Submitter : Dr. Gregory Marcoe **Date:** 08/05/2007

Organization : MidMichigan Anesthesiology Group P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Gregory P. Marcoe D.O.
4087 Old Pine Trail
Midland, Michigan 48642
(989)631-7579

CMS-1385-P-5019-Attach-1.DOC

#5019

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

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

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

Submitter : Dr. Wendy Forreest **Date:** 08/05/2007

Organization : ASA

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

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

Dear Ms. Norwalk:

You or a loved one will need anesthesia care one day. You will want the most highly skilled physician available to provide that care. To attract and attain the brightest and most highly-educated individuals, physician payments will need to be set at a level that will prevent a brain-drain to other professions or other countries.

Thus, 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.

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.

An increase of nearly $4.00 per anesthesia unit would 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. 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.

Wendy Forrest, M.D.

Submitter : **Raymond Barbera** **Date: 08/05/2007**

Organization : **AANWD**

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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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.

Dr Tom Barbera

CMS-1385-P-5022

Submitter : Dr. Jan Gillespie-Wagner **Date:** 08/05/2007

Organization : Intermountain Anesthesia Consultants, LLP

Category : Physician

Issue Areas/Comments

Background

Background

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 glad 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. I was paid more from Medicare for the same services 20 years ago than I am today. Commercial contracts pay $50-$65 per unit instead of the $16.19 per unit. I previously worked at a hospital taking care of many Medicare patients. I was offered a job at a surgery center taking care of mostly commercial patients and I took the job. Like many other anesthesiologists, I left a practice with a disproportionately high Medicare population.

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. Murray Willis **Date:** 08/05/2007

Organization : Dr. Murray Willis

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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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 addition, the low Medicare rate is causing significant cost shifting to the private commercial payers.

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

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

Thank you for your consideration of this serious matter.

Sincerely, Murray S. Willis, M.D.

Submitter : **James Heaberlin** **Date: 08/05/2007**

Organization : **James Heaberlin**

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.

James R. Heaberlin, M.D.

Submitter : Dr. Ronggang Wang **Date:** 08/05/2007

Organization : Summit Anesthesiology Ltd

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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.

R. Wang, MD, PhD

Submitter : **Dr. Clarence Ward** **Date: 08/05/2007**

Organization : **Dr. Clarence Ward**

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.

Clarence F. Ward M.D.

Submitter : Dr. Scott Schenck **Date:** 08/05/2007

Organization : Dr. Scott Schenck

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.

Sincerely,

Scott C. Schenck, MD

Submitter : Mr. Narayan Neupane **Date:** 08/05/2007

Organization : Methodist Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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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. Joseph Forand** **Date: 08/05/2007**

Organization : **Dr. Joseph Forand**

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. To put this in perspective, my plumber charges $24.95 for the same time period and twice that after 4 PM. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which all anesthesia providers are being forced away from areas with disproportionately high Medicare populations, unless subsidized by either a hospital or the Federal government.

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 important matter.

Submitter : Dr. Kevin Miller **Date:** 08/05/2007

Organization : Dr. Kevin Miller

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.

P.S.-It is getting harder to recruit new anesthestiologists to work in hospitals, as they have less Medicare patients in surgerycenter or office settings. Hopefully, your increase in the anesthesia conversion factor will help with this.

Sincerely,
Kevin B. Miller, M.D.

Submitter : Stephen Nelson **Date:** 08/05/2007

Organization : Stephen Nelson

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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. Jonathan Abrams** **Date: 08/05/2007**

Organization : **Dr. Jonathan Abrams**

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.

Submitter : Dr. Thomas Pellino **Date:** 08/05/2007

Organization : Madison Anesthesiology Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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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.

Thomas Pellino, M.D.

Submitter : **Dr. Thomas Satterfield** **Date: 08/05/2007**

Organization : **PAG**

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,

Thomas A Satterfield M.D.

Submitter : **Dr. Traci Satterfield** **Date: 08/05/2007**

Organization : **OB-Gyn Assoc of Spokane**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Sincerely,

Traci Satterfield M.D.

Submitter : Dr. Beemeth Robles **Date:** 08/05/2007

Organization : Metro LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5036-Attach-1.DOC

#5036.

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. Nonetheless, as complicated as this issue may seem for some, in reality it is a straightforward issue in that in consideration of the suggested increase in reimbursement, it merely touches the surface of where we need to go if seniors are to continue be able to access care. When Medicare reimbursement for anesthesiologist's services cannot compete on the open market with indemnity payers due to the fact that Medicare currently only reimburses approximately 31% of what one otherwise could collect, clearly only those individuals that **must accept** Medicare reimbursement are actually accepting it. Simply what this means is that Medicare either directly or indirectly is creating a multi-tiered healthcare system where those who can and are willing to pay for their healthcare, will be able to dictate their timeliness in the care that they receive and possibly the quality of their care due to the fact that as individuals tailor their practice to include fewer poor payers, those who will be left with having to care for the poorly reimbursed work will be those with fewer options.

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 time has passed due to the fact that Medicare has not considered our claims of gross underpayment, several things have happened and will continue to intensify. First and foremost, clinicians have left hospital based care due to the fact that the majority of Medicare patients will be seen in the hospital setting. Given that caring for Medicare patients creates the greatest burden for any practice, limiting ones exposure to these patients provides the greatest protection. Ultimately the one to suffer will be the Medicare recipient. Second, due to the ever increasing burden of a poorly reimbursing clientele, hospitals have had to shore up the deficiency created by poor payers such that they have been required to institute stipend programs to obtain the necessary coverage for their patients. In the end what Medicare and Medicaid have

created, are unsustainable deficient programs that will either bankrupt the American Healthcare system and therefore forcing hospitals to close their emergency rooms and possibly their doors. In the end the failure to pay for healthcare will result in its demise and a greater deficiency in care. The reality of healthcare is that it has a cost and if the government did not have such an easy time with unconscionable price fixing, Medicare would have long ago become the coverage for second class citizens. Nonetheless, it is slowly moving in that direction and without finally coming to terms with the reality that all that is desired by anesthesiologists is equitable consideration, the movement away from the elderly will continue. Fewer and fewer doctors will want to care for Medicare patients because at the end of the day, if there is no financial incentive, and worse, there is a financial burden to the individual to care for Medicare patients, it simply makes no business sense to increase ones liability and at the same time lose money.

Thus, 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 (still too low)—a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a minor 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 despite the fact that the proposed increase continues to leave anesthesiology reimbursement severely undervalued. The only caveat in instituting this change is that it is my sincere desire that you understand that even at this level, Medicare is not even close to being competitive with market forces. Despite the fact that if CMS accepts the RUC recommendation of a $4.00 increase to the unit value, I do hope that you understand that your reimbursement still has further to go to be able to compete with what current market conditions dictate. As an example, even if you consider the worst indemnity payer (excluding government payers) reimburses anesthesiologists at about $40.00 per unit, I hope it becomes clear to you why your clients will continue to have a short fall in coverage. More physicians are moving toward the option of opting out of Medicare coverage and although that may not seem evident to you now, due to the fact that doctors may not formally be withdrawing from your program, fewer doctors are making themselves available to care for these patients by altering their practice patterns. Thus, I hope you understand that this is but the beginning of the rectification of the problems created by the RVRBS and if one is to remain "competitive", you have at least another $15.00 a unit to consider. Given that it has been about 15 years since Medicare unilaterally cut our reimbursement, and Medicare went from being a good payer a lousy payer in one fell swoop, this change is long overdue. Unfortunately given that it has taken 15 years in order to obtain this increase should it come to pass, I am not sure that I can wait another 15 years to see another $4.00 increase. I along with hundreds more see our only options to rectify this unconscionable reimbursement, is to finally opt out of Medicare altogether. Many of us have limited our exposure but as expenses increase, Medicare patients become older and sicker and therefore expose us to greater liability, the only option we have left is to opt out of a bad program. I see this change is coming and it is long overdue.

To ensure that our patients continue to 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. This suggested increase is truly the least that you can do and much more is necessary if you are going to compete with the open market for our services. In my opinion, it will require at least another $15.00 per unit increase to secure the future coverage of Medicare patients, at least in the short term. I do hope that you can understand the necessity of instituting this $4.00 increase but as you accept this change, it is sincere desire that you commence discussion on taking the Medicare unit value back to its 1990 level. When unit values from our contracted insurers are coming in at the high $40 range, we can do our part and care for the elderly at a reasonable discount but $20.00 a unit is not that price.

Thank you for your consideration of this serious matter and I look forward to serious and significant change.

Sincerely,

Beemeth Robles MD

Submitter : Lance Christensen **Date:** 08/05/2007

Organization : Lance Christensen

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As an anesthesia provider, please value my services appropriately. With increasing age and size of patients, more and more risk is taken. Please just reimberse us based on the approriate value.

Submitter : Dr. Kristin Spanjian **Date:** 08/05/2007

Organization : Dr. Kristin Spanjian

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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. Michael Liddy** **Date: 08/05/2007**

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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Thank you for your consideration of this serious matter.

Submitter : **Dr. Joseph Soderberg** **Date: 08/06/2007**

Organization : **Desert Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Centers for Medicare and Medicaid Services
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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.

Even with the increase of $4.00 per anesthesia unit, the payment to anesthesiologists is pathetic. Here in Las Vegas, plumbers, massage therapists, and many other low skilled positions make more money per hour than does an Anesthesiologist doing medicare cases. And what is the risk of giving a massage or putting in plumbing? Certainly it is not the posible death of the customer, as it is with Anesthesiology. Becoming an Anesthesiologist takes 12 years after High School, at the least, and a substatial amount of money. If we depended only on medicare cases, no one could possibly pay back student loans, and remain above the poverty level

And now with the further intrusion of Government into medicine, the federal government and state governments want to base their payment on medicare reimbursement. That would be the death nail in the coffin of Anesthesiology. Realistically, the reimbursement should be at $50.00 per unit.

Sincerely,

Joseph Soderberg M. D.

Submitter : **Mukesh Gupta** **Date: 08/06/2007**

Organization : **AMGR**

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 : **David Sawyer** **Date: 08/06/2007**

Organization : **Consultant Anesthesia Inc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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P.O. Box 8018
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Re: CMS-1385-P
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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. After many years and several studies have shown this to be true I am glad that this issue is finally being addressed.

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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Thank you for your consideration of this serious matter.

David Sawyer

Submitter : Dr. Jay Johansen **Date:** 08/06/2007

Organization : Emory University School of Medicine

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.

Submitter : **Dr. Brent Reich** **Date: 08/06/2007**

Organization : **Dr. Brent Reich**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Submitter : **Thomas Hanlon** **Date: 08/06/2007**

Organization : **Thomas Hanlon**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P

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 : Arun Bhandari **Date:** 08/06/2007

Organization : UPMC, Pittsburgh

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Thank you for your consideration of this serious matter.

Submitter : Dr. Kristen Kenyon **Date:** 08/06/2007

Organization : Dr. Kristen Kenyon

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I am in favor of increasing the Medicare payment to physicians. It is long overdue.

Submitter : **Vander Wynn** **Date: 08/06/2007**

Organization : **Vander Wynn**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

CMS-1385-P-5049

Submitter : Dr. Gary Ring **Date:** 08/06/2007

Organization : Amaerican Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support for the proposal to increase anesthesia payments under the 2008 Physician Fee Shedule.

Submitter : **Dr. Paul Sansone** **Date: 08/06/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Paul Sansone, M.D.

Submitter : **Dr. chad wagner** **Date: 08/06/2007**

Organization : **Vanderbilt**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Submitter : **Dr. William Stegall** **Date: 08/06/2007**

Organization : **Pinnacle Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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William C. Stegall M.D.

Submitter : **Dr. Mark Robinson** **Date: 08/06/2007**

Organization : **University of Arizona**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
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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.

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: 08/06/2007**

Organization : **Santa Rosa Memorial Hospital**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dr. Sir/Madam:
Re: Our support for grandfathering PTA's licensed by equivalency.

Thank you for the opportunity to comment on this proposed rule change. Our comments are directed towards the proposed grandfathering of physical therapist assistants who are licensed by equivalency prior to January 1, 2008.

We are completely in support of the proposed regulatory change outlined in Physician Fee Schedule dated July 12, 2007 that reference grandfathering Physical Therapist Assistants who are licensed by the state that they practice prior to January 1, 2008.

We wholeheartedly support this change as it is currently written, and furthermore ask that this change be put into effect as soon as possible instead of waiting until January 1, 2008 to implement.

We believe that this proposed change would bring the current rules regarding the qualifications of Physical Therapist Assistants to be more consistent with California licensure laws, would relieve hardships by employees, and would provide greater access to therapy services by patients in need of care.

California licenses Physical Therapist Assistants only if they are able to meet strict requirements regarding coursework/relevant work experience, and provided these applicants can pass the same examination that is required for applicants who have completed the APTA approved curriculum.

At Santa Rosa Memorial Hospital in Northern California (the Sonoma County Trauma Center) alone 7 out of the 17 licensed Physical Therapist Assistants have been impacted by the current rule, as well as 2 employees at St. Joseph Homecare. These employees have faced changing work locations/schedules, and most have chosen to go back to school to obtain the required coursework and in the case of homecare PTA's they have lost their jobs. All of these employees are highly skilled, and highly educated (all but 1 have Bachelors Degrees) and have demonstrated high level of competency in performing their jobs exceptionally well.

Thank you for allowing us to advocate for the implementation of the proposed rule regarding grandfathering Physical Therapist Assistants at the earliest possible date.

Thank you for this opportunity to advocate for these incredible PTA's.
Signed, the Rehabilitation Staff at Santa Rosa Memorial Hospital
Submitted on their behalf by Chris Ryan, Manager.

Submitter : Dr. William DeVore **Date:** 08/06/2007

Organization : Foothills Anesthesia Consulants

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. John Chatelain** **Date: 08/06/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

Background

Background

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.

John C. Chatelain, MD

Submitter : Mr. Jerry Parr **Date:** 08/06/2007

Organization : Mr. Jerry Parr

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,
I am most concerned with access to quality anesthesia providers in my area. Michigan is having a difficult time with its economy. Any consideration for the ongoing inequity in payment for anesthesia services, compared to all other medical specialities, will not only correct the long standing inequity, but also help to secure the access to quality anesthesia services in my state.
thank you,
Jerry Parr

Submitter : Dr. James Turner **Date:** 08/06/2007

Organization : Dr. James Turner

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Aug 6,2007. Dear Lesle V Norwal, Esq. Regarding CMS-1385-P provision for rectifying the gross undervaluation of anesthesiologist services to medicare patients. We strongly support the increase. Comming from an area with significant Medicare patient load, it is difficult to recrute personel to work with the poor reimbursement, and cost shifting is not an option. This is badly needed and long overdue. James Turner MD

Submitter : Dr. Daniel Redford **Date:** 08/06/2007

Organization : University of Arizona

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The anesthesia reimbursment for medicare is not at a finacial reimbursement level that allows a physician to adequately take care of our older growing population. This increase must happen for their sake.

Then add the teaching rule in an academic center where the reinbursement is cut by another 50% and no one can afford to train our next generation of Doctors.

CMS-1385-P-5059-Attach-1.DOC

#5059

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. Shahla Bolbolan** **Date: 08/06/2007**

Organization : **ACAMG**

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 Stangl **Date:** 08/06/2007

Organization : Pacific Anesthesia, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

August 6, 2007

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

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

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Thank you for your consideration of this serious matter.

Sincerely yours,

James Stangl, M.D.
Pacific Anesthesia, P.C.

CMS-1385-P-5061-Attach-1.DOC

#5061

August 6, 2007

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

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

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Thank you for your consideration of this serious matter.

Sincerely yours,

James Stangl, M.D.
Pacific Anesthesia, P.C.

