Submitter : **Dr. Bradley Bergman** **Date: 07/31/2007**

Organization : **Associated Anesthesiologists, PC**

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 : **Date: 07/31/2007**

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Submitter : **Date: 07/31/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : Dr. Perry Eisner **Date:** 07/31/2007

Organization : Dr. Perry Eisner

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

Perry Eisner, M.D.

Submitter : Dr. Perry Eisner **Date:** 07/31/2007

Organization : Dr. Perry Eisner

Category : Physician

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Sincerely,

Perry Eisner, M.D.

Submitter : Ms. Anne Bello **Date:** 07/31/2007

Organization : Ms. Anne Bello

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Hi,
I am writing about the proposed bundling of color Doppler into all other base codes.
Although its true that color doppler is an essential tool of echocardiography, it is also true that it takes much more time than doing 2D alone.
I feel that the work, dedication, knowledge and time dedicated to prforming and reading these studie are not appreciated at all.
It's a sin,
Please reconsider this decision.
Thanks,
Anne

Submitter : **Date: 07/31/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

Maurice M. Hart, MD

Submitter : **Dr. Lars Runquist** **Date: 07/31/2007**

Organization : **Coastal Cardiology**

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:

I am a Cardiologist who reads echos on Medicare patients and others in Charleston SC. 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 indepcndent consultant and submitted by the American College of Cardiology and the American Socicty 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 cstimated 400,000 color flow Doppler claims cach 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,

Lars Runquist MD, FSCAI
Coastal Cardiology, PA

Submitter : **Dr. Mitchell Baruchin** **Date: 07/31/2007**

Organization : **Total Cardiology Care**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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 Jersey City, NJ, 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. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

I have studied (and continue to study)long and hard so that I can accurately interpret Doppler. Why not remove half of the chapters from the textbook, and remove the test questions from the boards?

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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Mitchell Baruchin, MD
Total Cardiology Care

Submitter : **Dr. Robert Zellmer** **Date: 07/31/2007**

Organization : **Dr. Robert Zellmer**

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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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. My community hospital surgical population is almost a 60% Medicare and Medicaid population. My medical license, DEA certificate, liability insurance, and continuing medical education fees, continue to rise unabated while CMS has stagnated or reduced (almost 9% just this year) an already undervalued reimbursement for anesthesia practice.

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

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Thank you for your consideration of this serious matter.

Sincerely,

Robert J. Zellmer, M.D.

Submitter : kathryn crookston **Date:** 07/31/2007

Organization : kathryn crookston

Category : Other Health Care Professional

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Subj. Echocardiograms. Obviously you have no medical backgroung. If you did, you would realize how important Color Flow is in aiding Doppler. If a pt. is refered for a murmur, it can pick up subtlies that spectral might miss if probe note angled just so. It takes expertise to perform and the analyze. You are really tying the hands of those of us who are more knowledgeable than you and are more concerned with patient care than you are. Kathryn Crookston RDCS

Submitter : **Dr. Christine Baguley** **Date: 07/31/2007**

Organization : **Wenatchee Anesthesia Associates**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Submitter : Dr. Rene Gonzalez **Date:** 07/31/2007

Organization : Dr. Rene Gonzalez

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I strongly support an increase in Medicare Anesthesiology CF

Submitter : Dr. Rene Gonzalez **Date:** 07/31/2007

Organization : Dr. Rene Gonzalez

Category : Physician

Issue Areas/Comments

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Thank you for your consideration of this serious matter.

Submitter : Dr. Stephen Schnugg **Date:** 07/31/2007

Organization : The Heart Clinic of Southern Oregon

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Very bad idea to batch the codes for Doppler in with the echo codes and not pay for them. Acquiring and interpreting the Doppler information takes time, experience, training and study. Tissue Doppler, in particular, is new, time-intensive and complex, and will soon be standard. We cardiologists expect to read the Doppler data, consider it useful and use it clinically. We expect and deserve to be paid for our efforts.

For a contractual relationship to sustain, there must be some amount of trust between the parties. Don't violate that trust by arbitrarily dropping the compensation for this valuable service that you will still demand that we provide to your beneficiaries. That's just strongarming.

Submitter : Dr. Hugh Cowdin **Date:** 07/31/2007

Organization : American Society 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
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Thank you for your consideration of this serious matter.

Hugh P. Cowdin, Jr. MD
Cranston, RI

Submitter : **Dr. Fadi Tahrawi** **Date: 07/31/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Submitter : Dr. Marguerite Crawford **Date:** 07/31/2007

Organization : Dr. Marguerite Crawford

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-4767-Attach-1.DOC

CMS-1385-P-4767-Attach-2.DOC

4767

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

Re. File Code: CMS–1385–P, CODING—ADDITIONAL CODES FROM 5-YEAR REVIEW

To CMS:

I am writing regarding the proposed change to bundle CPT 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350 when provided together.

As a pediatric cardiologist, this is of particular concern to me because:

1. I do not believe the appropriate process has been followed with respect to this change. After significant interaction and research between the RUC and the appropriate specialty societies (in this case The American College of Cardiology and the American Society of Echocardiography), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that the list of above echo codes be bundled as well with the 93325.

