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

Organization : Atlantic Anesthesia Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1385-P-5126-Attach-1.DOC

#5126

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Lorraine Bundschuh** **Date: 08/06/2007**

Organization : **Atlantic Anesthesia Inc.**

Category : **Nurse Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments.

CMS-1385-P-5127-Attach-1.DOC

#5127

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

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

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Franklin Montellano** **Date: 08/06/2007**

Organization : **CAP**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attachment.

CMS-1385-P-5128-Attach-1.TXT

#5128

Franklin D.R. Montellano, M.D., S.C.

August 6, 2007

Dear Sir/ Madam:

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 Geneva, IL as part of Pathology Consultants, S.C. – a 5-member pathology group practice.

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

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

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

Sincerely,

Franklin D.R. Montellano, M.D.

1252 N. Rohlwing Rd.
Palatine, IL 60074
Tel: (847) 991-7165

Delnor-Community Hospital
300 Randall Rd.
Geneva, IL 60134

Submitter : **Mr. Ellis Herz** **Date: 08/06/2007**

Organization : **Maxsons Drugs**

Category : **Pharmacist**

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

This would be a terrible idea. Many software programs are not able to get electronic prescriptions. Also those that do come directly to our computer ge filled but have no provision to let us know if it really is a new RX or an OK on one we are waiting for the doctor to call back on. This leads to multiple fills of the same medication or multiple calls to the doctor for the same medication.

Ellis
818-789-0301

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

Organization : **Northwestern Feinberg School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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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.

John T. Sullivan, M.D
Associate Professor of Anesthesiology
Northwestern Feinberg School of Medicine
251 E. Huron St., F 5-704
Chicago, IL, 60611

Submitter : Dr. Vijaya Joshi **Date:** 08/06/2007

Organization : University of Tennessee

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

The federal register eitation 72 Federal Register 38122. re: COLOR FLOW DOPPLER.
I am the director of a PEDIATRIC ECHOCARDIOGRAPHY LAB where color flow doppler is used.To do color flow doppler we first have to do 2D imaging. Then the color flow is added and finally the spectral doppler. The color flow essentially DOUBLES the time that a 2D study needs to do and images that need to be scrutininzed. In pediatries our on call and community hospital studies are largely done by physicians ,without sonographers, for no additional reimbursement. For congenital heart defects this 2 step and twice the time eonsuming process is essential to accuracy. In some patients (e.g. premature babies and children that have had multiple surgeries or complex lesions) the color flow is essential to make the diagnosis , but it must be be done IN ADDITION to the 2D studies. Otherwise the 2D does not define provide the FLOW through structures. A color flow only study does not show the anatomy adequatley. One cannot replace the other but needs to be done in ADDITION. As it it we don't get reimbursed for doing newer additional imaging modalities (e.g. there is no way to bill for saline contrast which takes time effort and patient consent) (e.g. as of this time we do tissue doppler imaging and color m mode on select patients without additional charges) that add further time and effort. Finally since I practice mostly in the heart of Memphis , most of my patients are on Tennessee, Mississippi or Arkansas medicaid plans or have no insurance. Our ability to continue to devote resources and allocate time to these needy children depends on adequate reimbursement. Our overhead costs keep going up.
I realize that the government is trying to cut costs but for those of us in pediatric cardiolgogy where the echo is the foundation for surgical management of complex lesions and studes are typically significantly more complex than in adult cardiology we should be continued to be reimbursed for the additional time needed andded value provided by color flow doppler. Thanks

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

Organization : Brian Haworth MD PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1385-P-5132-Attach-1.DOC

5132

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

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

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Brian Haworth

Submitter : **Dr. Hongxiu Ji** **Date: 08/06/2007**

Organization : **Eastside Pathology**

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 Bellevue, WA as part of a 16-member pathology group. We operate an indcpendent laboratory and practice in three regional hospitals. I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology scrvices. 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-offiec ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to climinatc 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 of patient care. 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,
Hongxiu Ji, MD, PhD

Submitter : **Dr. daniel mcdonald** **Date: 08/06/2007**

Organization : **Dr. daniel mcdonald**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

I am writing to give my 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, moastly due to undervaluation of anesthesia work compared to other physician services. Today , 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 senoirs , 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 situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32% work undervaluation- a move that would result in an increase of nearly $4 per anesthesia unit and serve as a major step forward in correcting the undervaluation of anesthesia services. I am pleased that the Agency accepted the recommendation in its prop[osed rule, and I support full implementation of the RUC's recommendation.
To ensure that our patients have access to expert anesthesiology 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 serios nmatter.

Dan McDonald, M.D.

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

Organization : **Untied Anesthesia Inc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern:

It is my understanding that the RUC has recommended to CMS to increase the conversion factor for anesthesia services by just under $4.00 per unit based on the undervaluation of anesthesia work. After many years of suffering cuts in the conversion factor, along with a wide difference in reimbursement for anesthesia services as compared to other specialties, this proposed increase is strongly encouraged by myself and my group.