Submitter : Dr. John Hill **Date:** 08/06/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Sincerely,

John W. Hill, MD

Submitter : **Dr. Cynthia Monsey** **Date: 08/06/2007**

Organization : **ASA**

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

Rc: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

C Monsey M.D., Ph.D.

Submitter : Tawnya Tretschok **Date:** 08/06/2007

Organization : University Physicians Health Care

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule (RE: CMS-1385-P). As an academic anesthesiology administrator I see the impact of the current Medicare per unit rate of $16.19 every day. This rate is further reduced in the academic environment when the "Teaching Rule" is applied, resulting in an additional 50% reduction in payment.

I am pleased that the Agency accepted the RUC recommendation and I support full implementation of that recommendation.

If anesthesiologists are to continue to provide anesthesia care in academic centers for our senior population, as well as to provide excellence in teaching and research, it is imperative that CMS move forward on this action.

Thank you for your consideration of this serious matter.

Submitter : Dr. Elizabeth Nicholas **Date:** 08/06/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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Thank you for your consideration of this serious matter.

Sincerely yours,
Elizabeth J. Nicholas, M.D.

Submitter : **Dr. Elizabeth Nicholas** **Date: 08/06/2007**

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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Thank you for your consideration of this serious matter.

Sincerely yours,
Elizabeth J. Nicholas, M.D.

Submitter : Ms. Alice Huss **Date:** 08/06/2007

Organization : Partners In Therapy

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment: Stop proposed 9.9% reduction to 2008 Medicare fee schedule

#3067

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

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

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

Submitter : **Dr. Lynnus Peng** **Date: 08/06/2007**

Organization : **St Jude 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)

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Thank you for your consideration of this serious matter.

Lynnus Peng,MD
www.AnesthesiaRisk.net

Submitter : **Dr. Joseph Thibodeau** **Date: 08/06/2007**

Organization : **Nebraska Heart Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear CMS,

As a young cardiologist just starting my career, I remain impressed with the amount and quality of information one can obtain through the detailed acquisition and analysis of echocardiographic images. Excellence at both steps of this process are essential for the level care we expect to receive in this nation. A proposed bundling of color flow Doppler into the standard charge for an echo belittles the efforts of both the sonographer and the interpreting physician. Obtaining color flow images are not necessary for an echocardiographic exam, but when needed and used appropriately they are indispensible. The skill set required to acquire and interpret color Doppler images are held dear by all those who spent years mastering their skills through careful private study. The goal of such a skill is to make the correct diagnosis at the correct moment. Please recognize the unique nature of color Doppler, the skill it takes to acquire these images, the knowledge it takes to interpret these images, and refrain from bundling this code with standard 2D echocardiography.

Sincerely,

Joseph B. Thibodeau, MD
Cardiologist
Nebraska Heart Institute
4239 Farnam, Suite 100
Omaha, NE 68131

Submitter : Dr. Angel Gomez **Date:** 08/06/2007

Organization : St. Joseph Mercy Livingston Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Arthur Duncan** **Date: 08/06/2007**

Organization : **Southern Indiana Anesthesia Consultants, PLLC**

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. Denise McMillan** **Date: 08/06/2007**

Organization : **Dr. Denise McMillan**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment/Users/wademcmillan/Desktop/commentlettertemplate.doc

CMS-1385-P-5072-Attach-1.PDF

CMS-1385-P-5072-Attach-2.DOC

#5072

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. Bharat Patel** **Date: 08/06/2007**

Organization : **Dr. Bharat Patel**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Bharat Patel, MD

Submitter : Dr. Brian Gross **Date:** 08/06/2007

Organization : The Heart Clinic of So. Oregon and No. California

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CODING ADDITIONAL CODES FROM 5-YEAR REVIEW. The federal register citation is 72 Federal Register 38122 (July 12, 2007). Letter concerning Bundling of Color Flow Doppler is attached.

CMS-1385-P-5074-Attach-1.DOC

5074

heartclinic

SOUTHERN OREGON
NORTHERN CALIFORNIA, P.C.
520 Medical Center Drive #200, Medford, OR 97504
541-282-6600 (phone) 877-261-8072 (toll free)
541-282-6601 (fax) heart@the-heartclinic.com

Brian W. Gross, MD, FACC
Stephen J. Schnugg, MD, FACC
Mark M. Huth, MD, PhD, FACC
Bruce L. Patterson, MD, FACC
Kent W. Dauterman, MD, FACC
Eric A. Pena, MD, FACC
Jon R. Brower, MD
Thomas Norby, MS, FNP

August 6, 2007

HEADING: Additional Codes from 5-year Review with a Federal Register Citation 72, Federal Register 38122 (July 12, 2007)

To Whom It May Concern:

I am a cardiologist who relies heavily on cardiac Doppler and specifically color-flow Doppler in helping me make quality decisions regarding choices of therapies and prognosis for my patients.

The ability to accurately and effectively read echocardiograms requires a strong background in cardiac physiology, pathology and disease management. It relies heavily on utilizing the information from color-flow Doppler machines, along with the other intrinsic Doppler and 2-dimensional imaging features. This is an expensive technology that requires constant updating and a suggestion that it is trivial and could easily be bundled to save money is a shortsighted and not terribly respectful view of what we learn from the study and offer to our patients for quality care.

I respectfully request that Center for Medicare Services not consider bundling color-flow Doppler into other echo-based codes.

Sincerely,

BRIAN W. GROSS, MD, FACC
BWG/kmm

Submitter : **Dr. Marc Gianzero** **Date: 08/06/2007**

Organization : **Dr. Marc Gianzero**

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.
Marc Gianzero, M.D.

Submitter : **Dr. Sarah Barksdale** **Date: 08/06/2007**

Organization : **Sarah Barksdale, MD, PA**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007

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

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

Sarah Barksdale, MD

Submitter : **Dr. Bharat Patel** **Date: 08/06/2007**

Organization : **HealthCare Partners**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am extremely pleased that CMS is considering an increase in the anesthesia conversion factor for 2008 by $3.30 per unit.

Repeated yearly reductions in reimbursement have now reached a level, which in many cases, is below that of Medicaid. Coupled with an ever increasing Medicare population, a situation has been created that makes it more and more difficult to retain and recruit anesthesiologist. The enactment of CMS-1385-P would do a great deal in alleviating the situation.

Please consider this message an indication of my wholehearted support for your consideration of CMS-1385-P.

Bharat Patel, MD

Submitter : Dr. Thomas Ryan **Date:** 08/06/2007

Organization : American Society of Echocardiography

Category : Health Care Professional or Association

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

See attached letter with three attachments. Entire package also sent via Federal Express.

CMS-1385-P-5078-Attach-1.DOC

CMS-1385-P-5078-Attach-2.DOC

#2078

American Society of Echocardiography

August 6, 2007

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

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:

On behalf of the American Society of Echocardiography (ASE), I am writing to comment on the proposed changes in the Physician Fee Schedule (PFS) for CY 2008, published in the July 12, 2007 *Federal Register* (the "CY 2008 PFS Proposed Rule").

The ASE strenuously objects to CMS's proposal to "bundle" Medicare payment for color Doppler (CPT Code 93325) into all echocardiography ("echo") "base" services, effective January 1, 2008. This proposal:

- Is inconsistent with the approach to the "bundling" of color Doppler taken by the Relative Value Update Committee (RUC) – an approach that was taken at the urging of CMS;

- Is based on the faulty assumption that color Doppler is "intrinsic" to the performance of all echo services – an assumption that CMS has made despite ASE's prior transmittal of an analysis of Medicare claims that demonstrates that this assertion is incorrect; and

- Ignores the very real physician work and intra-service practice expenses associated with color Doppler – neither of which are reflected in any echo "base" services.

I. Background

A. Background: The Clinical Utility of Color Doppler

Color Doppler is performed in conjunction with one of the echo "base" imaging codes (transthoracic (TTE), transesophageal, congenital, fetal, or stress) to identify and quantify the severity of valvular malfunction, congenital lesions, myocardial dysfunction and other structural abnormalities. It is used to evaluate hemodynamic status, to select therapy, and to follow the results of treatment. Interpretation of the findings requires a systematic analysis of the color Doppler images, quantitation and integration of the data, and incorporation of this information into the echocardiographic report.

Careful review of color Doppler information is essential for decision making and patient management in a variety of clinical situations. This modality is typically the primary diagnostic technique used in determining optimum therapy for many conditions. For example, color Doppler provides quantitative diagnostic information on the severity of valve regurgitation and, therefore, is essential to identify patients with mitral or aortic regurgitation (in whom murmurs are not always audible and may be unimpressive) to optimize their treatment, and especially to identify those who are candidates for surgical repair.

In similar fashion, color Doppler is necessary for evaluating patients with more common clinical conditions, such as heart failure and acute myocardial infarction, to assess valvular, myocardial and hemodynamic status quantitatively. Color Doppler information is critical to the decision-making process in determining appropriate treatment and following up on the results of treatment. For example in these patients it is used to select patients for medical management versus surgical repair/replacement of valves and is used to assess myocardial synchrony to determine who does and does not need cardiac resynchronization therapy for heart failure.

B. Background: Valuation and "Bundling" of Color Doppler

CMS initially requested inclusion of CPT code 93325 in the five-year review because this service had not been subject to RUC review previously. Accordingly, in 2005 the ACC conducted a survey of the physician work associated with this code in accordance with established RUC survey procedures. Instead of considering the survey results, and based primarily on the fact that the number of claims for color Doppler approximated the number of claims for TTE, the RUC requested ACC to consider submitting a CPT code request that "bundled" color Doppler (but not spectral Doppler) into CPT code 93307.

Shortly thereafter, the ACC and ASE attempted to engage CMS in a dialogue on the issue, and sent an in-depth analysis to CMS setting forth numerous reasons to maintain current coding for color Doppler (the "2005 Position Paper") (Attachment A), including an independent consultant's study detailing the distribution of color Doppler services across echo base codes (the

"2005 Direct Research Analysis) [1] CMS did not respond until March 2, 2006, shortly before the Editorial Panel meeting.. At that time, CMS indicated in e-mail correspondence that: ***"If we decide to review this code {93325}, it will be as part of our usual rule-making process."*** (Emphasis added.) However, CMS did not convey to the CPT Editorial Panel any plan to handle the color Doppler issue in the context of the 2007 PFS, and the Editorial Panel referred the color Doppler back to the RUC "for valuation."

Prior to the next RUC meeting, attempts were made to confirm with the RUC and with CMS that the meeting would address color Doppler valuation – not bundling – and oral assurances were received from RUC sources. Despite these assurances, the RUC meeting once again focused on "bundling" of color Doppler. Subsequently, at the urging of the RUC and CMS, ACC submitted a request for a NEW CPT code for TTEs performed with **both** color and spectral Doppler (i.e., the combination of CPT codes 93307, 93325, and 93320). RUC staff confirmed in writing that this approach was consistent with the RUC's directive. The code request was approved by the Editorial Panel on June 7-10, 2007 and is scheduled for valuation by the RUC at its upcoming September meeting.

II. Comments

A. CMS's Color Doppler Proposal Is Inconsistent with the RUC Process

As discussed above, the RUC, with the full participation of CMS and based in part on what was understood as CMS's position, has already approved a new comprehensive transthoracic CPT code that bundles color Doppler (along with spectral Doppler) into a new CPT code for TTE (933xx). The new CPT code, which is slated for valuation by the RUC in September, 2007 and for implementation in 2009, addresses both spectral and color Doppler, and bundles Doppler services only with TTEs currently reported using CPT code 93307 – since 93% of color Doppler and 94% of spectral Doppler services are performed in conjunction with this base code. An estimated 400,000 Medicare claims (based on the 2005 Direct Research Report) and a substantial number of spectral Doppler services performed in conjunction with other echo "base" procedures remain separately reportable and separately payable. By contrast, CMS's proposal (a) bundles color Doppler with **all** echo base codes; and (b) does not address spectral Doppler.

It is unclear to us why CMS modified its view on this issue at this late date. However, we respectfully urge CMS to refrain from pre-empting all of the time and effort put into this matter by affected professional groups, the RUC, and the Editorial Panel by now adopting a completely different bundling policy which (as discussed below) does not reflect clinical practice insofar as it "bundles" color Doppler into "base" echo services with which color Doppler is not routinely performed.

[1] As discussed below, the 2005 Direct Research is analysis, which was also provided to the CPT Editorial Panel and the RUC (both of which include CMS representation), demonstrates that color Doppler is not an "intrinsic part" of all echo base codes.

B. Color Doppler Is Not "Intrinsic" to the Performance of **all** Echo "Base" Codes

Contrary to CMS's assumption (and as supported by the 2005 Direct Research Analysis), color Doppler is not "intrinsic" to the performance of all echo base services. In fact, the 2005 Direct Research Analysis that accompanied the 2005 Position Statement – which was provided previously to the RUC and Editorial Panel (including CMS) – demonstrates that the only echo "base" code with which color Doppler is billed more than 57% of the time (other than CPT code 93307) is the code for congenital echo (CPT 93303), which generally is not performed for Medicare beneficiaries. More recent data (Attachment C) drawn from the 5% Physician/Supplier Standard Analytic File for 2005 and analyzed by Direct Research (the 2007 Direct Research Report) confirms that this pattern has remained essentially unchanged: Of the 13 echo "base" codes, seven include color Doppler less than 50% of the time. Thus, CMS's own data demonstrate that the performance of color Doppler is not, in fact, "intrinsic" to all echocardiography services.

C. CMS's Color Doppler Proposal Ignores the Physician Work and Practice Expenses Involved in Color Doppler

CMS's proposal to "bundle" (and thereby eliminate payment for) color Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of color Doppler studies. Thus the proposal ignores RUC valuations that were previously accepted, without providing any explanation.

Preliminarily, please note that, as the result of CMS's recent modifications of its Practice Expense Relative Value Unit (PE-RVU) methodology, Medicare payment for color Doppler is already slated to decline by **over 60%.** Therefore, if CMS's interest in bundling color Doppler arises from the unstated assumption that this service is overpriced, significant reductions are already scheduled to occur.

Regardless of the value assigned to color Doppler, providing this service unquestionably does involve real work. While the current work-RVUs associated with color Doppler are minimal, the physician work is real – and growing. (Currently, .07 work RVUs are assigned to this service, which equates to approximately $2.66, assuming the current conversion factor.) The ASE's Guideline entitled, "Recommendations for Evaluation of the Severity of Native Valvular Regurgitation with Two-dimensional and Doppler echocardiography," (www.asecho.org/freepdf/vavularregurg.pdf) details the physician work involved in color Doppler for the assessment of valvular disease:

> This technique [color Doppler] provides visualization of the origin of the regurgitation jet and its width (vena contracta), the spatial orientation of the regurgitant jet area in the receiving chamber and, in cases of significant regurgitation, flow convergence into the regurgitant orifice. The size of the regurgitation jet by color Doppler and its temporal resolution however, are

> significantly affected by transducer frequency and instrument settings such as gain, output power, Nyquist limit, size and depth of the image sector. Thus, full knowledge by the sonographer and interpreting echocardiographer of these issues is necessary for optimal image acquisition and accuracy of interpretation.

This document requires the interpreting physician to perform a number of measurements. Yet, CMS's proposal ignores the physician work involved, assuming (without basis or explanation) that the additional value of this work is 0.

Likewise, CMS's proposal utterly ignores the practice expenses involved in performing color Doppler studies. It appears that CMS believes that because echo equipment now universally incorporates color Doppler capability, and because color Doppler is often performed concurrently with the imaging and spectral Doppler components of echo studies, there are no practice expenses involved. In fact, however, the provision of color Doppler adds sonographer and equipment time to the study, both of which are recognized under CMS's PE methodology.