   This new code is fully expected to address any outstanding issues relative to Medicare utilization of 93307, and has been analyzed at length by appropriate national medical societies, the CPT editorial panel, and the RUC. However, as a result of this proposed regulatory action by CMS, we are faced with resolving, in an accelerated timeframe of less than two months, an issue that directly impacts a distinctly non-Medicare population – namely, pediatric cardiology practices – and which is normally addressed over a multi-year period. Further, because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

2. The surveys performed to set the work RVUs for almost all of the echo codes utilized specifically by pediatric cardiologists and affected by this proposed change were performed more than 10 years ago. As a result, particularly with respect to the 93325, the RVUs are reflective of a focus on the cost of the technology and not the advances in care that have been developed as a result of the technology. Particularly among pediatric cardiologists, much needed new surveys would provide evidence that the work and risk components of the procedures that involve Doppler Color Flow Mapping have evolved to the point where the relative value of the procedures have shifted to a significantly greater work component and a lesser technology component.

   This shift is reflected in the development of national standards such as those present in the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL) initiative to develop and implement an echo lab accreditation process. The focus of this initiative is on process, meaning work performed, and not on the technology associated with the provision of echocardiography services. This echocardiography accreditation initiative will be mandated by many payors within the next year.

   In 1997 there were specific echocardiography codes implemented in CPT for congenital cardiac anomalies to complement the existing CPT codes for echocardiography for non congenital heart disease. "The codes were developed by the CPT Editorial Panel in response to the American Academy of

Pediatrics and the American College of Cardiology's request to delineate more distinctively the different services involved in *assessing* and *performing* echocardiography on infants and young children with congenital cardiac anomalies." *(CPT Assistant 1997).*

Consistent with this, I have significant concern with the continued approach (of which this bundling proposal is an example) of placing adult and pediatric patients in the same grouping when it comes to evaluation of the work associated with providing care to these significantly different patient populations. Because the adult cardiology population is much larger than the pediatric population, the RVUs for procedures that are common to both are established exclusively using adult patients as the basis. The work and expense associated with providing care to pediatric patients is not considered. The inaccuracies that result from this approach can be linked to anatomical differences between pediatric and adult patients (size, development, etc. - see references from the CPT Assistant below) as well as the basic issue of getting a child to be still while performing complex imaging procedures.

CPT Code 93325 describes Doppler color flow velocity mapping. This service is typically performed in *conjunction* with another echocardiography imaging study to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow velocities.

Pediatric echocardiography is unique in that it is frequently necessary to use Doppler flow velocity mapping (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 for the pediatric population stating that Doppler color flow velocity is "... even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." It should also be recognized that Doppler flow velocity mapping is an essential medical service being provided to patients with congenital and non-congenital heart disease in the pediatric population.

The following vignettes will illustrate the importance of the Doppler color flow velocity mapping (93325) remaining as a separate and distinct medical service and as an add-on code (+) for pediatric echocardiography services. These are just a few examples of the many complex anatomic and physiologic issues that we as pediatric cardiologists face on a daily basis when performing echocardiograms on infants, children, and adults with complex congenital or non-congenital heart disease. These are not unusual cases for us.

Vignette I *(quoted from CPT Assistant 1997)* (example of Congenital Heart Disease)

"A three-day-old neonate with transposition of the great vessels was initially treated with an atrial septostomy with a planned arterial switch procedure at seven days. On the third day post Raskind balloon septostomy increasing cyanosis is seen with saturation dropping to the low 70s. A repeat transthoracic echocardiography (93304) with color flow Doppler study is performed *(color flow Doppler is coded in addition as a 93325).* The physician reviews the echocardiographic images and prepares a report. The echocardiogram shows a closed patent ductus arteriousus and a small atrial septal defect. The child is returned to the cath-lab for a repeat septostomy and prostaglandin is restarted."

Vignette II (example of non-congenital heart disease)

A two-month-old infant is referred by the pediatrician to a pediatric cardiologist for a persistent murmur in an otherwise healthy infant. The pediatric cardiologist is concerned about a patent ductus arteriousus as a possible diagnosis. A ductus arteriousus, connecting the pulmonary artery and the aorta, is an essential structure during fetal life. Normally, the ductus arteriousus closes in the first few days after birth in healthy term infants. A persistent ductus arteriousus can give rise to long-term complications and needs to be followed carefully to evaluate if further intervention is needed (medical vs. surgical).

Echocardiography permits an accurate diagnosis of a patent ductus arteriousus with assessment of both the hemodynamic impact if there is a shunt. Estimated pulmonary artery pressure is obtained by Doppler imaging and can exclude other associated defects also. Color flow Doppler will be able to outline the flow of a patent ductus arteriousus from the aorta to the pulmonary artery. Color flow Doppler in this baby revealed no cardiac defects or patent ductus arteriousus and the murmur was determined to be innocent.

Vignette III (example of congenital heart disease)

An eight year-old child (or a 23-year-old young adult), with complex cyanotic congenital heart disease (functional single ventricle) is post-op completion of a fenestrated Fontan procedure several years ago. He has had a progressive decrease in saturations over the last year. There are several possible explanations and the pediatric cardiologist performs an echocardiogram to help determine the etiology. Color flow Doppler (93325) is essential to help elucidate the postoperative anatomy and blood flow patterns, but the process is complex and time-consuming involving assessment of the surgically constructed lateral tunnel or extracardiac conduit searching for a residual fenestration shunt or obstruction to flow, assessment of flow patterns through the previously surgically constructed Glenn anastomsis between the superior vena cava and pulmonary artery, assessment for obstruction to flow through the bulboventricular foramen, assessment for significant AV valve or semilunar valve insufficiency, and assessment for collateral vessels directing venous (desaturated blood) into the heart that may have developed over time. Any or all of these findings will then help dictate the next step in the care of this patient.

