families, and bundling color flow Doppler(CPT Code 93325) would NOT support this.

Sincerely yours,

Phyllis Holmes
Cardiac sonographer
Mission Hospitals Echo lab
Asheville, NC 28801

Submitter : **Dr. Richard Guidetti** **Date: 07/28/2007**

Organization : **Dr. Richard Guidetti**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Robert Middleton **Date:** 07/28/2007

Organization : Dr. Robert Middleton

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re inerease in anesthesia rates.

This a good first step, but medicare rates for anesthesia will still be about a third of commercial insurance rates. This means that market forces will work to cause the medicare patients to have difficulty getting first class anesthesia. The longer this difference in rates exists the more damage that will be done to the speciality of anesthesia.

Submitter : **Dr. Steven Mueller** **Date: 07/28/2007**

Organization : **Steven A Mueller MD INC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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.

Steven A Mueller MD

Submitter : **Dr. Miguel Quinones** **Date: 07/28/2007**

Organization : **Methodist DeBakey Heart Center**

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 CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others at the Methodist DeBakey Heart Center in Houston, Texas, 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 (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decision making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. This is becoming increasingly important as the incidence of valvular disease continues to rise among the elderly population. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions including the assessment of left ventricular filling pressures in patients with heart failure.

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,

Miguel A. Quinones, MD, FACC
Medical Director
Methodist DeBakey Heart Center

Submitter : Dr. Christopher Stalvey **Date:** 07/28/2007

Organization : Wake Forest University

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-4419-Attach-1.RTF

4419

Leslie V. Norwalk, Esq.
Acting Administrator
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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.

Sincerely,

Christopher F. Stalvey, D.O.
Anesthesiologist
Winston-Salem, NC
cstalvey@wfubmc.edu

Submitter : **Dr. Matthew Chynoweth** **Date: 07/28/2007**

Organization : **Kodiak Anesthesia, P.C.**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
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Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : Dr. Sheldon Litwin **Date:** 07/28/2007

Organization : Univ of Utah

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a cardiologist who provides echocardiography services to Medicare patients in Utah, Idaho and Wyoming 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.

Color Doppler information is critical to the decision making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. Echocardiography is arguabley the single most important and the most cost effective test in the field of cardiology.

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. For example, application of the PISA (proximal isovelocity surface area) method to the analysis of mitral valve regurgitation is now felt to be an important part of the quantification of this condition. However, PISA, which is based on color Doppler imaging, adds substantial time to an echo study.

The CMS proposal simply eliminates Medicare payment for a service that is important for accurate diagnosis and that is not reimbursed under any other CPT code.

CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. 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, TEE, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow is less than 50%. This practice pattern has not changed over the past several years. In my practice, color Doppler is frequently, but not always a part of stress echo examinations. In patients who present with dyspnea on exertion, it is common to assess the valves as well as to look for inducible cardiac ischemia. However, in some patients, it is only necessary to look for stress-induced wall motion abnormalities and color Doppler is not necessary.

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.

Sheldon Litwin
Professor of Internal Medicine
University of Utah

Submitter : **Dr. Grant Cravens** **Date: 07/28/2007**

Organization : **Dr. Grant Cravens**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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