More specifically, the practice expenses recognized by the PEAC when this code was valued set forth in detail the resources required, and establish quite clearly that there was no "double counting" of the color Doppler and the base code practice expenses. Attachment E. To the contrary, the **total** practice expenses involved in color Doppler (CPT code 93325), spectral Doppler (CPT 93320) and transthoracic echo (CPT 93307) were valued **together,** in reference to two other ultrasound codes – Duplex scan of extracranial arteries; complete bilateral study (CPT 93880) and Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study (CPT 93975). The presenter argued, and the PEAC agreed, that the total clinical labor time involved in the provision of 93307, 93325, and 93320 (93 minutes), considered together, was greater than the clinical labor time for a duplex scan (82 minutes) and less than the clinical labor time for an abdominal arterial and venous study (108 minutes). Of the total combined 93 minutes of clinical labor time, 13 minutes was accorded to color Doppler (11 minutes of intraservice time was approved for data acquisition, and two minutes for processing, analyzing, and recording the results). Because color Doppler is always performed in the same session as an echo "base" code, no pre- or post service time was requested by the presenter or approved by the PEAC: To avoid double counting, all pre and post-service time – which should be allowed only once for the entire session – was associated with the "base" code.

The direct practice expense data published on the CMS website appears to reflect only 11 (rather than 13) minutes of staff time, and presumably direct expenses for the necessary echo equipment were estimated on the basis of staff time. There are no supply costs associated with color Doppler.

The sonographer time and skill involved in providing color Doppler is not insubstantial. The protocol for data acquisition for color Doppler requires the cardiac sonographer to perform numerous tasks and obtain a number of measurements, as reflected in the ASE standard entitled,

"Recommendations for Quantification of Doppler Echocardiography" at www.asecho.org/freepdf/RecommendationsforQuantificationofDopplerEcho.pdf , as well as in the vavular regurgitation standard at www.asecho.org/freepdf/vavularregurg.pdf). Thus, allocating 11 minutes of time for the cardiac sonographer to acquire, process, and record the preliminary results of a color Doppler study is, if anything, conservative. CMS's proposal to pay nothing for the cardiac sonographer's time, the equipment time, and associated overhead is entirely unsupportable. In fact, if CMS's proposal were adopted, the practice expenses involved in the performance of a complete TTE examination, including spectral and color Doppler services, would be less than the practice expenses involved in performing a duplex study, which clearly was not the intent of the PEAC.[2]

Moreover, the Hospital Outpatient Prospective Payment System (HOPPS) Proposed Rule for CY 2008 includes an entirely different proposal for "bundling" color Doppler into echo base codes. Under this proposal, the practice expenses associated with **both color and spectral** Doppler are bundled: However, the Ambulatory Payment Classification (APC) rates of the associated "base" echo services are increased to account for the additional costs. While we have not yet fully analyzed the HOPPS color Doppler "bundling" proposal and we clearly disagree with the "bundling" rationale used in the HOPPS Proposed Rule for both spectral and color Doppler, the HOPPS "bundling" proposal at least does recognize the very real resources involved in the provision of color Doppler.

III. Our Request.

At this stage, the cardiology community is faced with no fewer than three proposals for "bundling" color Doppler into base echo codes:

- **Proposed PFS Approach**. This approach singles out *color Doppler* and "bundles" it into all echo codes, *without providing additional payment* on the grounds that color Doppler is an "inherent" part of echo. We disagree strongly with this approach and the underlying rationale.

- **Proposed HOPPS Approach**. This approach bundles Medicare payment for numerous add-on codes and other "ancillary support" services into the APC payment amounts for the associated principal procedures, and *increases APC rates* applicable to principal procedures proportionately. Under this proposal, *both spectral and Doppler* are bundled into all echo base codes, the former on the grounds that it is an "intra-operative procedure" and the latter on the grounds that it is an "image processing" service. In point of fact, neither of these rationales reflects an accurate understanding of cardiac Doppler services

[2] In fact, if this proposal is adopted, we believe that it would be appropriate to re-value the practice expenses accorded to both the carotid duplex and the AAA reference codes.

- **RUC Approach**. The RUC approach (taken with the apparent concurrence of CMS) would create a *new code* for the commonly performed combination of (resting) TTE (93307) with *color Doppler and spectral Doppler*, without bundling either spectral or color Doppler into any other echo base code. *Recommended valuation under the PFS would be provided by the RUC*, and payment under HOPPS for the new code would be determined in the interim final HOPPS rule for CY 2009.

Under these circumstances, we cannot help but conclude that CMS's approach to "bundling" of echo and other services is in need of additional study and coordination. **For this reason, we request a meeting that includes not only CMS personnel with authority over the CY 2008 PFS Proposed Rule but also those with authority over the CY 2008 HOPPS Proposed Rule, as soon as practicable.**

We appreciate the opportunity to comment on this proposal, and look forward to meeting with you to discuss the possibility of a more unified and well-reasoned approach to this issue.

Sincerely yours,

/s/ *Thomas Ryan, MD/by DSM*

Thomas Ryan, MD
President
ASE

Summary of Accreditation Provisions in Section 309 of H.R.

September 21, 2005

Via E-mail and U.S. Mail

Kenneth Simon, MD
Mail Stop 04-01-26
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Dr. Simon:

As Presidents of the American College of Cardiology (ACC) and the American Society of Echocardiography (ASE), we are writing to you to follow up on recent discussions regarding the potential modification of the CPT codes for echocardiography services, which were discussed during the August 25th Five Year Review meeting of RUC Workgroup 4. As you will recall, some Workgroup members suggested bundling the CPT code for color flow Doppler (CPT code 93325) into the CPT code for transthoracic echocardiography (CPT code 93307).

We understand that this suggestion was based on the observation that the RUC data base for 2003 reflected nearly equal numbers of CPT 93307 and CPT 93325 services and the subsequent conclusion that color Doppler was "always used with transthoracic echocardiographic imaging (CPT code 93307)." It was also observed that the echocardiography family of codes includes separate codes for color Doppler and spectral Doppler, while these services are bundled with the imaging component of extracranial vascular ultrasound services.

Both ACC and ASE strongly believe that the current CPT code for color flow Doppler services should not be bundled into CPT code 93307. Moreover, we do not believe that any other CPT changes are needed for the echocardiography code "family." The current echocardiography procedure nomenclature and codes are longstanding and have attained widespread acceptance among both payers and the physician community. This "building block" nomenclature enables physicians to describe precisely what services have been performed and enables payers to provide payment only for those services that actually were provided—no more, no less. The history and use of these codes are different from that of vascular ultrasound and general ultrasound services, and each set of codes serves the unique needs of those physicians who use them for accurate and consistent reporting.

I. The "Building Block" Approach to Flexible and Accurate Reporting

Echocardiography codes, like the codes for many other kinds of physicians' services, are characterized by a "building block" approach that enables the physician to bill for precisely those services that are provided. In the case of the echocardiography code "family," there are a number of "base" codes and three primary "add-on" codes—two for spectral Doppler (CPT Code 93320 (complete) and 93321 (limited)) and one for color flow Doppler (CPT Code 93325).

The descriptor for CPT code 93325 explicitly recognizes that this service is performed in conjunction with many different echocardiography imaging procedures. Specifically, the CPT description explicitly indicates that CPT code 93325 may be used in conjunction with any of the following "base" codes:

CPT code 76825—fetal echocardiographic imaging, complete study
CPT code 76826—fetal echocardiographic imaging, followup study
CPT code 93303—transthoracic echo imaging, complete, congenital heart disease
CPT code 93304—transthoracic echo imaging, limited, congenital heart disease
CPT code 93307—transthoracic echo imaging, complete, adult (aquired heart disease)
CPT code 93308---transthoracic echo imaging, limited, adult (acquired heart disease)
CPT code 93312—transesophageal echo imaging, (complete)
CPT code 93314—transesophageal echo imaging, image acquisition and reporting only
CPT code 93315—transesophageal echo imaging for congenital abnormalities,(complete)
CPT code 93317—transesophageal echo image acquisition and reporting, congenital
CPT code 93350—stress echo imaging

In addition, color flow Doppler CPT 93325) may be billed either with or without spectral Doppler for both fetal (CPT codes 76827 and 76828) and adult applications (CPT codes 93320 and 93321). Either complete or limited spectral Doppler applications may be appropriate depending on the clinical issues being addressed.

This building block approach enables physicians to bill accurately for all the services—and only those services—that are actually provided. Using the building block approach, physicians are able to bill for nearly 70 different combinations and permutations of various echocardiography services, as necessary to accurately describe their services.

Not surprisingly, the "building block" approach to ultrasound coding appears to be the rule, rather than the exception. The CPT section relating to Diagnostic Ultrasound indicates that Doppler evaluation of vascular structures is separately reportable and directs users to report using CPT codes 93875-93990.[1] In addition, the codes available to report obstetrical ultrasound parallel those available to report cardiac ultrasound: CPT code 76815 is used to report general fetal ultrasound imaging, while CPT codes 76820 and 76821 can be used in addition (when appropriate clinically) to report Doppler velocimetry of the umbilical and middle cerebral arteries, respectively. While these services are not generally provided to Medicare patients, the "building block" approach to coding is identical.

II. The Current "Building Block" Approach to Billing for Echocardiography and Other Ultrasound Services Should Be Retained.

We strongly believe that the current "building block" approach to echocardiography and other ultrasound service billing should be retained for a number of reasons:

1. We note that the CPT Editorial Panel considered and rejected the idea of "bundling" the echocardiography "add-on" codes into the echocardiography "base imaging" codes at least twice over the

[1] While color flow "used only for anatomic structure identification" does not appear to be separately reportable, we note that color flow Doppler used in conjunction with echocardiography is typically used not for "structure identification", but rather for identification of pathologic cardiac function (such as intracardiac shunting and valvular regurgitation), and for quantitation of the severity of these lesions.

past ten years—once in 1994 and once in 1996.[2] On both occasions, CMS decided not to "bundle" the echocardiography add-on codes into the base codes. Since practice patterns with respect to the use of the add-on codes do not appear to have changed substantially since the mid-1990's, it would be inappropriate for the RUC to recommend now that the CPT Editorial Panel again revisit the issue.

2. There are sound reasons why the vascular ultrasound codes include color and spectral Doppler while the echocardiography "base" codes do not. Historically, each set of codes was developed in a different manner to meet different clinical needs. Although the first clinical applications of color Doppler were described in congenital heart disease in 1978, soon thereafter the first commercial color Doppler instrument was produced for use with carotid ultrasound. This technology complemented early work by Strandness and colleagues using alterations of spectral Doppler waveforms as a marker of arterial stenosis severity. Rapidly, two dimensional imaging of the carotid arteries was combined with color Doppler imaging to localize regions of turbulence, and spectral Doppler to quantitate changes in flow velocity and turbulence in order to determine lesion severity. Hence, all three modalities (structure imaging, color Doppler flow localization, and spectral Doppler velocimetry) were "married" early on in what became termed "duplex" technology, with each modality serving a distinct clinical role in the diagnostic regimen. It was sensible to construct codes that bundled all three of these modalities since that is how they were used.

By contrast, cardiac ultrasound evolved in a different manner. Two-dimensional imaging became rapidly used for demonstrating cardiac structure and dynamics in the mid-1970's. Spectral Doppler was initially used for evaluating stenotic valve lesions in the late 1970's and early 1980's; additional uses of spectral Doppler for determining volume flow rate, for evaluating valvular regurgitation, and for assessing diastolic function were developed later on and incorporated gradually into clinical practice. Color Doppler flow imaging became commercially available in the mid-1980's, and new applications have continued to evolve over the last 20 years. Construction of a "building block" coding system was logical and practical since it allowed the clinician to describe accurately and precisely those services that he/she needed to use to answer the clinical question(s).

3. In fact, the coding nomenclature differs for vascular, cardiac, ophthalmic, gynecological and other ultrasound applications, and the codes for each have been developed based on the clinical needs of the various specialties involved. In the case of general ultrasound, there are separate codes based primarily on the anatomical site that is examined (e.g. separate codes for abdominal ultrasound (CPT codes 76700-76705), ultrasound of the bladder (CPT codes 51798), ultrasound of the colon (CPT codes 45391-45392 and 45341-45342), etc.) In the case of vascular ultrasound, separate codes have been developed based on whether the study is extracranial (CPT codes 93880-93882) or intracranial (CPT code 93886-93893); bilateral or unilateral (CPT code 93880 vs. 93882), and contrast- enhanced or unenhanced (CPT codes 93892-93893). Ophthalmic ultrasound (CPT codes 76506-76536) is based on whether an A-scan or B-scan is provided; whether the scan is performed to localize a foreign body or to determine intraocular lens power, whether the corneal or anterior segment is examined, and other factors. Cardiac ultrasound coding is similarly tailored to clinical needs. In view of the robust nature of cardiac

[2]On April 19, 1996, the then-President of the ASE, Dr. Alan Pearlman, wrote to Drs. Grant V. Rodkey (Chair, RUC) and T. Reginald Harris (Chair, CPT Editorial Panel) arguing against a proposal to bundle the echocardiography add-on codes into the base codes. An April 17, 1996 letter from Dr. James Blankenship (Chair, ACC Coding and Nomenclature Committee) to Dr. Harris also offers ACC's recommendation against bundling, as does another letter of the same date from Dr. Anthony DeMaria writing as chair of the ACC's Economics of Health Care Delivery Committee.

ultrasound, with evidence-based utility in virtually every different form of heart disease[3]. An echocardiography coding system that included a separate code for each structure examined or for each clinical entity of concern would be highly unwieldy at best. Thus, echocardiography coding is based primarily on which techniques are needed to address the clinical concerns.

4. The "building block" approach remains extremely useful in light of the breadth of echocardiography applications. For example, consider the use of add-on codes in conjunction with stress echocardiography (CPT 93350). This service would be provided alone to assess a patient with symptoms of exertional chest pain if coronary artery disease were suspected. However if the patient also had a systolic murmur or if a thickened and immobile aortic valve were noted on echocardiographic imaging prior to the stress test, then spectral Doppler (93320) would be mandatory to evaluate the severity of aortic stenosis, and color Doppler flow imaging (93325) would be necessary to help assess for and determine the severity of associated aortic and mitral regurgitation. As another example, consider a patient with shortness of breath and a systolic heart murmur sent by his primary care provider to determine the cause and significance of the murmur and the cause of dyspnea. If mitral valve redundancy and obvious prolapse were evident on 2-dimensional echo imaging (CPT 93307), then the use of spectral Doppler (CPT 93320) and color Doppler flow imaging (CPT 93325) would be mandatory in order to determine the severity of mitral regurgitation and to document the presence and degree of pulmonary hypertension. On the other hand, if the echocardiographic imaging study demonstrated a large pericardial effusion with right heart chamber compression (as a cause for the patient's symptoms) with normal valve morphology and mobility, it might be more appropriate to do a limited spectral Doppler (93321) evaluation to help document the presence of tamponade and the need for pericardiocentesis; a complete spectral Doppler or a color Doppler flow imaging evaluation might not be necessary. We would be delighted to provide additional examples for other echocardiography "base" codes.

5. As a practical matter, CPT 93325 is often (although clearly not always) done with virtually every base imaging code in the echocardiography family. [4] Attachment A sets forth an analysis of data from the CY 2003 Medicare 5% Physician/Supplier Standard Analytic File, prepared by Chris Hogan of Direct Research (the "Hogan Analysis"). While most color flow Doppler services are provided in conjunction with two dimensional transthoracic echo (CPT code 93307), an estimated 388,230 color flow Doppler claims each year are provided in conjunction with other echocardiography services,[5] including fetal echo, transesophageal echo, congenital echo and stress echo. The proportion of claims for each of these types of echocardiography services that include color flow Doppler varies substantially. For example, the Hogan Analysis indicates that approximately 36% of stress echo claims include color flow Doppler, while approximately 80% of congenital echo (complete) claims include the color flow Doppler code. For many of the echocardiography imaging codes, the proportion of claims that include color flow Doppler hovers in the 50% range. Therefore, any effort to "bundle" color flow Doppler into the base codes and to provide payment on the basis of services provided to the "typical" patient would be extremely difficult and would necessarily result in less accurate payment for a substantial number of claims.