3. I am concerned that this change would adversely impact access to care for pediatric cardiology patients. Pediatric cardiology programs provide care not only to patients with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for pediatric cardiology services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to our patients will not be sufficient to continue to do so should the proposed change to bundle 93325 with other pediatric cardiology echocardiography codes be implemented.

   Thus the effect of this change on pediatric cardiology programs throughout the country will be an increase in the need for subsidies from already resource-challenged children's hospitals and academic programs, or a significant increase in Medicaid reimbursement for the proposed bundled services, in order for pediatric cardiology patients to have the same access to care and resources that they do today.

I strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other pediatric cardiology echocardiography codes until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Thank you for your consideration of this serious matter.

Sincerely,

Marguerite Crawford, MD
Pediatric Cardiology Associates
880 6th St South #280
St. Petersburg, FL 33701

Submitter : **Dr. Paul Seitz** **Date: 07/31/2007**

Organization : **American Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I STONGLY SUPPORT an increase in anesthesia payments for the 2008 physician fee schedule.
This is essential to provide compensation for care of senior citizens in the future.
Thank you.

Submitter : **Dr. John Schlitt** **Date: 07/31/2007**

Organization : **Capitol Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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. Steven Haddy, MD** **Date: 07/31/2007**

Organization : **Dr. Steven Haddy, MD**

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.

We are unable to attract faculty into academic anesthesiology due to our inability to complete with the private seetor anesthesia practices. If this trend continues, we will soon have an even more severe shortage of qualified anesthesiologists than currently.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Reginald Rousseau** **Date: 07/31/2007**

Organization : **North American Partners in Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Thomas Root** **Date: 07/31/2007**

Organization : **Bay Area Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Mark Casha **Date:** 07/31/2007

Organization : Casha-Cros Chiropractic

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

CMS 1385-P

X-rays are essential for chiropractic physicians to demonstrate spinal subluxations in order to paid for spinal adjustments to medicare recipients. We coordinate physical exam findings plus x-ray findings to determine subluxations. Radiologists don't necessarily have the physical findings to properly evaluate the patient.

Eliminating access to x-ray reimbursement places an unnecessary burden to medicare patients.

Thank you for your consideration,

Mark Casha, DC

Submitter : **Dr. Peter Feldkamp** **Date: 07/31/2007**

Organization : **Dr. Peter Feldkamp**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Feldkamp Chiropractic Clinic
Dr. Peter D. Feldkamp
4227 Hoover Road
Grove City, Ohio 43123
Telephone: (614) 875-3338
Fax: (614) 875-3034

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Peter D. Feldkamp, DC

Submitter : Dr. John Heath **Date:** 07/31/2007

Organization : Regional Anesthesia, PLLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1385-P-4775-Attach-1.DOC

#4775

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. Jerome Bormes** **Date: 07/31/2007**

Organization : **Dr. Jerome Bormes**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

listen to what everyone is saying!!! Anesthesiologists are being ROBBED!!!! Please increse their reimbursement!!!!
thank you
Jerome E. Bormes, MD

Submitter : Dr. Lee Arthur **Date:** 07/31/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

Background

Background

As an Anesthesiologist, I would welcome increased reimbursement for anesthesia related services. Unfortunately, the Medicare population is older, sicker, and takes more work and effort on my part to treat well. Most of these patients have multiple diseases which must be managed with care in order to maximize outcome. Increased reimbursement will help insure a continued supply of Medicare participating Anesthesiologists of quality caliber. Thanks for investigating this matter. Lee Arthur MD

Submitter : **Dr. Jerome Bormes** **Date: 07/31/2007**

Organization : **Dr. Jerome Bormes**

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.

Jerome E. Bormes, M.D.

Submitter : **Date: 07/31/2007**

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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Thank you for your consideration of this serious matter.

Submitter : Dr. Carl Smith **Date:** 07/31/2007

Organization : Star Anesthesia, P.A.

Category : Physician

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

As a private practice anesthesiologist, I am absolutely insulted by Medicare's physician reimbursement rates. Most of my sickest patients are Medicare patients and the amount I'm paid by Medicare for their complex anesthetic care is pathetic. And now its been decreased even more?! A 9% decreases in anesthesiology reimbursments during a period when all costs related to our practice, as well as the cost of living, are going up. I have a wife and three children. Now I see them less than ever, and my income is going DOWN despite an increased case load. This problem must be fixed immediately. Some of the surgeons I work with are already considering limiting their practices to non-Medicare patients. I dont blame them.

Submitter : **Dr. Basavaraj Nagappala** **Date: 07/31/2007**

Organization : **AAMGI**

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.

Basavaraj Nagappala

Submitter : **Mrs. Veena Thippeswamy** **Date: 07/31/2007**

Organization : **Shamrock Materials**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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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.

Veena Thippeswamy

Submitter : **Dr. Ben Martin** **Date: 07/31/2007**

Organization : **AMGR, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Rc: CMS-1385-P

The following letter states it as well as can be stated. For me personally, as a practicing anesthesiologist for over 20 years, I have seen many colleagues retreat from the care of seniors and those covered by Medicare programs because of declining reimbursement. I believe that this is human nature, but the end result will be increasingly limited access to excellent health care for seniors, including myself in a few years. I hope these modest fee increases will be considered with due priority. Thank you. Dr. Ben Martin.....(see letter following)

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

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Thank you for your consideration of this serious matter.