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[3] See Cheitlin MD, Armstrong WF, Aurigemma, GP, Beller GA, Bierman FZ, Davis JL, Douglas PS, Faxon DP, Gillam LD, Kimball TR, Kussmaul WG, Pearlman AS, Philbrick JT, Rakowski H, Thys,DM. ACC/AHA/ASE 2003 guideline update for the clinical application of echocardiography: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/ASE Committee to Update the 1997 Guidelines for the Clinical Application of Echocardiography). 2003. American College of Cardiology Web Site. Available at: www.acc.org/clinical/guidelines/echo/index.pdf.

[4] As the number of CPT 93307 services is quite large, it is not surprising that the majority of CPT 93325 services are performed in conjunction with CPT 93307 as the base imaging code

[5] The Hogan Analysis indicates that approximately 5.3% of the 336,255 color flow Doppler claims in the 5% file are provided in conjunction with CPT base codes other than CPT code 93307.

6. The Hogan Analysis makes it clear that bundling the color flow or spectral Doppler codes into the echocardiography base codes would not simplify billing. On the contrary, bundling would necessarily result in either (a) less accurate coding and billing, or (b) a considerably more complex coding and billing structure for echocardiography services. Color flow Doppler services not only are commonly billed with a wide range of echocardiography "base" codes, but also may be billed either with or without spectral Doppler. And, as illustrated above, either complete or limited spectral Doppler may be appropriate in different clinical circumstances. Therefore, if bundling were mandated, a series of "permutations" would be necessary to describe the range of clinical scenarios accurately. For example, to preserve accuracy in the face of "bundling", CPT code 93307, which is currently used to report the most common echocardiographic imaging procedure, would explode to include separate codes for:

*Transthoracic echo alone—CPT 93307.
*Transthoracic echo with spectral Doppler (complete)—CPT 93307 and CPT 93320.
*Transthoracic echo (complete) with spectral Doppler (limited)—CPT 93307 and CPT 93321
*Transthoracic echo with color flow Doppler—CPT code 93307 and 93325.
*Transthoracic echo with spectral Doppler (complete) and color flow —CPT 93307, 93320 and 93325
*Transthoracic echo (complete) with spectral Doppler (limited) and color flow -- CPT 93307, 93321 and 93325.

Similar multiple permutations also would be required for all of the other echocardiography imaging services—limited transthoracic, fetal, congenital transthoracic echo, transesophageal echo, congenital transesophageal echo, and stress echo. In order to bill with accuracy equivalent to what is now possible using the "building block" approach, the physician community would need nearly 70 different codes, rather than the 11 imaging and 5 "add on" codes that currently comprise the echocardiography code "family." This is certainly not a "coding simplification". Moreover, we note that changes to the CPT codes used to describe echocardiography services would also necessitate changes in the APC categories used to code and bill for these services in the Hospital Outpatient setting. Since for many base imaging codes, the use of spectral and color Doppler "add on" codes hovers around 50%, determining appropriate hospital charge data for new APC's would be extremely challenging.

7. The "building block" approach to ultrasound codes also facilitates efficient addition of new codes without requiring the revaluation of existing codes. For example, if and when new codes are developed for three dimensional echocardiography, these can be added to the echocardiography code "family" without requiring revaluation of any existing code. The same is true for other new technologies, such as tissue Doppler and Left Ventricular Synchrony. If the building block approach is abandoned and the codes combined, the addition of new codes to reflect advances in echocardiography will further complicate the echocardiography coding scheme and require frequent revaluation of existing codes. We note as well that a "building block" approach also has been used in many other sections of CPT precisely because it preserves flexibility and accuracy in describing combinations of specific services, without requiring users to employ "modifiers" for "reduced" or "prolonged" services, and because it reduces the need for manual review of claims.

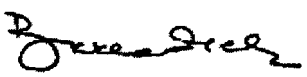
Summarizing, then, in light of ultrasound's broad utility in the diagnosis of various illnesses, it is neither surprising that there is considerable variation in the applicable coding conventions--nor is it clear that consistency in coding format ought to prevail over descriptive accuracy. Making all ultrasound CPT codes consistent would require a major undertaking involving a broad array of specialties and a substantial commitment of time and resources by both the CPT Editorial Panel and the RUC. This is especially true insofar as the use of building block codes for services such as Doppler appears to be the rule, rather than the exception in the CPT.

The physician work involved in all of the major echocardiography "base" codes have been valued by RUC, and almost all of the "high volume" echocardiography services have undergone review through the Five Year Review process. The practice expense inputs of all of the current echo codes have been reviewed by the PEAC. The various echocardiographic imaging, spectral Doppler, and color Doppler codes have been written and valued in a manner that avoids duplication of work and/or time, and so represent "independent" services the combination of which accurately reflects both physician work and practice expense. Both the Editorial Panel and the RUC already have expended considerable energy and resources in developing and valuing the current echocardiography and other ultrasound codes, and we do not think it makes sense to overhaul the current system (which is well understood, flexible enough to meet clinical needs, and allows users to describe exactly those services they have provided) in order to develop a new CPT coding system for cardiac ultrasound that likely would be either less accurate or substantially more complex than the current "building block" approach.

We appreciate your consideration of this issue, and urge you to contact Rebecca Kelly, Director of Regulatory Affairs for the American College of Cardiology (RKelly@acc.org) or Diane Millman, Washington Counsel for the American Society of Echocardiography (DMillman@ppsv.com) if you have any questions or concerns.

Sincerely yours,

Pamela S. Douglas, MD, FACC, President
American College of Cardiology



Bijoy Khandheria, MD, FASE, President
American Society of Echocardiography

Cc. Edith Hambrick, MD
Robert Zwolak, MD
James Blankenship, MD
Alan Pearlman, MD
Michael Picard, MD
Rebecca Kelly
Denise Garris
Diane Millman
Janice Brannon

Submitter : **Dr. Moira Larsen** **Date: 08/06/2007**

Organization : **Pathology Associates Laboratories, PC**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Baltimore, Maryland as part of a three member group serving both a hospital laboratory, free-standing surgery center and private physicians.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,
Moira P. Larsen, MD, MBA, FCAP

Submitter : Dr. Thomas Ryan **Date:** 08/06/2007

Organization : American Society of Echocardiography

Category : Health Care Professional or Association

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

See attached comment letter with 4 attachments. Document also submitted via Federal Express.

CMS-1385-P-5083-Attach-1.PDF

#5083

American Society of Echocardiography

1500 Sunday Drive, Suite 102 • Raleigh, North Carolina 27607 • (919) 861-5574 • Fax: (919) 787-4916
E-mail: ase@asecho.org • Web site: www.asecho.org

August 6, 2007

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

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:

On behalf of the American Society of Echocardiography (ASE), I am writing to comment on the proposed changes in the Physician Fee Schedule (PFS) for CY 2008, published in the July 12, 2007 *Federal Register* (the "CY 2008 PFS Proposed Rule").

The ASE strenuously objects to CMS's proposal to "bundle" Medicare payment for color Doppler (CPT Code 93325) into all echocardiography ("echo") "base" services, effective January 1, 2008. This proposal:

- Is inconsistent with the approach to the "bundling" of color Doppler taken by the Relative Value Update Committee (RUC) – an approach that was taken at the urging of CMS;
- Is based on the faulty assumption that color Doppler is "intrinsic" to the performance of all echo services – an assumption that CMS has made despite ASE's prior transmittal of an analysis of Medicare claims that demonstrates that this assertion is incorrect; and
- Ignores the very real physician work and intra-service practice expenses associated with color Doppler – neither of which are reflected in any echo "base" services.

I. Background

A. Background: The Clinical Utility of Color Doppler

Color Doppler is performed in conjunction with one of the echo "base" imaging codes (transthoracic (TTE), transesophageal, congenital, fetal, or stress) to identify and quantify the severity of valvular malfunction, congenital lesions, myocardial dysfunction and other structural abnormalities. It is used to evaluate hemodynamic status, to select therapy, and to follow the results of treatment. Interpretation of the findings requires a systematic analysis of the color Doppler images, quantitation and integration of the data, and incorporation of this information into the echocardiographic report.

Careful review of color Doppler information is essential for decision making and patient management in a variety of clinical situations. This modality is typically the primary diagnostic technique used in determining optimum therapy for many conditions. For example, color Doppler provides quantitative diagnostic information on the severity of valve regurgitation and, therefore, is essential to identify patients with mitral or aortic regurgitation (in whom murmurs are not always audible and may be unimpressive) to optimize their treatment, and especially to identify those who are candidates for surgical repair.

In similar fashion, color Doppler is necessary for evaluating patients with more common clinical conditions, such as heart failure and acute myocardial infarction, to assess valvular, myocardial and hemodynamic status quantitatively. Color Doppler information is critical to the decision-making process in determining appropriate treatment and following up on the results of treatment. For example in these patients it is used to select patients for medical management versus surgical repair/replacement of valves and is used to assess myocardial synchrony to determine who does and does not need cardiac resynchronization therapy for heart failure.

B. Background: Valuation and "Bundling" of Color Doppler

CMS initially requested inclusion of CPT code 93325 in the five-year review because this service had not been subject to RUC review previously. Accordingly, in 2005 the ACC conducted a survey of the physician work associated with this code in accordance with established RUC survey procedures. Instead of considering the survey results, and based primarily on the fact that the number of claims for color Doppler approximated the number of claims for TTE, the RUC requested ACC to consider submitting a CPT code request that "bundled" color Doppler (but not spectral Doppler) into CPT code 93307.

Shortly thereafter, the ACC and ASE attempted to engage CMS in a dialogue on the issue, and sent an in-depth analysis to CMS setting forth numerous reasons to maintain current coding for color Doppler (the "2005 Position Paper") (Attachment A), including an independent consultant's study detailing the distribution of color Doppler services across echo base codes (the

"2005 Direct Research Analysis)[1] CMS did not respond until March 2, 2006, shortly before the Editorial Panel meeting.. At that time, CMS indicated in e-mail correspondence that: ***"If we decide to review this code {93325}, it will be as part of our usual rule-making process."*** (Emphasis added.) However, CMS did not convey to the CPT Editorial Panel any plan to handle the color Doppler issue in the context of the 2007 PFS, and the Editorial Panel referred the color Doppler back to the RUC "for valuation."

Prior to the next RUC meeting, attempts were made to confirm with the RUC and with CMS that the meeting would address color Doppler valuation – not bundling – and oral assurances were received from RUC sources. Despite these assurances, the RUC meeting once again focused on "bundling" of color Doppler. Subsequently, at the urging of the RUC and CMS, ACC submitted a request for a NEW CPT code for TTEs performed with **both** color and spectral Doppler (i.e., the combination of CPT codes 93307, 93325, and 93320). RUC staff confirmed in writing that this approach was consistent with the RUC's directive. The code request was approved by the Editorial Panel on June 7-10, 2007 and is scheduled for valuation by the RUC at its upcoming September meeting.

II. Comments

A. CMS's Color Doppler Proposal Is Inconsistent with the RUC Process

As discussed above, the RUC, with the full participation of CMS and based in part on what was understood as CMS's position, has already approved a new comprehensive transthoracic CPT code that bundles color Doppler (along with spectral Doppler) into a new CPT code for TTE (933xx). The new CPT code, which is slated for valuation by the RUC in September, 2007 and for implementation in 2009, addresses both spectral and color Doppler, and bundles Doppler services only with TTEs currently reported using CPT code 93307 – since 93% of color Doppler and 94% of spectral Doppler services are performed in conjunction with this base code. An estimated 400,000 Medicare claims (based on the 2005 Direct Research Report) and a substantial number of spectral Doppler services performed in conjunction with other echo "base" procedures remain separately reportable and separately payable. By contrast, CMS's proposal (a) bundles color Doppler with **all** echo base codes; and (b) does not address spectral Doppler.

It is unclear to us why CMS modified its view on this issue at this late date. However, we respectfully urge CMS to refrain from pre-empting all of the time and effort put into this matter by affected professional groups, the RUC, and the Editorial Panel by now adopting a completely different bundling policy which (as discussed below) does not reflect clinical practice insofar as it "bundles" color Doppler into "base" echo services with which color Doppler is not routinely performed.

[1] As discussed below, the 2005 Direct Research is analysis, which was also provided to the CPT Editorial Panel and the RUC (both of which include CMS representation), demonstrates that color Doppler is not an "intrinsic part" of all echo base codes.

B. Color Doppler Is Not "Intrinsic" to the Performance of **all** Echo "Base" Codes

Contrary to CMS's assumption (and as supported by the 2005 Direct Research Analysis), color Doppler is not "intrinsic" to the performance of all echo base services. In fact, the 2005 Direct Research Analysis that accompanied the 2005 Position Statement – which was provided previously to the RUC and Editorial Panel (including CMS) – demonstrates that the only echo "base" code with which color Doppler is billed more than 57% of the time (other than CPT code 93307) is the code for congenital echo (CPT 93303), which generally is not performed for Medicare beneficiaries. More recent data (Attachment C) drawn from the 5% Physician/Supplier Standard Analytic File for 2005 and analyzed by Direct Research (the 2007 Direct Research Report) confirms that this pattern has remained essentially unchanged: Of the 13 echo "base" codes, seven include color Doppler less than 50% of the time. Thus, CMS's own data demonstrate that the performance of color Doppler is not, in fact, "intrinsic" to all echocardiography services.

C. CMS's Color Doppler Proposal Ignores the Physician Work and Practice Expenses Involved in Color Doppler

CMS's proposal to "bundle" (and thereby eliminate payment for) color Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of color Doppler studies. Thus the proposal ignores RUC valuations that were previously accepted, without providing any explanation.

Preliminarily, please note that, as the result of CMS's recent modifications of its Practice Expense Relative Value Unit (PE-RVU) methodology, Medicare payment for color Doppler is already slated to decline by **over 60%.** Therefore, if CMS's interest in bundling color Doppler arises from the unstated assumption that this service is overpriced, significant reductions are already scheduled to occur.

Regardless of the value assigned to color Doppler, providing this service unquestionably does involve real work. While the current work-RVUs associated with color Doppler are minimal, the physician work is real – and growing. (Currently, .07 work RVUs are assigned to this service, which equates to approximately $2.66, assuming the current conversion factor.) The ASE's Guideline entitled, "Recommendations for Evaluation of the Severity of Native Valvular Regurgitation with Two-dimensional and Doppler echocardiography," (www.asecho.org/freepdf/vavularregurg.pdf) details the physician work involved in color Doppler for the assessment of valvular disease:

> This technique [color Doppler] provides visualization of the origin of the regurgitation jet and its width (vena contracta), the spatial orientation of the regurgitant jet area in the receiving chamber and, in cases of significant regurgitation, flow convergence into the regurgitant orifice. The size of the regurgitation jet by color Doppler and its temporal resolution however, are

> significantly affected by transducer frequency and instrument settings such as gain, output power, Nyquist limit, size and depth of the image sector. Thus, full knowledge by the sonographer and interpreting echocardiographer of these issues is necessary for optimal image acquisition and accuracy of interpretation.

This document requires the interpreting physician to perform a number of measurements. Yet, CMS's proposal ignores the physician work involved, assuming (without basis or explanation) that the additional value of this work is 0.

Likewise, CMS's proposal utterly ignores the practice expenses involved in performing color Doppler studies. It appears that CMS believes that because echo equipment now universally incorporates color Doppler capability, and because color Doppler is often performed concurrently with the imaging and spectral Doppler components of echo studies, there are no practice expenses involved. In fact, however, the provision of color Doppler adds sonographer and equipment time to the study, both of which are recognized under CMS's PE methodology.

More specifically, the practice expenses recognized by the PEAC when this code was valued set forth in detail the resources required, and establish quite clearly that there was no "double counting" of the color Doppler and the base code practice expenses. Attachment E. To the contrary, the **total** practice expenses involved in color Doppler (CPT code 93325), spectral Doppler (CPT 93320) and transthoracic echo (CPT 93307) were valued **together,** in reference to two other ultrasound codes - Duplex scan of extracranial arteries; complete bilateral study (CPT 93880) and Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study (CPT 93975). The presenter argued, and the PEAC agreed, that the total clinical labor time involved in the provision of 93307, 93325, and 93320 (93 minutes), considered together, was greater than the clinical labor time for a duplex scan (82 minutes) and less than the clinical labor time for an abdominal arterial and venous study (108 minutes). Of the total combined 93 minutes of clinical labor time, 13 minutes was accorded to color Doppler (11 minutes of intraservice time was approved for data acquisition, and two minutes for processing, analyzing, and recording the results). Because color Doppler is always performed in the same session as an echo "base" code, no pre- or post service time was requested by the presenter or approved by the PEAC: To avoid double counting, all pre and post-service time - which should be allowed only once for the entire session - was associated with the "base" code.

The direct practice expense data published on the CMS website appears to reflect only 11 (rather than 13) minutes of staff time, and presumably direct expenses for the necessary echo equipment were estimated on the basis of staff time. There are no supply costs associated with color Doppler.

The sonographer time and skill involved in providing color Doppler is not insubstantial. The protocol for data acquisition for color Doppler requires the cardiac sonographer to perform numerous tasks and obtain a number of measurements, as reflected in the ASE standard entitled,

"Recommendations for Quantification of Doppler Echocardiography" at www.asecho.org/freepdf/RecommendationsforQuantificationofDopplerEcho.pdf, as well as in the vavular regurgitation standard at www.asecho.org/freepdf/vavularregurg.pdf). Thus, allocating 11 minutes of time for the cardiac sonographer to acquire, process, and record the preliminary results of a color Doppler study is, if anything, conservative. CMS's proposal to pay nothing for the cardiac sonographer's time, the equipment time, and associated overhead is entirely unsupportable. In fact, if CMS's proposal were adopted, the practice expenses involved in the performance of a complete TTE examination, including spectral and color Doppler services, would be less than the practice expenses involved in performing a duplex study, which clearly was not the intent of the PEAC.[2]

Moreover, the Hospital Outpatient Prospective Payment System (HOPPS) Proposed Rule for CY 2008 includes an entirely different proposal for "bundling" color Doppler into echo base codes. Under this proposal, the practice expenses associated with **both color and spectral** Doppler are bundled: However, the Ambulatory Payment Classification (APC) rates of the associated "base" echo services are increased to account for the additional costs. While we have not yet fully analyzed the HOPPS color Doppler "bundling" proposal and we clearly disagree with the "bundling" rationale used in the HOPPS Proposed Rule for both spectral and color Doppler, the HOPPS "bundling" proposal at least does recognize the very real resources involved in the provision of color Doppler.

III. Our Request.

At this stage, the cardiology community is faced with no fewer than three proposals for "bundling" color Doppler into base echo codes:

- **Proposed PFS Approach**. This approach singles out *color Doppler* and "bundles" it into all echo codes, *without providing additional payment* on the grounds that color Doppler is an "inherent" part of echo. We disagree strongly with this approach and the underlying rationale.

- **Proposed HOPPS Approach**. This approach bundles Medicare payment for numerous add-on codes and other "ancillary support" services into the APC payment amounts for the associated principal procedures, and *increases APC rates* applicable to principal procedures proportionately. Under this proposal, *both spectral and Doppler* are bundled into all echo base codes, the former on the grounds that it is an "intra-operative procedure" and the latter on the grounds that it is an "image processing" service. In point of fact, neither of these rationales reflects an accurate understanding of cardiac Doppler services

[2] In fact, if this proposal is adopted, we believe that it would be appropriate to re-value the practice expenses accorded to both the carotid duplex and the AAA reference codes.

- **RUC Approach**. The RUC approach (taken with the apparent concurrence of CMS) would create a *new code* for the commonly performed combination of (resting) TTE (93307) with *color Doppler and spectral Doppler*, without bundling either spectral or color Doppler into any other echo base code. *Recommended valuation under the PFS would be provided by the RUC*, and payment under HOPPS for the new code would be determined in the interim final HOPPS rule for CY 2009.

Under these circumstances, we cannot help but conclude that CMS's approach to "bundling" of echo and other services is in need of additional study and coordination. **For this reason, we request a meeting that includes not only CMS personnel with authority over the CY 2008 PFS Proposed Rule but also those with authority over the CY 2008 HOPPS Proposed Rule, as soon as practicable.**

We appreciate the opportunity to comment on this proposal, and look forward to meeting with you to discuss the possibility of a more unified and well-reasoned approach to this issue.

Sincerely yours,

Thomas Ryan, MD

Thomas Ryan, MD
President
ASE

Summary of Accreditation Provisions in Section 309 of H.R.

American Society of Echocardiography

September 21, 2005

Via E-mail and U.S. Mail

Kenneth Simon, MD
Mail Stop 04-01-26
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Dr. Simon:

As Presidents of the American College of Cardiology (ACC) and the American Society of Echocardiography (ASE), we are writing to you to follow up on recent discussions regarding the potential modification of the CPT codes for echocardiography services, which were discussed during the August 25th Five Year Review meeting of RUC Workgroup 4. As you will recall, some Workgroup members suggested bundling the CPT code for color flow Doppler (CPT code 93325) into the CPT code for transthoracic echocardiography (CPT code 93307).

We understand that this suggestion was based on the observation that the RUC data base for 2003 reflected nearly equal numbers of CPT 93307 and CPT 93325 services and the subsequent conclusion that color Doppler was "always used with transthoracic echocardiographic imaging (CPT code 93307)." It was also observed that the echocardiography family of codes includes separate codes for color Doppler and spectral Doppler, while these services are bundled with the imaging component of extracranial vascular ultrasound services.

Both ACC and ASE strongly believe that the current CPT code for color flow Doppler services should not be bundled into CPT code 93307. Moreover, we do not believe that any other CPT changes are needed for the echocardiography code "family." The current echocardiography procedure nomenclature and codes are longstanding and have attained widespread acceptance among both payers and the physician community. This "building block" nomenclature enables physicians to describe precisely what services have been performed and enables payers to provide payment only for those services that actually were provided—no more, no less. The history and use of these codes are different from that of vascular ultrasound and general ultrasound services, and each set of codes serves the unique needs of those physicians who use them for accurate and consistent reporting.

I. The "Building Block" Approach to Flexible and Accurate Reporting

Echocardiography codes, like the codes for many other kinds of physicians' services, are characterized by a "building block" approach that enables the physician to bill for precisely those services that are provided. In the case of the echocardiography code "family," there are a number of "base" codes and

Attachment A

ultrasound coding is similarly tailored to clinical needs. In view of the robust nature of cardiac ultrasound, with evidence-based utility in virtually every different form of heart disease[3]. An echocardiography coding system that included a separate code for each structure examined or for each clinical entity of concern would be highly unwieldy at best. Thus, echocardiography coding is based primarily on which techniques are needed to address the clinical concerns.

4. The "building block" approach remains extremely useful in light of the breadth of echocardiography applications. For example, consider the use of add-on codes in conjunction with stress echocardiography (CPT 93350). This service would be provided alone to assess a patient with symptoms of exertional chest pain if coronary artery disease were suspected. However if the patient also had a systolic murmur or if a thickened and immobile aortic valve were noted on echocardiographic imaging prior to the stress test, then spectral Doppler (93320) would be mandatory to evaluate the severity of aortic stenosis, and color Doppler flow imaging (93325) would be necessary to help assess for and determine the severity of associated aortic and mitral regurgitation. As another example, consider a patient with shortness of breath and a systolic heart murmur sent by his primary care provider to determine the cause and significance of the murmur and the cause of dyspnea. If mitral valve redundancy and obvious prolapse were evident on 2-dimensional echo imaging (CPT 93307), then the use of spectral Doppler (CPT 93320) and color Doppler flow imaging (CPT 93325) would be mandatory in order to determine the severity of mitral regurgitation and to document the presence and degree of pulmonary hypertension. On the other hand, if the echocardiographic imaging study demonstrated a large pericardial effusion with right heart chamber compression (as a cause for the patient's symptoms) with normal valve morphology and mobility, it might be more appropriate to do a limited spectral Doppler (93321) evaluation to help document the presence of tamponade and the need for pericardiocentesis; a complete spectral Doppler or a color Doppler flow imaging evaluation might not be necessary. We would be delighted to provide additional examples for other echocardiography "base" codes.

5. As a practical matter, CPT 93325 is often (although clearly not always) done with virtually every base imaging code in the echocardiography family. [4] Attachment A sets forth an analysis of data from the CY 2003 Medicare 5% Physician/Supplier Standard Analytic File, prepared by Chris Hogan of Direct Research (the "Hogan Analysis"). While most color flow Doppler services are provided in conjunction with two dimensional transthoracic echo (CPT code 93307), an estimated 388,230 color flow Doppler claims each year are provided in conjunction with other echocardiography services,[5] including fetal echo, transesophageal echo, congenital echo and stress echo. The proportion of claims for each of these types of echocardiography services that include color flow Doppler varies substantially. For example, the Hogan Analysis indicates that approximately 36% of stress echo claims include color flow Doppler, while approximately 80% of congenital echo (complete) claims include the color flow Doppler code. For many of the echocardiography imaging codes, the proportion of claims that include color flow Doppler hovers in the 50% range. Therefore, any effort to "bundle" color flow Doppler into the base codes and to

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[3] See Cheitlin MD, Armstrong WF, Aurigemma, GP, Beller GA, Bierman FZ, Davis JL, Douglas PS, Faxon DP, Gillam LD, Kimball TR, Kussmaul WG, Pearlman AS, Philbrick JT, Rakowski H, Thys,DM. ACC/AHA/ASE 2003 guideline update for the clinical application of echocardiography: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/ASE Committee to Update the 1997 Guidelines for the Clinical Application of Echocardiography). 2003. American College of Cardiology Web Site. Available at: www.acc.org/clinical/guidelines/echo/index.pdf.

[4] As the number of CPT 93307 services is quite large, it is not surprising that the majority of CPT 93325 services are performed in conjunction with CPT 93307 as the base imaging code

[5] The Hogan Analysis indicates that approximately 5.3% of the 336,255 color flow Doppler claims in the 5% file are provided in conjunction with CPT base codes other than CPT code 93307.

provide payment on the basis of services provided to the "typical" patient would be extremely difficult and would necessarily result in less accurate payment for a substantial number of claims.

6. The Hogan Analysis makes it clear that bundling the color flow or spectral Doppler codes into the echocardiography base codes would not simplify billing. On the contrary, bundling would necessarily result in either (a) less accurate coding and billing, or (b) a considerably more complex coding and billing structure for echocardiography services. Color flow Doppler services not only are commonly billed with a wide range of echocardiography "base" codes, but also may be billed either with or without spectral Doppler. And, as illustrated above, either complete or limited spectral Doppler may be appropriate in different clinical circumstances. Therefore, if bundling were mandated, a series of "permutations" would be necessary to describe the range of clinical scenarios accurately. For example, to preserve accuracy in the face of "bundling", CPT code 93307, which is currently used to report the most common echocardiographic imaging procedure, would explode to include separate codes for:

*Transthoracic echo alone—CPT 93307.
*Transthoracic echo with spectral Doppler (complete)—CPT 93307 and CPT 93320.
*Transthoracic echo (complete) with spectral Doppler (limited)—CPT 93307 and CPT 93321
*Transthoracic echo with color flow Doppler—CPT code 93307 and 93325.
*Transthoracic echo with spectral Doppler (complete) and color flow —CPT 93307, 93320 and 93325
*Transthoracic echo (complete) with spectral Doppler (limited) and color flow -- CPT 93307, 93321 and 93325.

Similar multiple permutations also would be required for all of the other echocardiography imaging services—limited transthoracic, fetal, congenital transthoracic echo, transesophageal echo, congenital transesophageal echo, and stress echo. In order to bill with accuracy equivalent to what is now possible using the "building block" approach, the physician community would need nearly 70 different codes, rather than the 11 imaging and 5 "add on" codes that currently comprise the echocardiography code "family." This is certainly not a "coding simplification". Moreover, we note that changes to the CPT codes used to describe echocardiography services would also necessitate changes in the APC categories used to code and bill for these services in the Hospital Outpatient setting. Since for many base imaging codes, the use of spectral and color Doppler "add on" codes hovers around 50%, determining appropriate hospital charge data for new APC's would be extremely challenging.

7. The "building block" approach to ultrasound codes also facilitates efficient addition of new codes without requiring the revaluation of existing codes. For example, if and when new codes are developed for three dimensional echocardiography, these can be added to the echocardiography code "family" without requiring revaluation of any existing code. The same is true for other new technologies, such as tissue Doppler and Left Ventricular Synchrony. If the building block approach is abandoned and the codes combined, the addition of new codes to reflect advances in echocardiography will further complicate the echocardiography coding scheme and require frequent revaluation of existing codes. We note as well that a "building block" approach also has been used in many other sections of CPT precisely because it preserves flexibility and accuracy in describing combinations of specific services, without requiring users to employ "modifiers" for "reduced" or "prolonged" services, and because it reduces the need for manual review of claims.

Summarizing, then, in light of ultrasound's broad utility in the diagnosis of various illnesses, it is neither surprising that there is considerable variation in the applicable coding conventions--nor is it clear that consistency in coding format ought to prevail over descriptive accuracy. Making all ultrasound CPT codes consistent would require a major undertaking involving a broad array of specialties and a substantial commitment of time and resources by both the CPT Editorial Panel and the RUC. This is

especially true insofar as the use of building block codes for services such as Doppler appears to be the rule, rather than the exception in the CPT.

The physician work involved in all of the major echocardiography "base" codes have been valued by RUC, and almost all of the "high volume" echocardiography services have undergone review through the Five Year Review process. The practice expense inputs of all of the current echo codes have been reviewed by the PEAC. The various echocardiographic imaging, spectral Doppler, and color Doppler codes have been written and valued in a manner that avoids duplication of work and/or time, and so represent "independent" services the combination of which accurately reflects both physician work and practice expense. Both the Editorial Panel and the RUC already have expended considerable energy and resources in developing and valuing the current echocardiography and other ultrasound codes, and we do not think it makes sense to overhaul the current system (which is well understood, flexible enough to meet clinical needs, and allows users to describe exactly those services they have provided) in order to develop a new CPT coding system for cardiac ultrasound that likely would be either less accurate or substantially more complex than the current "building block" approach.

We appreciate your consideration of this issue, and urge you to contact Rebecca Kelly, Director of Regulatory Affairs for the American College of Cardiology (RKelly@acc.org) or Diane Millman, Washington Counsel for the American Society of Echocardiography (DMillman@ppsv.com) if you have any questions or concerns.

Sincerely yours,

Pamela S. Douglas, MD, FACC, President
American College of Cardiology

Bijoy Khandheria, MD, FASE, President
American Society of Echocardiography

Cc. Edith Hambrick, MD
Robert Zwolak, MD
James Blankenship, MD
Alan Pearlman, MD
Michael Picard, MD
Rebecca Kelly
Denise Garris
Diane Millman
Janice Brannon

Attachment B

CY 2003 Medicare 5% Physician/Supplier Standard Analytic File, All Claims Lines
For all claims with these base codes, what fraction of claims also had each of the add-on codes?
Note: Percentages on a line may sum to more than 100% if claims typically had multiple add-on codes.