Submitter : **Neil Guenther** **Date: 07/31/2007**

Organization : **Individual**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter

Neil Guenther

Submitter : **Dr. John Jambura** **Date: 08/01/2007**

Organization : **Dr. John Jambura**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

John Jambura, Ph. D

Submitter : **Mrs. Jill Jones** **Date: 08/01/2007**

Organization : **Mrs. Jill Jones**

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.

Jill Jones, BS,RDH,MS

Submitter : **Mrs. Jeannette Jones** **Date: 08/01/2007**

Organization : **Mrs. Jeannette Jones**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Jeannette Jones

Submitter : **Dr. Brian Jones** **Date: 08/01/2007**

Organization : **Northwest Anesthesia Physicians**

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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Thank you for your consideration of this serious matter.

Brian Jones, MD

Submitter : **Dr. William Carr** **Date: 08/01/2007**

Organization : **AMGR**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

William R. Carr, MD

Submitter : **Dr. Wayne Miller** **Date: 08/01/2007**

Organization : **Dr. Wayne Miller**

Category : **Chiropractor**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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

Re: TECHNICAL CORRECTIONS

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

The patient clinically will require an X-ray to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

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

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

Sincerely,

Wayne Miller, D.C.

Submitter : **Ms. Sarah Farish** **Date: 08/01/2007**

Organization : **Roper St. Francis Healthcare**

Category : **Other Technician**

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 a cardiac sonographer who provides echocardiography services to Medicare patients and others in [insert location], 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. [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,

Sarah Farish
BS,RDMS,RDCS
Roper St. Francis Healthcare

Submitter : **Ms. Eirene Chaney** **Date: 08/01/2007**

Organization : **Roper Saint Francis Healthcare**

Category : **Other Technician**

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 a Cardiac Sonographer who provides echocardiography services to Medicare patients and others in Charleston, South Carolina, 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 is used to identify cardiac malfunctions such as valvular regurgitation and intracardiac shunts. It also quantitates the severity of these lesions. In particular, color Doppler information is critical to the decision making process in patients with suspicion of valvular 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 is performed during a 2-dimensional Echo exam, it does increase the exam time. 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 represented in the RVUs for any other Echo base procedure. CMS s proposal eliminates Medicare payment for a service that is critical 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, each component of an Echocardiogram (2-D Echo, Color Doppler and PW/CW Doppler) has its own specificity in the diagnosis of cardiac problems. They compliment one another but each is distinct in the information it provides. Further, the technical expertise, as well as the professional interpretive expertise, is distinct.

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,

Georganne Ridgill

Eirene Chaney, B.A., RDCS
Echocardiography Lab
Roper Saint Francis Healthcare

Submitter : **Dr. Robert Landry** **Date: 08/01/2007**

Organization : **Upper Cumberland Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

P.O. Box 8018

Submitter : Vu Duong **Date:** 08/01/2007

Organization : Vu Duong

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Rc: CMS-1385-P

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Thank you for your consideration of this serious matter.

Vu Duong

Submitter : **Dr. William Mahle** **Date: 08/01/2007**

Organization : **Emory University**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

CODING ADDITIONAL CODES FROM 5-YEAR REVIEW

To Whom It May Concern,

As a major provider of Pediatric Cardiology diagnosis and treatment services at Emory University and the Grady Clinic, I would like to express opposition to the proposed bundling of echo codes 93325 with other imaging codes.

Addition of color Doppler imaging to pediatric echocardiography is time consuming and requires a high level of expertise. Often, echocardiography can be performed without color Doppler imaging--such as in the assessment of a child at risk for anthracycline-mediated cardiomyopathy. In such, cases conventional two-dimensional imaging and M-mode would be sufficient to address the clinically relevant issues. If CMS believes that the color Doppler procedure and code are being used inappropriately, I would support audits of providers and education about the judicious use of adjunct echocardiographic modalities such as spectral and color Doppler imaging. However, to bundle the codes ignores the additional time and expertise both in imaging acquisition and interpretation.

I strenuously urge you to cancel this erroneous proposal.

William T. Mahle, MD
Associate Professor of Pediatrics
Emory University School of Medicine and the Grady Clinic

Submitter : **Dr. Andrew Vantreese** **Date: 08/01/2007**

Organization : **Dr. Andrew Vantreese**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Andrew Vantreese

Submitter : **Dr. Armando Janeira** **Date: 08/01/2007**

Organization : **American Society 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

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Sue Burke** **Date: 08/01/2007**

Organization : **Cardiology and Vascular Associates**

Category : **Health Care Professional or Association**

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. The federal register citation is 72 Federal Register 38122 (July 12, 2007).

Dear Mr. Kuhn:

As a cardiac sonographer who provides echocardiography services to Medicare patients and others in [Rochester Hills Michigan, 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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Sincerely yours,

Sue A. Burke, RDCS, RVS, CVT
Technical Director
Cardiology and Vascular Associates

Submitter : **Dr. Juhan Paiste** **Date: 08/01/2007**

Organization : **LVH**

Category : **Physician**

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. Douglas Bacon** **Date: 08/01/2007**

Organization : **Dr. Douglas Bacon**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

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Thank you for your consideration of this serious matter.

Sincerely,

Douglas R. Bacon, M.D., M.A.

Submitter : **Dr. Daniel Judge** **Date: 08/01/2007**

Organization : **Dr. Daniel Judge**

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 can not fully appreciate the difficulty and complexity of your task. You are faced with de facto rationing through a significantly underfunded health insurance program. However I am convinced that anesthesiology has, for too long, borne an disproportionate share. I believe has led to diminished access for the subpopulation that most needs it. I urge you to accept and implement the recommendations and seek other less harmful means to maintain budget neutrality.

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 : Mr. **Date:** 08/01/2007

Organization : Mr.

Category : Other Technician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Bundling color doppler coding will help offset other healthcare expenses at the cost of the quality of these exams. Everyone everywhere wants more for less, however less reimbursement for the exams means to the healthcare system less time with patients more exams per day to compensate.

Color doppler is an additional skill accompanied with two dimensional imaging for the identification and quantification of heart disorders. Echocardiography is not an all inclusive exam, you don't push a button and have a machine that does the work. Accurate diagnostic imaging takes time and skilled health care professionals, not underpaid grunts who are going to spit out a high quantity of low quality exams. What next?, MORE MEDICARE REIMBURSED EXAMS to diagnose a patient when it could be done if the time and resources were provided and it won't be if the funding to these departments decreases.

Instead lets consider coming up with a usefull solution people, if the lab is unaccredited they should be reimbursed less. As part of the Mayo clinic we are required to perform high quality imaging on patients who have often been misdiagnosed due to these 15 min in and out echos done elsewhere, lets separate the reimbursement there. Why do we get reimbursed the same amount as a facility producing these kinds of exams in larger numbers with less employees leading to information that lacks and more testing as a result.

I understand that these letters get discarded, correct?
If this is read I thank you for your time as I have taken my time to write this.
Registered Diagnostic Cardiac Sonographer

Submitter : **Dr. Cleveland Thompson** **Date: 08/01/2007**

Organization : **Asheville Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Cleveland Thompson, IV, MD

Submitter : Dr. Scott Gullquist **Date:** 08/01/2007

Organization : Virginia Commonwealth University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

To CMS:

I am writing regarding the proposed change to bundle CPT 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350 when provided together.

As a pediatric cardiologist, this is of particular concern to me because:

1.

I do not believe the appropriate process has been followed with respect to this change. After significant interaction and research between the RUC and the appropriate specialty societies (in this case The American College of Cardiology and the American Society of Echocardiography), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that the list of above echo codes be bundled as well with the 93325.

This new code is fully expected to address any outstanding issues relative to Medicare utilization of 93307, and has been analyzed at length by appropriate national medical societies, the CPT editorial panel, and the RUC. However, as a result of this proposed regulatory action by CMS, we are faced with resolving, in an accelerated timeframe of less than two months, an issue that directly impacts a distinctly non-Medicare population namely, pediatric cardiology practices and which is normally addressed over a multi-year period. Further, because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

2.

The surveys performed to set the work RVUs for almost all of the echo codes utilized specifically by pediatric cardiologists and affected by this proposed change were performed more than 10 years ago. As a result, particularly with respect to the 93325, the RVUs are reflective of a focus on the cost of the technology and not the advances in care that have been developed as a result of the technology. Particularly among pediatric cardiologists, much needed new surveys would provide evidence that the work and risk components of the procedures that involve Doppler Color Flow Mapping have evolved to the point where the relative value of the procedures have shifted to a significantly greater work component and a lesser technology component.

Consistent with this, I have significant concern with the continued approaeh (of which this bundling proposal is an example) of placing adult and pediatric patients in the same grouping when it comes to evaluation of the work associated with providing care to these significantly different patient populations. Because the adult cardiology population is much larger than the pediatric population, the RVUs for procedures that are common to both are established exclusively using adult patients as the basis. The work and expense associated with providing eare to pediatric patients is not considered. The inaccuracies that result from this approach can be linked to anatomical differences between pediatric and adult patients (size, development, etc. - see references from the CPT Assistant) as well as the basic issue of getting a child to be still while performing complex imaging procedures.

To summarize: Due process has not been reached in this matter with respect to the Pediatric Patient. Would you please consider further evaluation.
Thank you, Scott D. Gullquist M.D.
Associate Professor of Pediatrics

Submitter : **Dr. Peter O'Rourke** **Date: 08/01/2007**

Organization : **East Carolina Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms Norwalk:

I strongly support CMS 1385 P. Current reimbursement for anesthesia services for medicare patients is unacceptably low.
I work in an area where medicare and medicaid make up roughly 2/3 of the patients I take care of. As a result, I am acutely aware of the fact that reimbursement does not cover the cost of hiring a CRNA to cover the operating room. The current crisis is unsustainable in areas like mine. It has become common practice for the hospital to support anesthesia departments primarily because of the medicare/medicaid under payments and indigent care.

I hope that this opportunity to ensure the availability of quality care for our medicare patients by providing a more fair level of reimbursement does not slip away. I strongly urge you to increase anesthesia reimbursement for medicare patients.

Sincerely,
Peter J O'Rourke III

Submitter : Dr. James Beckman **Date:** 08/01/2007

Organization : Hospital for special surgery

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

It should be obvious that the cost of practice and the cost of living is MUCH HIGHER in certain parts of the country. While Mediacare reimbursements have been coming down fore MORE THAN A DECADE (during which time the cost of fuel has nearly tripled for example), it is now absolutely necessary to increase reimbursements accross the board and to a greater extent in certain areas. I believe congress has had multiple raises over the last decade.