Base Code	Description	Number of claims, 5	93320 Spectral (complete)	93321 Spectral (ltd)	93325 Color flow	No Add'l service None of the add-on codes on the claim
76825	Echo exam of fetal heart	36	0.00%	0.00%	47.20%	52.80%
76826	Echo exam of fetal heart	2	0.00%	0.00%	0.00%	100.00%
76827	Echo exam of fetal heart	36	0.00%	0.00%	50.00%	50.00%
76828	Echo exam of fetal heart	20	0.00%	0.00%	20.00%	80.00%
93303	Echo transthoracic	277	78.30%	1.80%	80.10%	17.70%
93304	Echo transthoracic	52	26.90%	38.50%	67.30%	28.80%
93307	Echo exam of heart	336,036	95.50%	0.20%	92.10%	3.40%
93308	Echo exam of heart	4,442	18.80%	37.90%	42.20%	40.10%
93312	Echo transesophageal	11,007	57.00%	2.30%	65.50%	31.90%
93314	Echo transesophageal	1,235	41.40%	4.50%	52.20%	46.20%
93315	Echo transesophageal	117	41.00%	1.70%	40.20%	53.80%
93317	Echo transesophageal	65	29.20%	0.00%	29.20%	70.80%
93350	Echo transthoracic	26,043	34.20%	1.60%	36.10%	61.30%

*Excludes spectral and color flow claims that did not include base code.

Medicare 5% Sample LDS SAF Physician/Supplier File 2005.
All Claims Lines with the Indicated CPT Codes -- Crosstab Showing Add-on Codes Appearing With Base Codes

		Count of Claims With Add-on Codes					Percent of Base Code Claims Having Add-On Code					Percent of all Add-On Code Occurrences				
Base Codes	All Claims	93320	93321	93325	92978	92979	93320	93321	93325	92978	92979	93320	93321	93325	92978	92979
Total all claims	422,018	379,204	4,280	376,567	1,587	176						100%	100%	100%	100%	100%
No base code on claim	10,454	4,678	252	6,936	1,576	176						2%	1%	6%	2%	99%
76825	40	-	-	18	-	-	0%	0%	45%	0%	0%	0%	0%	0%	0%	0%
76826	5	-	-	3	-	-	0%	0%	60%	0%	0%	0%	0%	0%	0%	0%
76827	31	-	-	6	-	-	0%	0%	19%	0%	0%	0%	0%	0%	0%	0%
76828	22	-	-	6	-	-	0%	0%	27%	0%	0%	0%	0%	0%	0%	0%
93303	293	249		253	-	-	85%	0%	86%	0%	0%	0%	0%	0%	0%	0%
93304	44		16	28	-	-	0%	36%	64%	0%	0%	0%	0%	0%	0%	0%
93307	369,139	357,750	669	349,376	11		97%	0%	95%	0%	0%	87%	94%	16%	93%	1%
93308	5,327	654	2,262	2,115	-	-	12%	42%	40%	0%	0%	1%	0%	53%	1%	0%
93312	10,997	6,469	292	7,423	-	-	59%	3%	68%	0%	0%	3%	2%	7%	2%	0%
93314	1,008	431	65	531	-	-	43%	6%	53%	0%	0%	0%	0%	2%	0%	0%
93315	102	58		61	-	-	57%	0%	60%	0%	0%	0%	0%	0%	0%	0%
93317	64	48	-	15	-	-	75%	0%	23%	0%	0%	0%	0%	0%	0%	0%
93350	24,492	8,861	716	9,796	-	-	36%	3%	40%	0%	0%	6%	2%	17%	3%	0%

Note: Totals reflect 5% sample data. Multiply by 20 to get estimated US totals. Data blanked if fewer than ten claims.

Attachment C

				93880 Reference		93975 - Reference		TTE (total) Reference				
	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE			Duplex scan of extracranial arteries; complete bilateral study		Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study		93307 + 93320 + 93325				
LOCATION				In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office	In Office
GLOBAL PERIOD				XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
TOTAL CLINICAL LABOR TIME	CS - 13004			62	0	108	0	93	0	59	0	21
PRE-SERVICE				3	0	3	0	3	0	3	0	0
Start: Following visit when decision for surgery or procedure made												
Other Clinical Activity (please specify) Review prior echo studies*				3		3		3		3		
End: When patient enters office for surgery/procedure												
SERVICE PERIOD				71	0	97	0	64	0	50	0	21
Start: When patient enters office for surgery/procedure												
Pre-service services												
Review charts												
Greet patient and provide gowning				3		3		3		3		
Obtain vital signs				3		3		3		3		
Provide pre-service education/obtain consent												
Prepare room, equipment, supplies				3		3		3		3		
Prepare and position patient/ monitor patient/ set up IV (incl. attach electrodes)				3		3		3		3		
Document clinical elements (" patient history")*				1		1		1		1		
Sedate/apply anesthesia												
Intra-service												
Assist physician in performing procedure (acquire ultrasound data)*				42		67		52		25		16
Process data, measure, record preliminary findings				10		9		13		6		5
Post-Service												
Monitor pt. following service/check tubes, monitors, drains												
Clean room/equipment by physician staff				3		3		3		3		
Complete diagnostic forms, lab & X-ray requisitions												
Review/read X-ray, lab, and pathology reports												
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions												
Other Clinical Activity (please specify) Patient education, instruction, counseling*				3		5		3		3		
End: Patient leaves office												
POST-SERVICE Period				8	0	8	0	6	0	6	0	0
Start: Patient leaves office												
Conduct phone calls/call in prescriptions (Communication with ordering physician/ patient/ family)*				4		4		2		2		
Total Office Visit Time												
Conduct phone calls between office visits												
Other Activity (please specify) (QA documentation required for accreditation)*				3		4		4		4		
End: with last office visit before end of global period												
MEDICAL SUPPLIES	Code	Unit	Unit Cost									
patient gown, disposable	11107	item	$ 0.570	1		1		1		1		
exam table paper	11111	foot	$ 0.015	7		7		7		7		
pillow case, disposable	11112	item	$ 0.320	1		1		1		1		
paper towel	11118	item	$ 0.010	3		1		5		5		
drape, sheet	11106	item	$ 0.260	1		1		1		1		
patient ed. booklet (50% of the time)	11140	item	$ 0.460	1		1		1		1		
gloves, non-sterile	11302	pair	$ 0.120	1		1		1		1		
Transducer wipe (echo ultrasound)	11520	wipe	$ 0.094	2		2		3		3		
aquasonic gel	71001	10 ml	$ 0.270	60		60		6		6		
film, 14x17	73402	sheet	$ 2.800	2		2						
tape, VHS	73408	item	$ 3.000	1		1		0.200		0.200		
recording paper	73414	sheet	$ 0.150	0		0						
film, 8x10 color	73403	item	$ 0.850	3		3						
Enviroside Cleaner	52302	10 ml	$ 0.340	1		1		1		1		
ECG electrodes	71006	item	$ 0.080					3		3		
pillow case, disposable	11112	item	$ 0.320					1		1		
drape, sheet	11106	item	$ 0.260					1		1		
pt education booklet	11115	item	$ 0.920					1		1		
PROCEDURE SPECIFIC EQUIPMENT												
Vascular Lab Room (=Ultrasound Room) Prices to be updated	E52018		$ 272,000									
Stretcher	E11002		$2,664					84		50		21
Computer	E52003		$2,800									
Processor	E51060											
Viewbox, 2 panes	E51001											
Sony Video Color Printer	E52010							84		50		21
SVHS Video Recorder	E53012							84		50		21
Computer	E52003		$ 2,800									
Processor	E51060		$ 55,100									
Viewbox, 2 panes	E51001		$ 909									
Sony Video Color Printer	E52010		$ 10,500					84		50		21
Review Station:AG7300SVHS 17 in. (VCR)	E52013		$ 900					84		50		21
Digital Acquisition unit (Nova Microsonics Image Vue DCR or ...)	E52007		$ 29,900					84		50		21
Sony Color Monitor	?		?					84		50		21

Attachment D

	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE			[illegible]	[illegible]		[illegible]		[illegible]	
LOCATION				Out Office	In Office	Out Office	In Office	Out Office	In Office	Out Office
GLOBAL PERIOD				XXX	XXX	XXX	XXX	XXX	XXX	XXX
TOTAL CLINICAL LABOR TIME	CS - 13004			0	13	0	44	0	11	0
PRE-SERVICE				0	0	0	3	0	0	0
Start: Following visit when decision for surgery or procedure made										
Other Clinical Activity (please specify) Review prior echo studies*							3			
End: When patient enters office for surgery/procedure										
SERVICE PERIOD				0	13	0	35	0	11	0
Start: When patient enters office for surgery/procedure										
Pre-service services										
Review charts										
Greet patient and provide gowning							3			
Obtain vital signs							3			
Provide pre-service education/obtain consent										
Prepare room, equipment, supplies							3			
Prepare and position patient/ monitor patient/ set up IV (incl. attach electrodes)							3			
Document clinical elements (" patient history")*							1			
Sedate/apply anesthesia										
Intra-service										
Assist physician in performing procedure (acquire ultrasound data)*					11		13		8	
Process data, measure, record preliminary findings					2		3		3	
Post-Service										
Monitor pt. following service/check tubes, monitors, drains										
Clean room/equipment by physician staff							3			
Complete diagnostic forms, lab & X-ray requisitions										
Review/read X-ray, lab, and pathology reports										
Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
Other Clinical Activity (please specify) Patient education, instruction, counselling*							3			
End: Patient leaves office										
POST-SERVICE Period				0	0	0	0	0	0	0
Start: Patient leaves office										
Conduct phone calls/call in prescriptions (Communication with ordering physician/ patient/ family)*							2			
Total Office Visit Time										
Conduct phone calls between office visits										
Other Activity (please specify) (QA documentation required for accreditation)*							4			
End: with last office visit before end of global period										
MEDICAL SUPPLIES	Code	Unit	Unit Cost							
patient gown, disposable	11107	item	$ 0.570				1			
exam table paper	11111	foot	$ 0.015				7			
pillow case, disposable	11112	item	$ 0.320				1			
paper towel	11118	item	$ 0.010				5			
drape, sheet	11106	item	$ 0.260				1			
patient ed. booklet (50% of the time)	11140	item	$ 0.460				1			
gloves, non-sterile	11302	pair	$ 0.120				1			
Transducer wipe (echo ultrasound)	11520	wipe	$ 0.094				3			
aquasonic gel	71001	10 ml	$ 0.270				3			
film, 14x17	73402	sheet	$ 2.800							
tape, VHS	73406	item	$ 3.000				0.200			
recording paper	73414	sheet	$ 0.150							
film, 8x10 color	73403	item	$ 0.850							
Envirocide Cleaner	52302	10 ml	$ 0.340				1			
ECG electrodes	71006	item	$ 0.080				3			
pillow case, disposable	11112	item	$ 0.320				1			
drape, sheet	11106	item	$ 0.260				1			
pt education booklet	11115	item	$ 0.920				1			
PROCEDURE SPECIFIC EQUIPMENT										
Vascular Lab Room (=Ultrasound Room) Prices to be updated	E52018		$ 272,000							
Stretcher	E11002		$2,864		13		35		11	
Computer	E52003		$2,800							
Processor	E51080									
Viewbox, 2 panes	E51001									
Sony Video Color Printer	E52010				13		35		11	
SVHS Video Recorder	E53012				13		35		11	
Computer	E52003		$ 2,800							
Processor	E51080		$ 55,100							
Viewbox, 2 panes	E51001		$ 909							
Sony Video Color Printer	E52010		$ 10,500		13		35		11	
Review Station:AG7300SVHS 17 in. (VCR)	E52013		$ 900		13		35		11	
Digital Acquisition unit (Nova Microsonics Image Vue DCR or ...)	E52007		$ 29,900		13		35			
Sony Color Monitor	?		?		13		35		11	

Submitter : **Dr. stacy coffin** **Date: 08/06/2007**

Organization : **Dr. stacy coffin**

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 serviees. 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.

Stacy Coffin MD

Submitter : **Dr. Thomas Hansen** **Date: 08/06/2007**

Organization : **College of American Pathologists**

Category : **Physician**

Issue Areas/Comments

CAP Issues

CAP Issues

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a pathologist and a junior member of the College of American Pathologists. I practice in New York City, New York as part of Memorial SLoan-Kettering Cancer Center.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

Thomas Hansen, MD
Memorail Sloan-Kettering Cancer Center
Department of Pathology
1275 York Ave.
New York, NY 10065

Submitter : **Dr. Theresa Emory** **Date: 08/06/2007**

Organization : **Highlands Pathology Consultants**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007
Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practiee in Bristol, Tennessee as part of 11-member pathology group that operates an independent laboratory and serves several local rural hospitals in the Appalachian Mountains.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of, and have been eneouraged join into arrangements in my practiee area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology serviees.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.
Sincerely,
Theresa S. Emory, MD

Submitter : Dr. Michael Gistrak **Date:** 08/06/2007

Organization : Rahway Pathology, P.A.

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Rahway, NJ as part of hospital-based 4 member private practice.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of numerous arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services. I do not believe that the Stark law ever intended for such arrangements to be permitted.

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

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. Nothing could be farther from the truth and I have specific examples to refute this assertion. I believe many of these arrangements provide no value whatsoever to the patient, and exist strictly for the economic benefit of those performing procedures. For example, I have observed increases in specimen volume under these arrangements, and the performance of unnecessary ancillary testing strictly for the generation of profit. For instance, some urology groups perform immunohistochemistry on every single biopsy specimen as a routine procedure, even though immunohistochemistry is indicated only in the event of an equivocal biopsy. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,

Michael Gistrak, MD

Submitter : **Dr. Richard Gomez** **Date: 08/06/2007**

Organization : **Topeka Pathology Group, P.A.**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Topeka, KS as part of an eight person group practice, contracting with two hospitals in Topeka and with several outreach community hospitals in Northeast Kansas.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

Richard R. Gomez, M.D.
Topeka Pathology Group, P.A.

Submitter : **Dr. Jonathan Strauss** **Date: 08/06/2007**

Organization : **Dr. Jonathan Strauss**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Las Vegas, Nevada as part of 25 member private pathology group that serves nine area hospitals.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

Jonathan S. Strauss, MD

Submitter : **Dr. Ronald Voice** **Date: 08/06/2007**

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 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,

Ronald A. Voice, MD
Thoracic Cardiovascular Institute

Submitter : Dr. Gustavo de la Roza **Date:** 08/06/2007

Organization : College of American Pathologists

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Syracuse, New York as part of a large practice in a university hospital.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the groups patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

Gustavo de la Roza, MD

Submitter : **Dr. James Williams** **Date: 08/06/2007**

Organization : **Poudre Valley Hospital**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician self referral and so called POD laboratories ARE abusive and result in MASSIVE uncontrolled costs. Loopholes in current regulations MUST BE CLOSED for these abusive practices if there is to be ANY chance of cost containment. Hospital-physician consortiums and partnerships in this area amount to "semi legal" evasion of at leasest the spirit of Stark provisions enacted years ago.

Submitter : Dr. Jeff McCraw **Date:** 08/06/2007

Organization : Dr. Jeff McCraw

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: 08/06/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Referrral Provisions of CMS-1385-P entititiled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calender Year 2008." I am a board certified pathologist and a member of The College of American Pathologists. I practice in Columbus Ohio as part of a twelve person patholgy group.

I applaud CMS for undertaking this important initiative to end the self-referral aubses in the billing and payment for pathology services. I am aware of arrangements in my practiee area that give physician groups a share of revenues from the pathology serviees ordered and performed for the group's patients. I believe these arrangements are in abuse of Stark law prohibition against physician self-referrals and I support revisions to the loopholes that allow physicians to profit from pathology serviees.

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

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

Sincerely,

David C. Taylor, M.D.
Columbus OH
Mt Carmel East Hospital

Submitter : Dr. james mcdermott **Date:** 08/06/2007

Organization : Dr. james mcdermott

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Charlotte, NC, as part of Carolinas Pathology Group, a 21 member multispecialty pathology group serving the Carolinas Medical Center, several regional hospitals, and a private laboratory.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Let there be no doubt about the sole purpose of these POD labs. They are set up to allow non-pathologists to subcontract anatomic pathology services at discounted prices, then selling the diagnosis to the patient at a markup. No savings are realized by the patient or the payer, but profit is generated for the non-pathologist physician who did not perform any service. This is an absurd and unethical practice that will ultimately hurt the patient by driving good pathologists out of business. This must not be allowed to happen.

Sincerely,

James McDermott, MD

Submitter : Dr. Jo Ann Shaw **Date:** 08/06/2007

Organization : Greensboro Pathology Associates, P.A.

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for taking the initiative to address the sef-referral abuses for the billing and payment for pathology services. I am a board certified pathologist and a member for the College of American Pathologists (CAP). I practice in a 12 member group in Greensboro, North Carolina. We mostly provide anatomic pathology services (biopsy pathology) but also cover the labs of areas hospitals for anatomic and clinical pathology.

I am aware of specialty groups and billing services entering our market that deeply discount pathology services so that physician groups can share in the revenue from the pathology services ordered and performed on their patients. I am concerned that the physician groups inflate the price billed to third party payors and governmental payors to generate a source of revenue for their practices. I suspect they bill more than what I charge for the same service I directly provide, but of course they would not share in the revenue stream in that scenario. I am also concerned that physician groups sharing in revenues from pathology services have an incentive to do more biopsies and increase the revenue for the practice. In my humble opinion I believe this is an abuse of the Stark law against physician self-referral and I wholeheartedly support revisions to close the loopholes that allow physicians to profit from pathology services. Pathologists who provide the pathology services should be DIRECLTY paid for those services.

Although I am a member of a relatively large pathology group, I am not only worried about how these abuses will affect our revenue, but how small pathology groups who practice good medicine will be affected. Physicians should be paid DIRECTLY for the services they provide and those services should be within the scope of pratice of the physician's board certification and specialty to ensure the best patient care and patient safety. This can easily be overlooked in these discussions.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. These proposed changes do not impact the availability or delivery of quality pathology services, but simply remove an obvious financial and clinical conflict of interest that compromises the integrity of the Medicare program.

Thanks you very much for addressing this issue.

Submitter : Dr. Megan Kressin **Date:** 08/06/2007

Organization : Dr. Megan Kressin

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a resident pathologist and a member of the College of American Pathologists. I am currently in my third year of training at Vanderbilt University Medical Center in Nashville, TN, and I am concerned about the billing and payment abuses taking place in the workplace I will soon be entering.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group's patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,
Megan Kielt Kressin, MD

Submitter : **Dr. Eugene Segall** **Date: 08/06/2007**

Organization : **Dr. Eugene Segall**

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.

Eugene Segall, M.D.

Submitter : **Dr. Brent Huddleston** **Date: 08/06/2007**

Organization : **Dr. Brent Huddleston**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007:

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a physician in resident training and a member of the College of American Pathologists. I practice in Salt Lake City, UT as a pathology resident in training at an academic hospital.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

Brent J. Huddleston, M.D.

Submitter : **Dr. Gene Winkelmann** **Date: 08/06/2007**

Organization : **Minnesota Anesthesiologist**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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.

Gene Winkelmann, MD
303 Catlin Street
Buffalo, MN 55313
763-684-7735

Submitter : Dr. Henry Travers **Date:** 08/06/2007

Organization : Physician's Laboratory, Ltd.

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The following comments are submitted regarding Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. My practice in Sioux Falls, South Dakota, includes 10 other pathologists, all of whom are board-certified and members of the College of American Pathologists. We provide professional services to four hospitals in Sioux Falls, Yankton and Mitchell South Dakota as well as Spencer, Iowa as well as to numerous clinics in South Dakota, Minnesota, Iowa and Nebraska.

For years it has been the practice of large clinics to coerce pathology laboratories into client billing where clinics paid a flat fee for pathology services, then marked the fee to patients up and pocketed the profit. The coercion was based on the threat of loss of referrals. Over the years, this practice has been refined to levels I could not have imagined. We are continuously under pressure from some of our clients to support these kinds of arrangements. Regardless of the variations, the outcomes are the same: providers billing for work performed by others for which they take no professional responsibility. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

I am pleased that CMS has initiated a process to end self-referral abuses in the billing and payment for pathology services. Expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law are specific revisions I particularly strongly support. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service. In the absence of this capability, financial self-interest too often becomes an important element in clinical decision-making rather than the interest of the patient.

The proposed changes impact neither the availability or delivery of pathology services. They are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program. While opponents to the proposed changes suggest that existing self-referral arrangements enhance patient care, they exist for another purpose entirely and that is to maximize physician practice income. The Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality.

Please accept my compliments on a well-written proposal which I fully support.

Submitter : Dr. John Cooney **Date:** 08/06/2007

Organization : Quincy Pathology Associates

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a board certified anatomic and clinical pathologist, and a member of the College of American Pathologists and the American Socicty for Clinical Pathology. I practice in Quincy, MA as a member of a 6-member pathology group (with 2 pathologist assistants), and am the Chief of Pathology at my hospital as well as the VP of the Medical Staff.

I am very pleased to see that CMS has undertaken this initiative to end self-referral abuses in the billing and payment of pathology services. There are practiec arrangements in our region of the country that give physician groups a share of the revenues from the pathology services ordered and performed for the group's patients. I believe these arrangements violate the Stark law prohibition against physician self-referrals. Hence, I support your efforts to close loopholes that allow physicians to profit from pathology services.

In particular, I support expanding the anti-markup rule to purchased pathology diagnoses and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. The proposed revisions to the Medicare reassignment rule and physiciun self-referral provisions are needed to eliminate financial self-interest in clinical decision making. I strongly believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable (through appropriate training and credentialling) of personally performing or supervising the service. To me, this is analogous to a primary care doctor billing for performing prostate biopsies (while having no training as a urologist) in their office, while the biopsies are being performed at a cut-ratc off-sitc location by the cheapest urologist available with a financial 'kick-back' incentive to the referring primary care doc. The only incentive for the 'gatekeeper' physician is to maximize their revenue by increasing utilization with whatever contracting cntity will enable him to capturc the greatest margin!

Opponents to the proposed changes may claim that their captive pathology arrangements enhance patient care. Considering the very real incentives present for the 'gatekecper' physicians in these arrangements, their claim is in fact bogus. I believe that CMS should ensure that physicians furnish care and provide referrals (such as the medical consultations that are anatomic pathology diagnoses) that encourage the best care of their patients. To this end, restricting physician self-referrals is imperative. The proposed changes seem to me to remove financial conflict of interest from the gatekeeper MD's, which will if anything improve the availability and delivery of pathology diagnostic services.

Sincerely,

John V. Cooney, M.D., Ph.D.

Submitter : Dr. Vinod Shidham **Date:** 08/06/2007

Organization : Medical College of Wisconsin

Category : Academic

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Milwaukee, WI as part of academic faculty in the department of pathology at the Medical College of Wisconsin in tertiary care setting.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Submitter : Dr. Kevaghn Fair **Date:** 08/06/2007

Organization : Dominion Pathology Laboratories

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Norfolk, VA as part of an independent laboratory serving all of eastern Virginia.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area and elsewhere that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are a seldom-recognized abuse of the Stark law prohibition against physician self-referral and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care although no data exists to support this assertion. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,
Kevaghn P. Fair, D.O.
Dominion Pathology Laboratories
Norfolk, VA 23510

Submitter : **Date: 08/06/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Due to the continued increased in cost of providing medical services (malpractice insurance, taxes, and other overhead), I have had to discontinue a Medicare-based clinic. I am unable to see patients in my outpatient office on Medicare due to the very low reimbursements. The reimbursements are also delayed at times (last year 2 months!). It is not possible to provide medical care to individuals on Medicare under these circumstances. It does not appear that the government is listening to what is really going on in the country regarding health care.

Submitter : **Dr. Donald Bluh** **Date: 08/06/2007**

Organization : **Cayuga Medical Center, Ithaca, NY**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Donald G. Bluh, M.D.

Submitter : Dr. Elaine Wagner **Date:** 08/06/2007

Organization : Unipath

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Littleton, Colorado as part of group of 20 pathologists.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

Elaine Wagner M.D.

Submitter : Dr. Ben Davis **Date:** 08/06/2007

Organization : Associated Pathologists

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Nashville, TN as President and CEO of Associated Pathologists/PathGroup, a 50+ pathologists group practice in multiple states including TN, KY, GA, IN and IL. We operate in an independent laboratory system serving over 50 hospitals in urban and rural settings. In addition we serve im excess of 1,000 nonhospital clients consisting of physican offices, surgical centers and endoscopy centers.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I strongly support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Submitter : **Dr. Stephen Smith** **Date: 08/06/2007**

Organization : **Missouri Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

Background

Background

August 6, 2007

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 strongly support the proposed anesthesia payment increase included in the 2008 Physician Fee Schedule. Despite the advances in patient safety made by the anesthesiology specialty and the leadership role anesthesiologists have taken, past Physician Fee Schedules have grossly undervalued anesthesia services, much to our detriment. I am greatly pleased that CMS has recognized this payment inequity and is taking steps to address the issue.

The institution of the RBRVS created a huge payment disparity for anesthesia care, resulting from a significant undervaluation of anesthesia work as compared to other physician services. Presently, a decade since the RBRVS took effect, Medicare reimbursement for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of providing care and is creating an unsustainable system in which anesthesiologists are forced away from areas with disproportionately high Medicare populations, precisely those patients most requiring skilled anesthesia care.

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.

Stephen R. Smith MD, Commissioner (2003-2004)
Missouri Commission on Patient Safety

CMS-1385-P-5109-Attach-1.DOC

CMS-1385-P-5109-Attach-2.DOC

#5709

August 6, 2007

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 strongly support the proposed anesthesia payment increase included in the 2008 Physician Fee Schedule. Despite the advances in patient safety made by the anesthesiology specialty and the leadership role anesthesiologists have taken, past Physician Fee Schedules have grossly undervalued anesthesia services, much to our detriment. I am greatly pleased that CMS has recognized this payment inequity and is taking steps to address the issue.

The institution of the RBRVS created a huge payment disparity for anesthesia care, resulting from a significant undervaluation of anesthesia work as compared to other physician services. Presently, a decade since the RBRVS took effect, Medicare reimbursement for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of providing care and is creating an unsustainable system in which anesthesiologists are forced away from areas with disproportionately high Medicare populations, precisely those patients most requiring skilled anesthesia care.

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.

Stephen R. Smith MD, Commissioner (2003-2004)
Missouri Commission on Patient Safety

Submitter : **Dr. James Gulizia** **Date: 08/06/2007**

Organization : **Caris Diagnostics**

Category : **Physician**

Issue Areas/Comments

CAP Issues

CAP Issues

August 6, 2007

Dear CMS:

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Irving, TX as a pathologist at Caris Pathology, an affiliate of Caris Diagnostics. We employ 27 pathologists and have offices in Irving, TX, Phoenix, AZ, and Newton, MA.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

James M. Gulizia, M.D., Ph.D.
Caris Diagnostics
8400 Esters Blvd, #190
Irving, TX 75063

Submitter : Dr. Paul Taylor-Smith **Date:** 08/06/2007

Organization : Dr. Paul Taylor-Smith

Category : Health Care Provider/Association

Issue Areas/Comments

TRHCA-Section 104: Physician Pathology Services

TRHCA-Section 104: Physician Pathology Services

I am a pathologist in active practice.

Organizations attempting get CMS to prohibit anyone but pathologists from performing the technical component of surgical pathology appears to be entirely self serving.

It is useful for many larger clinics to process the technical component of surgical specimens (as dermatologists have been doing for many years). As long as the clinic truly owns the lab, its employees and all expenses and pays all of these expenses the clinic should be permitted to bill directly for these services. There is no more likehood of abuse than that of a pathology group ordering expensive and un-needed special tests and stains on specimens that they then perform in the pathologist owned histology lab.

A histology lab is a tecnical process and is NOT a pahologist provided exclusive service. It is similar to any other test, including clinical lab tests and imaging services, where clinics very commonly own and bill for the technical component.

I would urge CMS simply to prohibit any mark-up of these technical services and let each physician decide where the technical process is performed in addition to where the professional service is performed.

Thank you.

Submitter : Dr. Stephen Sarewitz **Date:** 08/06/2007

Organization : Valley Medical Center

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice Renton, Washington, at Valley Medical Center. I am a member of a group of 16 board-certified pathologists that services three hospitals and an independent anatomic pathology laboratory.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless 1, the physician is capable of personally performing or supervising the service, and 2, the physician is not able to significantly affect the volume of services.

I have actually seen a pro forma from a company that sets up arrangements for gastroenterologists to bill for the technical histology preparation of the biopsies they perform. This pro forma, prepared for a local group of gastroenterologists, projected that the group would double the volume of CPT codes submitted to third party payors. I am aware of another local group of gastroenterologists that stopped referring its biopsies to a pathology group that includes an expert, fellowship-trained gastrointestinal pathologist, in order to participate in an arrangement allowing the gastroenterologists to profit from the technical preparation of biopsies despite the fact that the biopsies are now being examined by individuals without special expertise in gastrointestinal pathology.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. As the above example shows, this assertion is simply a ruse to try to disguise their purely mercenary interest.

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

Sincerely yours,

Stephen J. Sarewitz, MD

Submitter : **Dr. Susan Porter** **Date: 08/06/2007**

Organization : **Dr. Susan Porter**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fcc 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. William Kasimer** **Date: 08/06/2007**

Organization : **South Shore Hospital**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached letter.

#5114

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

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

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

Submitter : **Dr. Rance Siniard** **Date: 08/06/2007**

Organization : **Baptist Health Systems**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled 'Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008.' I am a first-year pathology resident and a member of the College of American Pathologists. I am training in Birmingham, Alabama in AP/CP.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group's patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,
Rance C. Siniard, M.D.
PGY-1, Pathology
Baptist Health Systems

Submitter : **Mr. Robert Knorr** **Date: 08/06/2007**

Organization : **Tapestry Medical, Inc.**

Category : **Other Health Care Professional**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

In section II.B.2.b.(iii) of CMS-1385-P, CMS indicates that it has adjusted the time in use for the home monitor equipment for G0249 to 1440 minutes to reflect that the monitor is dedicated for use 24 hours a day and unavailable for others receiving this service. While we appreciate this attempt by CMS to address comments previously raised by us and others, we believe that the result of this proposed change is still unreasonable because it does not reflect the minimum cost of providing G0249 services.

It is important to consider that each unit of G0249 service consists of 4 INR tests performed on a weekly basis over the course of four weeks. Each INR test requires a piece of equipment (i.e. INR Monitor, home [Equipment Code EQ031]) dedicated for use by a single beneficiary. Since home INR monitoring is limited to weekly testing, the maximum number of G0249 units that can be provided in any year is 13 (i.e. 52 weeks divided by 4 INR tests). The problem with the equipment cost calculation proposed by CMS is that the resulting RVU calculation for home INR equipment is limited to only 18,720 minutes (i.e. 13 units of G0249 times 1,440 minutes). Because CMS has based the equipment cost per minute on 75,000 minutes per year (i.e. 150,000 minutes per year times an equipment utilization rate of 50%), the proposed PE RVUs related to the home INR monitor is in fact understated by a factor of 4 (i.e. 18,720 minutes versus 75,000 minutes). For these reasons, we believe that using only 1440 minutes for each G0249 unit of service is incorrect because it captures only 25% of the minutes per year that the equipment is in use with any given beneficiary. Because each home INR monitor is dedicated for use by a single beneficiary, providers of G0249 services have no other means to recover the cost for a particular monitor.

In order to correct this error we believe that the time in use of the home INR monitor should be recalculated using 5,760 minutes to account for the 4 tests that comprise each G0249 unit (i.e. 1,440 minutes times 4 INR tests). The attached excel spreadsheet shows that this recalculation supports an overall increase of at least 1.13 RVUs. As a result, the proposed Fully Implemented PE RVUs would also increase from 2.72 to at least 3.85.