Submitter : **David Martin** **Date: 08/01/2007**

Organization : **David Martin**

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.

David Martin
5274 Carrington Lane NW
Rochester, MN 55901

Submitter : **Dr. Richard Stauffer** **Date: 08/01/2007**

Organization : **American Society 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

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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. Our payment in Virginia is less than $15.00 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

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Thank you for your consideration of this serious matter.
Richard A. Stauffer MD MBA
Richmond, VA
August 1, 2007

Submitter : Dr. Robert Harowitz **Date:** 08/01/2007

Organization : Dr. Robert Harowitz

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am an anesthesiologist in a community hospital. Present reimbursement for anesthesia services through the CMS are 35% of the rate I receive from all other carriers. This is a hardship on my practice, making it difficult to compensate my personnel and to attract qualified providers. The proposed increase in the aneshtesia conversion factor will greatly enhance my ability to continue to care of patients in the medicare program.

Submitter : Mr. Brian Morris **Date:** 08/01/2007

Organization : Techno-House

Category : Health Care Industry

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Re: PROPOSED ELIMINATION OF EXEMPTION FOR COMPUTERGENERATED FACSIMILES; file code CMS-1385-P
http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1385p.pdf
PDF pg 74 of 275; Heading pg 38194

Executive Summary: It was good to have CMS take steps to set standards, but more time is needed for the market to develop naturally and this new legislation goes too far, in effect trying to regulate operational and business decisions that would adversely impact all stakeholders, including patients this seeks to help. This will significantly increase costs of care with net little or no care benefits from current practices. This will cause many providers to revert to paper. I hope CMS withdraws this NPRM and does not change the current legislation on this issue.

Re: "This would include information about eligibility, benefits (including drugs included in the applicable formulary, any tiered formulary structure and any requirements for prior authorization), the drug being prescribed or dispensed and other drugs listed in the medication history, as well as the availability of lower cost, therapeutically appropriate alternatives (if any) for the drug prescribed."
This is wrong in a number of ways. Transactions today don't carry all this information. The information is not always readily available at the point of prescribing. Systems are not fully matured to support this information. Costs are still prohibitively high to bring all this into play. When it is available, the medication history, abstracted from disparate sources and reliability in question, creates information overload and reduces the efficiency and effectiveness of downstream providers, especially pharmacies and pharmacists. Benefits, costs and burden are not properly distributed.
In short, this lead-in point is misinformed and misleading.

Re: "Initial standards were recognized by the Secretary in 2005 and then tested in a pilot project during CY 2006"
It should be noted the pilot tests did result in several findings and recommended changes to the standards, with NCPDP/SDO approval. Moreover, the 'standards' have since morphed considerably with new versions and several different implementation guides based on radically different architectures (XML vs. EDI). The named HIPAA standards are already far behind what the industry is pushing for. This shows there is still very little stability and consistency in the standards, which poses a great risk to all stakeholders.
It should also be noted the pilot tests were very limited, many in closed settings and many participants had to make major system modifications to meet then-current 'standards', which does not extrapolate to the broader market in a manner conducive to legislation forcing compliance on all.
It should also be noted the pilot participants had strong motivations to make extreme and risky investments in their products to help promote their positions in the industry as 'innovative first-movers' and further by offering these capabilities to participants without charges. Again, this is not practical or possible in an open and competitive market. These changes need to be made based on wise investments with some reasonable ROI; these capabilities are not free. Otherwise we set the stage for unsustainable endeavors that will jeopardize patient care and outcomes.

Re: "Based on data provided to CMS by SureScripts..."
It should be noted that SureScripts is an extremely biased organization that benefits greatly in financial terms by moving transactions to the electronic standards. In fact, SureScripts is practically a monopoly and this would seal it for them.
The following parts of this paragraph fall short of explaining WHY the gap remains so large between electronic and paper.

MORE....Please see attached.

CMS-1385-P-4810-Attach-1.DOC

#4810

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http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1385p.pdf
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The following parts of this paragraph fall short of explaining WHY the gap remains so large between electronic and paper. It does not mention or consider:

- Privacy - Despite what proponents of HIPAA say on this matter, there is merit and real concern that this is a DISCLOSURE law more than a privacy law. People have their data flowing in all sorts of directions and they don't have any idea. This NPRM would force more personal data through unknown networks and channels resulting in more risk to patient privacy. Networks and systems need more time to mature, get better security and transparency for stakeholders, especially patients.
- Choice/Access/Convenience - This NPRM would restrict patient choice and reduce access/convenience in many cases where a fax is just more practical.

COSTS - The analysis of costs is completely misinformed and/or misrepresented. Costs are a major factor for all stakeholders. More on this below.

Re: "The costs to convert to e-prescribing using NCPDP SCRIPT for these prescribers would in most cases be included in the annual maintenance fee they pay their software vendor."
ABSOLUTELY WRONG. In fact, SureScripts charges significant fees that directly add to costs in all cases. Moreover, these fees are extremely biased toward pharmacies and even more so to small independents who are already scraping by after sweeping changes in recent years: medicare/medicaid reforms - removing cash business, consolidating buying power to focus almost entirely on price (instead of outcomes and service), slowing reimbursements and reducing rates.

Re: "the number of practices that currently use legacy versions of software that are not capable of generating SCRIPT transactions and the amount of lead time they would need to comply"
The market is highly fragmented and the rate and complexity of regulatory changes has never been greater for both federal and state changes. This is aside from typical business needs and updates. Systems need at least a couple years to get on top of all this. Otherwise there is significant risk to providers with bugs, higher costs and general sustainability; again adversely impacting all stakeholders, including patients this seeks to help.
Another essential but missing fact is that SureScripts requires certification of software to use their monopolistic network. This certification goes beyond validating transactions are flowing per the standard. SureScripts is employing subjective criteria that impact operations and appears bias and unfair to larger chain constituents so they can claim large numbers for connectivity. This is another key impediment especially to independents, keeping them out of the market.

Re: "SureScripts reports that all chain drug stores"
ABSOLUTELY WRONG. There are a number of large regional chains (>40 stores) that still don't have this capability at all and would require completely changing systems; potentially a multi-year effort with extremely high costs. I could name several but that would not be appropriate here. You need to check your facts and again realize and remove the bias from SureScripts in this issue.
The number for independents is also questionable, but there aren't any unbiased and solid facts here for debate; so likewise yours should be better qualified.

Re: Since computer-generated faxing retains some of the disadvantages of paper prescribing (for example, the administrative cost of keying the prescription into the pharmacy system and the related potential for data entry errors that may impact patient safety)..."
This is somewhat misleading. It's important to remember how this really works.

Prescribers don't specify exactly what will be dispensed, so the pharmacy effectively always has to do some key entry and transcription

Similar issues apply for other script data beyond the product...patient, payer(s), claim details and more.

In general:

It's still unclear based on this NPRM, when if ever is fax acceptable any more from a prescriber to the pharmacy and back??

Fax can sometimes provide a better solution than any other means. Removing it entirely as an option is overly bureaucratic and draconian.

Submitter : **Dr. thomas javorsky** **Date: 08/01/2007**

Organization : **aaa**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. James Waters** **Date: 08/01/2007**

Organization : **Dr. James Waters**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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James Waters M.D.

Submitter : Dr. Martha Szabo **Date:** 08/01/2007

Organization : OSUMC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Dr. Martha Zorko Szabo

Submitter : **Dr. Earl Leeman** **Date: 08/01/2007**

Organization : **Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

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Be aware that the discrepancy in anesthesia payment has existed from the start. It has resulted in tremendous cost shifting by anesthesiologists to third party payers and to self-pay individuals. You now have an opportunity to make adjustments that will make things equitable. Please do so.

Thank you for your consideration of this serious matter.

Earl K. Leeman, M.D.

Submitter : **Mrs. Susana Garcia** **Date: 08/01/2007**

Organization : **South Miami Hospital**

Category : **Other Technician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Mr. Kuhn:

As a cardiac sonographer who provides echocardiography services to Medicare patients and others in [insert location], 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 flow imaging is a modality that requires expertise on its own apart from 2D -mode echocardiography not only for the technologist but for the physicians.
Please reconsider this proposal.
Thanks
Susana Garcia.

Submitter : Dr. JOHN MacCarthy **Date:** 08/01/2007

Organization : FULLERTON ANESTHESIA ASSOCIATES

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment: http://www.asahq.org/Washington/commentlettertemplate.doc

CMS-1385-P-4816-Attach-1.DOC

CMS-1385-P-4816-Attach-2.DOC

CMS-1385-P-4816-Attach-3.DOC

#4816.

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. Arthur Boudreaux** **Date: 08/01/2007**

Organization : **University of Alabama Health Services Foundation**

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

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Submitter : **Dr. Edmund Fangman** **Date:** **08/01/2007**

Organization : **Dr. Edmund Fangman**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-4818-Attach-1.WPD

Submitter : **Date: 08/01/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the RUC recommendation that the Anesthesia Conversion Factor be increased in the 2008 Physician payment schedule.

Submitter : **Matthew Faier** **Date: 08/01/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Sincerely,
Matthew Y. Faier, CRNA/APN

Submitter : **Dr. Nicholas Gagliano** **Date: 08/01/2007**

Organization : **Anesthesia Services, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Submitter : **Dr. Christopher D'Haem** **Date: 08/01/2007**

Organization : **Thoracic Cardiovascular Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

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

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (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 Echoeardiography 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,

Christopher M. D Haem, DO
Thoracic Cardiovascular Institute

Submitter : **Dr. Richard Pinke** **Date: 08/01/2007**

Organization : **Thoracic Cardiovascular Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Sincerely yours,

Richard M. Pinke, DO
Thoracic Cardiovascular Institute

Submitter : **Dr. Mark Veenendaal** **Date: 08/01/2007**

Organization : **Thoracic Cardiovascular Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Mark Veenendaal, MD
Thoracic Cardiovascular Institute

Submitter : Dr. Matthew Wilcox **Date:** 08/01/2007

Organization : Thoracic Cardiovascular Institute

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Sincerely yours,

Matthew D. Wilcox, DO
Thoracic Cardiovaseular Institute

#4818

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 : **Mr. Kerry Luciani** **Date: 08/01/2007**

Organization : **PREMERA Blue Cross**

Category : **Individual**

Issue Areas/Comments

Background

Background

CMS CY 2008 Proposed Revisions to Payment Policies under the Physician Fee Schedule Comment