CMS-1385-P-5116-Attach-1.PDF

CMS-1385-P-5116-Attach-2.PDF

#5116

TAPESTRY MEDICAL

1404 Concannon Blvd., Livermore, CA 94550

August 6, 2007

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

Dear Ms. Norwalk:

We wish to comment specifically on proposed § II.B.2.b.(iii) of CMS-1385-P as it relates to the Resource-Based Practice Expense (PE) RVU Proposals for CMS Billing Code G0249. Tapestry Medical is an approved Medicare provider focused exclusively on providing Home INR Monitoring services. Several years ago, I was personally involved in the original estimation of resource requirements when the Home INR Monitoring Program was first implemented. At the time, we provided CMS with a comprehensive analysis of our good faith estimate of the resource requirements for these atypical services. Our comments today are based on the experience and data that we have collected while providing over 5,000 G0249 services to hundreds of eligible beneficiaries over the past three years.

I am very concerned that the Direct Practice Expense Values used to create Resource-Based Practice Expense Relative Value Units in the Proposed Rule have resulted in substantial proposed reductions in the Non-Facility Fully Implemented PE RVUs for this service. If fully implemented, these proposed reductions would result in a net 30% decrease in G0249 RVUs versus the 2006 levels at a time when costs for providing these services are increasing. We believe that such reductions are unreasonable and are substantially less than the true cost of providing these services. Furthermore, such reductions do not adequately consider the substantial risk that providers such as Tapestry Medical have already borne with beneficiaries have who have been provided with one of our INR monitors.

In section II.B.2.b.(iii) of CMS-1385-P, CMS indicates that it has *"adjusted the time in use for the home monitor equipment for G0249 to 1440 minutes to reflect that the monitor is dedicated for use 24 hours a day and unavailable for others receiving this service."* While we appreciate this attempt by CMS to address comments previously raised by us and others, we believe that the result of this proposed change is still unreasonable because it does not reflect the minimum cost of providing G0249 services.

It is important to consider that each unit of G0249 service consists of 4 INR tests performed on a weekly basis over the course of four weeks. Each INR test requires a piece of equipment (i.e. "INR Monitor, home" [Equipment Code EQ031]) dedicated for use by a single beneficiary.

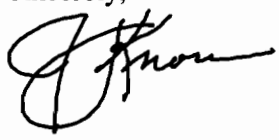
Since home INR monitoring is limited to weekly testing, the maximum number of G0249 units that can be provided in any year is 13 (i.e. 52 weeks divided by 4 INR tests). The problem with the equipment cost calculation proposed by CMS is that the resulting RVU calculation for home INR equipment is limited to only 18,720 minutes (i.e. 13 units of G0249 times 1,440 minutes). Because CMS has based the equipment cost per minute on 75,000 minutes per year (i.e. 150,000 minutes per year times an equipment utilization rate of 50%), the proposed PE RVUs related to the home INR monitor is in fact understated by a factor of 4 (i.e. 18,720 minutes versus 75,000 minutes). For these reasons, we believe that using only 1440 minutes for each G0249 unit of service is incorrect because it captures only 25% of the minutes per year that the equipment is in use with any given beneficiary. Because each home INR monitor is dedicated for use by a single beneficiary, providers of G0249 services have no other means to recover the cost for a particular monitor.

In order to correct this error we believe that the time in use of the home INR monitor should be recalculated using 5,760 minutes to account for the 4 tests that comprise each G0249 unit (i.e. 1,440 minutes times 4 INR tests). The attached excel spreadsheet shows that this recalculation supports an overall increase of at least 1.13 RVUs. As a result, the proposed Fully Implemented PE RVUs would also increase from 2.72 to at least 3.85.

Home INR Monitoring is a unique benefit that involves providing beneficiaries with dedicated capital equipment and ancillary supplies to enable self-testing. Non-physician providers such as Tapestry Medical play an important role in providing access to this unique service because treating physicians have expressed strong reluctance to provide the services themselves.[1,2] Considering the reluctance of physicians to provide these services, CMS should expect that access to Home INR Monitoring will be seriously compromised if the substantial proposed RVU reductions are implemented.

As one of the few providers in the country providing Home INR Monitoring services, we believe that properly calculating the cost of the home INR monitor is the minimum required for us to continue servicing beneficiaries in the future. On behalf of the hundreds of beneficiaries and physicians that we service, I sincerely appreciate the opportunity to provide these comments.

Sincerely,



Robert J. Knorr
Chief Executive Officer
Phone: 925.606.4998

[1] See CMS-1321-P Public Comment (#92425) submitted by Dr. Jack Ansell – Chairman of Anticoagulation Forum on October 5, 2006.

[2] See also, the August 2002 of "CAP TODAY" (www.cap.org) which highlights concerns expressed by the American College of Cardiology and other stakeholders.

Submitter : **Dr. Dirk Brom** **Date: 08/06/2007**

Organization : **VA Central Iowa Healthcare System**

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.

Thank you for your consideration.

Dirk H. Brom, MD
3320 Foxley Drive
Ames, IA 50010

Submitter : **Dr. Robert Moore** **Date: 08/06/2007**

Organization : **TLC Chiropractic, P.C.**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

Re: TECHNICAL CORRECTIONS

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a 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.

In most cases the patient 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,

Robert J. Moore, D.C.

Submitter : Dr. Megan Smith-Zagone **Date:** 08/06/2007

Organization : St. Joseph Hospital

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Submitter : Dr. Richard Griswold **Date:** 08/06/2007

Organization : North Mississippi medical Center

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in a large regional medical center as associate medical director of a 5-person general pathology practice seeking to meet the needs of a diverse medical staff of over 200 physicians. Our hospital serves a 13 county area and is one of the largest medical centers in a rural area in the Unitied States.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. Nothing could be further from the truth, because these arrangements are being done in almost all cases because the clinician ordering the test (who is NOT a pathologist) is allowed to "mark up" the test for billing; and enhance their revenue.

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

As as pathologist with over 20 years experience in community based clinical and anatomic pathology, I am certain that to allow these types of abuses will have very serious impacts on our ability to provide comprehensive pathology services to all physicians and their patients in our community.

Sincerely,
Richard Griswold, M.D.

Submitter : Mr. Robert Knorr **Date:** 08/06/2007

Organization : Tapestry Medical, Inc.

Category : Other Health Care Professional

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

In section II.B.2.b.(iii) of CMS-1385-P, CMS indicates that it has 'adjusted the time in use for the home monitor equipment for G0249 to 1440 minutes to reflect that the monitor is dedicated for use 24 hours a day and unavailable for others receiving this service.' While we appreciate this attempt by CMS to address comments previously raised by us and others, we believe that the result of this proposed change is still unreasonable because it does not reflect the minimum cost of providing G0249 services.

It is important to consider that each unit of G0249 service consists of 4 INR tests performed on a weekly basis over the course of four weeks. Each INR test requires a piece of equipment (i.e. 'INR Monitor, home' [Equipment Code EQ031]) dedicated for use by a single beneficiary. Since home INR monitoring is limited to weekly testing, the maximum number of G0249 units that can be provided in any year is 13 (i.e. 52 weeks divided by 4 INR tests). The problem with the equipment cost calculation proposed by CMS is that the resulting RVU calculation for home INR equipment is limited to only 18,720 minutes (i.e. 13 units of G0249 times 1,440 minutes). Because CMS has based the equipment cost per minute on 75,000 minutes per year (i.e. 150,000 minutes per year times an equipment utilization rate of 50%), the proposed PE RVUs related to the home INR monitor is in fact understated by a factor of 4 (i.e. 18,720 minutes versus 75,000 minutes). For these reasons, we believe that using only 1440 minutes for each G0249 unit of service is incorrect because it captures only 25% of the minutes per year that the equipment is in use with any given beneficiary. Because each home INR monitor is dedicated for use by a single beneficiary, providers of G0249 services have no other means to recover the cost for a particular monitor.

In order to correct this error we believe that the time in use of the home INR monitor should be recalculated using 5,760 minutes to account for the 4 tests that comprise each G0249 unit (i.e. 1,440 minutes times 4 INR tests). The attached excel spreadsheet shows that this recalculation supports an overall increase of at least 1.13 RVUs. As a result, the proposed Fully Implemented PE RVUs would also increase from 2.72 to at least 3.85.

CMS-1385-P-5121-Attach-1.PDF

CMS-1385-P-5121-Attach-2.PDF

#5121

TAPESTRY MEDICAL

1404 Concannon Blvd., Livermore, CA 94550

August 6, 2007

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

Dear Ms. Norwalk:

We wish to comment specifically on proposed § II.B.2.b.(iii) of CMS-1385-P as it relates to the Resource-Based Practice Expense (PE) RVU Proposals for CMS Billing Code G0249. Tapestry Medical is an approved Medicare provider focused exclusively on providing Home INR Monitoring services. Several years ago, I was personally involved in the original estimation of resource requirements when the Home INR Monitoring Program was first implemented. At the time, we provided CMS with a comprehensive analysis of our good faith estimate of the resource requirements for these atypical services. Our comments today are based on the experience and data that we have collected while providing over 5,000 G0249 services to hundreds of eligible beneficiaries over the past three years.

I am very concerned that the Direct Practice Expense Values used to create Resource-Based Practice Expense Relative Value Units in the Proposed Rule have resulted in substantial proposed reductions in the Non-Facility Fully Implemented PE RVUs for this service. If fully implemented, these proposed reductions would result in a net 30% decrease in G0249 RVUs versus the 2006 levels at a time when costs for providing these services are increasing. We believe that such reductions are unreasonable and are substantially less than the true cost of providing these services. Furthermore, such reductions do not adequately consider the substantial risk that providers such as Tapestry Medical have already borne with beneficiaries have who have been provided with one of our INR monitors.

In section II.B.2.b.(iii) of CMS-1385-P, CMS indicates that it has *"adjusted the time in use for the home monitor equipment for G0249 to 1440 minutes to reflect that the monitor is dedicated for use 24 hours a day and unavailable for others receiving this service."* While we appreciate this attempt by CMS to address comments previously raised by us and others, we believe that the result of this proposed change is still unreasonable because it does not reflect the minimum cost of providing G0249 services.

It is important to consider that each unit of G0249 service consists of 4 INR tests performed on a weekly basis over the course of four weeks. Each INR test requires a piece of equipment (i.e. "INR Monitor, home" [Equipment Code EQ031]) dedicated for use by a single beneficiary.

Since home INR monitoring is limited to weekly testing, the maximum number of G0249 units that can be provided in any year is 13 (i.e. 52 weeks divided by 4 INR tests). The problem with the equipment cost calculation proposed by CMS is that the resulting RVU calculation for home INR equipment is limited to only 18,720 minutes (i.e. 13 units of G0249 times 1,440 minutes). Because CMS has based the equipment cost per minute on 75,000 minutes per year (i.e. 150,000 minutes per year times an equipment utilization rate of 50%), the proposed PE RVUs related to the home INR monitor is in fact understated by a factor of 4 (i.e. 18,720 minutes versus 75,000 minutes). For these reasons, we believe that using only 1440 minutes for each G0249 unit of service is incorrect because it captures only 25% of the minutes per year that the equipment is in use with any given beneficiary. Because each home INR monitor is dedicated for use by a single beneficiary, providers of G0249 services have no other means to recover the cost for a particular monitor.

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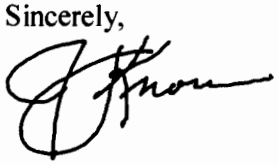
Home INR Monitoring is a unique benefit that involves providing beneficiaries with dedicated capital equipment and ancillary supplies to enable self-testing. Non-physician providers such as Tapestry Medical play an important role in providing access to this unique service because treating physicians have expressed strong reluctance to provide the services themselves.[1,2] Considering the reluctance of physicians to provide these services, CMS should expect that access to Home INR Monitoring will be seriously compromised if the substantial proposed RVU reductions are implemented.

As one of the few providers in the country providing Home INR Monitoring services, we believe that properly calculating the cost of the home INR monitor is the minimum required for us to continue servicing beneficiaries in the future. On behalf of the hundreds of beneficiaries and physicians that we service, I sincerely appreciate the opportunity to provide these comments.

Sincerely,



Robert J. Knorr
Chief Executive Officer
Phone: 925.606.4998

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[1] See CMS-1321-P Public Comment (#92425) submitted by Dr. Jack Ansell – Chairman of Anticoagulation Forum on October 5, 2006.

[2] See also, the August 2002 of "CAP TODAY" (www.capporg) which highlights concerns expressed by the American College of Cardiology and other stakeholders.

Tapestry Medical, Inc.
Comments to CMS-1385-P
Section II.B.2.b.(iii)
Home INR Monitoring

SUMMARY								
CMS-1385-P	G0249	1440	0	$14.2973	INR Monitor, home (EQ031)	4	2000	$0.0099
Recalculation	**G0249**	**5760**	**0**	**$57.1893**	**INR Monitor, home (EQ031)**	**4**	**2000**	**$0.0099**

Recalculation Comparison	Wks/year	Hrs/wk	Min/yr (calculated)	Usage (percent of time office is open that equipment is in use)	Equipment Cost	Interest Rate	Useful Life (years)	Maintenance costs	Time-NF (intra-service clinical labor time)	Equip Cost/min	Direct Cost of Equipment-NF	$ Change in Direct Cost of Equip	% Change in Direct Cost of Equip
CMS-1385-P	50	50	#####	50%	$2,000	11%	4	5%	1440	$0.0099	$14.2973	NA	NA
Recalculation	**50**	**50**	**#####**	**50%**	**$2,000**	**11%**	**4**	**5%**	**5760**	**$0.0099**	**$57.1893**	**$42.8920**	**300%**

CMS assumption of 150,000 minutes per year = (50 wks/year)(50hrs/wk)(60min/hr)

CMS formula: (1/(mins_yr*usage))*price*((intrate/(1-(1/((1+intrate)^life)))+maint)) where mins_yr=150,000, usage=0.5, maint=.05 and intrate=0.11.

	CMS Published		Recalculated	
	COST_MIN	Cost-NF	COST_MIN	Cost-NF
Cost/minute calculation for G-0249	$0.0099	$14.2973	$0.0099	$57.1893

Impact of Recalculation on Fully Implemented RVUs	Per G0249 unit
Recalculated Cost-NF	$57.1893
Less: CMS-1385-P	$14.2973
= Net Change	$42.8920
2007 Conversion Factor	37.8975
Recommended Increase to RVUs	1.13
Plus: Proposed Fully Implemented RVUs	2.72
= Recommended Fully Implemented RVUsIncrease to RVU	3.85

Submitter : Dr. James Karn M.D. **Date:** 08/06/2007

Organization : Dr. James Karn M.D.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment...

CMS-1385-P-5122-Attach-1.DOC

#5122

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 : **Jane Emerson** **Date: 08/06/2007**

Organization : **University of California, Irvine**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

These comments are submitted in reference to the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008 .
I am a board-certified pathologist practicing in an academic setting at the University of California, Irvine Medical Center and strongly support closing loopholes that allow physicians to profit from pathology services. I believe arrangements that give physician groups a share of revenues ordered and performed for the group s patients are in violation of the spirit and letter of the Stark law prohibiting physician self-referral. Physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
These revisions are necessary to eliminate financial self-interest and will not adversely impact the delivery of pathology services to Medicare patients.
I appreciate the initiative on the part of CMS in this important undertaking.
Thank you.
Jane F. Emerson, MD, PhD.

Submitter : **Dr. Randall Haase** **Date: 08/06/2007**

Organization : **Dr. Randall Haase**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Clarksville Tennesee as part of a small group of Pathologists that live our community and are trying to raise our families while our costs increase and your payments decrease. I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

Randall R. Haase DO

Submitter : **Date: 08/06/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1385-P-5125-Attach-1.RTF

#5125

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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