File Code: CMS-1385-P

Issue Identifier: Adjustments to RVUs Budget Neutral

It is clear that due to the section 1848(c)(2)(B)(ii) of the Omnibus Budget Reconciliation Act of 1989, the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what the expenditures would have been in the absence of these changes. If outside the $20 million corridor, CMS must make adjustments to preserve budget neutrality. However, multiple options exist for making these adjustments. In the past, options have included a reduction to all work RVUs or an adjustment the conversion factor (CF). Historically, CMS/HCFA has opted for the former option. During the 2nd 5 year refinement cycle, CMS applied a work RVU adjustor. In 1997, a RVU work adjustment factor was applied. And again in 1998, the 1997 work adjustment factor was replaced with a new RVU adjuster. However in 1999, the budget neutrality work adjustment factor was eliminated or absorbed. Given the above, CMS is urged to absorb the work component budget neutrality adjustor for 2008 in order to simplify the formula and thus make it more straightforward to compute compensation. Taking this action now would make it easier for Physicians to calculate, plus it would administratively simplify transactions performed by other non-governmental entities that conduct business off of the RVUs that CMS issues.

Thanks for your consideration of the matter.

Sincerely,

Kerry Luciani

Kerry F. Luciani
HCE Manager
PREMERA Blue Cross
3900 E Sprague, MS 729
Spokane, WA 99220
509-252-7163
Fax: 509-252-7199

CMS-1385-P-4826-Attach-1.DOC

4826

CMS CY 2008 Proposed Revisions to Payment Policies under the Physician Fee Schedule Comment

File Code: CMS-1385-P

Issue Identifier: Adjustments to RVUs – Budget Neutral

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Fax: 509-252-7199

Submitter : **Dr. Elizabeth Kao** **Date: 08/01/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Submitter : Dr. David Cambier **Date:** 08/01/2007

Organization : Anesthesia Associates of Kansas City

Category : Physician

Issue Areas/Comments

GENERAL

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Centers for Medicare and Medicaid Services
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Sincerely,
David W. Cambier, M.D.
12901 Walmer
Overland Park, Ks. 66209
dwcambier@hotmail.com

Submitter : **Dr. Paul Chiu** **Date: 08/01/2007**

Organization : **Dr. Paul Chiu**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Paul H. Chiu, M.D.

Submitter : **Dr. Dag Holmsen** **Date: 08/01/2007**

Organization : **Dr. Dag Holmsen**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

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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, or in many rural states out of private practice and into subsidized hospital employed and subsidized positions.

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.

Dag Holmsen MD
Waterville Anesthesia Associates
Waterville Maine

Submitter : Dr. Michael Duzy **Date:** 08/01/2007

Organization : HeartCare Associates

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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 and others in Pennsylvania], 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. 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,

Michael J. Duzy, D.O., F.A.C.C.
HeartCare Associates

Submitter : **Dr. Tricia Pancoast** **Date: 08/01/2007**

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

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.

Regards,

Tricia Pancoast MD

Submitter : Dr. Johanna Chookaszian **Date:** 08/01/2007

Organization : Swedish Covenant Hospital

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

I practice Anesthesia in Chicago, where the costs of drugs and technology are high, yet the percentage of uninsured patients is also high. Neither the hospital nor I can provide services for these people without proper reimbursement.

Submitter : **Dr. Andrew Wong** **Date: 08/01/2007**

Organization : **Dr. Andrew Wong**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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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. David Schinderle** **Date: 08/01/2007**

Organization : **Dr. David Schinderle**

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 reeognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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

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.

David B. Schinderle, MD

Submitter : Stewart Chritton **Date:** 08/01/2007

Organization : Brigham & Women's Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-4836-Attach-1.DOC

#4836

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.

Stewart Chritton
16 Revere Street
Jamaica Plain, MA 02130

Submitter : **Dr. Paul Judson** **Date: 08/01/2007**

Organization : **American Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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.
Paul F. Judson MD

Submitter : **Ms. Lena Tung** **Date: 08/01/2007**

Organization : **Ms. Lena Tung**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. As a senior, 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. As my husband recently passed way, I well understand the importance of adequate accesss to health care resources.

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. I am pleased that the Agency accepted the RUC recommendation to increase anesthesia reimbursement in its proposed rule. I believe it will be a major step forward in correcting the long-standing undervaluation of anesthesia services. I support full implementation of the RUC s recommendation.

To ensure that patients such as myself 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 faetor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Brenden Hanks** **Date: 08/01/2007**

Organization : **Loma Linda University Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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 reetify 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. David Pennington** **Date: 08/01/2007**

Organization : **Physician Anesthesia Services**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Emily Peoples **Date:** 08/01/2007

Organization : Univ of PA, Dept of Anesthesiology & Critical Care

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1385-P-4841-Attach-1.DOC

#4841

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

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Emily Peoples, M.D.

Submitter : **Dr. Edward Toyooka** **Date: 08/01/2007**

Organization : **American Society of Anesthesiologist**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Margaret Yoakum-Pyle **Date:** 08/01/2007

Organization : American Society of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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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.

Margaret A. Yoakum-Pyle, MD

Submitter : **Ms. Lindsay Logan** **Date: 08/01/2007**

Organization : **Georgia Anesthesiologists, P. C.**

Category : **Physician Assistant**

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.

Submitter : **Dr. Michael Wainfeld** **Date: 08/01/2007**

Organization : **American Society 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.

Thank you for your consideration of this serious matter.

Sincerely

Michael Wainfeld MD