Sincerely,

Robert E. Heflin II MD

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

Organization : Georgia Anesthesiologists, PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Earlier this year, the RUC submitted to CMS a recommendation to boost the anesthesia conversion factor to account for a calculated 32 percent work undervaluation. This would go a long way in keeping good anesthesia providers in the hospital settings where most the medicare patients are going. Anesthesiologists are flocking to outpatient ASCs - they get reimbursed significantly more to take care of healthier patients. The Hospitals then can't staff to take care of the medicare / medicaid patients. Anesthesiologists get reimbursed at .30 on the dollar per medicare compared to commercial insurance companies which is one of the worst conversion factors in all medicine specialties. Hospitals are going to have a hard time staffing ORs because of this - both anesthesiologsts and anesthetists are leaving the hospital setting and finding out patient centers because they know the medicare population goes up exponentially in 2010 / 2011. This bill would go a long way to ensure good anesthesia care in all hospital settings and make hospitals more competitive in the anesthesia market without having to have help from the hospitals or shut down ORs. Increasing the conversion factor would go a long way to help ailing Hospitals who are subsidizing anesthesia groups to help them attract anesthesia providers. Thank you for this consideration.

Submitter : **Dr. Phillip Reed** **Date: 08/07/2007**

Organization : **Dr. Phillip Reed**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Carol Ann Fischer **Date:** 08/07/2007

Organization : Dr. Carol Ann Fischer

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I strongly urge Medicare to table this proposal. Medicare patients with fixed incomes and limited resources would be unable to pay for the additional costs to visit an orthopedist just to get x-rays so that they could get chiropractic care. By limiting a chiropractor from referring to another physician to take x-rays, all Medicare costs will increase. A better solution would be to allow chiropractors to take their own x-rays. All chiropractors are licensed and trained to take x-rays, and they should be reimbursed for the x-rays instead of making it more difficult to get x-rays taken by other physicians, Please eliminate 'technical corrections', and consider letting chiropractors treat and diagnose as they are licensed.

Submitter : **Dr. Robert Franklin** **Date: 08/07/2007**

Organization : **Dr. Robert Franklin**

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 pathologist and a member of the College of American Pathologists. I practice in Evansville, Indiana as part of a 5-member pathology group within a non-profit 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,

Robert M. Franklin, M.D.

Submitter : Dr. Jason Cunnan **Date:** 08/07/2007

Organization : Anesthesia Medical Group of Riverside

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

The GPCI needs to be increased in the rapidly growing urban area of Riverside CA.

Submitter : **Dr. Kent Elliott** **Date: 08/07/2007**

Organization : **Scott & White Memorial Hospital and Clinics**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Julie Bell** **Date: 08/07/2007**

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Bahram Robert Oliai** **Date: 08/07/2007**

Organization : **ProPath Laboratory**

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 (certified in Anatomic, Clinical, and Cytopathology)and a member of the College of American Pathologists. I practice in Dallas, Texas as part of large group pathology practice.

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

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

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Sincerely,

Bahram Robert Oliai M.D.
ProPath Laboratory
8267 Elmbrook Drive
Suite 100
Dallas, TX 75247

Submitter : Dr. Nirav Shah **Date:** 08/07/2007

Organization : University of Michigan

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.

Submitter : **Dr. Gerald Bailey** **Date: 08/07/2007**

Organization : **Ameripath**

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 member of the College of American Pathologists. My practice is located in Shelton, CT where I am part of a multi-member independent laboratory pathology group.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give clinical physician groups a share of the revenues from the pathology services that are 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 support revisions to close the loopholes that allow physicians to profit from pathology services.

Specifically, I support expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the current 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. Because the Medicare program should ensure that providers furnish care in the best interests of their patients, restrictions on physician self-referrals are an imperative 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. Robert Forte** **Date: 08/07/2007**

Organization : **Associated Anesthesiologists of Fort Wayne**

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.

Over the last several years we have seen the loss of 12 physicians in our group. Our physician group serves a high acuity hospital with a large medicare population. Due to lack of income and increasing workloads we were forced to restrict the services we could offer to our hospital. Only now with a great deal of support from the hospital have we been able to recruit some physicians to offer adequate coverage to the high medicare sevrvices in our hospital. This though is only temporary, and an increase in the medicare conversion factor would greatly increase the chances of our group surviving on its own in the long run. Please help us.

Thank you for your consideration of this serious matter.

Robert A Forte MD

Submitter : **Dr. Beth Ann Traylor** **Date: 08/07/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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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,

Beth Ann Traylor M.D.

Submitter : **Dr. Charles Abbott** **Date: 08/07/2007**

Organization : **Dr. Charles Abbott**

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 [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other 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.

Sincerely,

Charles Abbott MD

Submitter : **Date: 08/07/2007**

Organization :

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

What a travesty it would be to restrict patients from getting the chiropractic care that they need and deserve. This non-paymnet of X-Rays would be a major road block for these people. Please, do not put this into effect. I have already had a Medicare patinet that has been affected by this issue. They are now struggling to pay off Mercy Memorial Hosiptal in Monroe, MI because the Xrays were not covered because I(a chiropractor) referred them for the procedures.

Submitter : **Dr. Patrick Williams** **Date: 08/07/2007**

Organization : **Greenville Anesthesiology, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Patrick F. Williams, M.D>

Submitter : **Dr. Wayne Gabriel** **Date: 08/07/2007**

Organization : **Greenville Anesthesiology, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Respectfully,
Wayne M. Gabriel, M.D.

Submitter : Dr. Gary Kirshenbaum **Date:** 08/07/2007

Organization : Midwest Diagnostic 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 Chicago, IL as part of a 40 member pathology group, practicing in a hospital as well as involvement in a reference 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,

Gary Kirshenbaum, M.D.

Submitter : Dr. J. Martin Tingey **Date:** 08/07/2007

Organization : Dr. J. Martin Tingey

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

At current Medicare reimbursements for anesthesia services, it will eventually become impossible to provide for the elderly.

Submitter : **Date: 08/07/2007**

Organization :

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
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.

E.Douglas Culverhouse JR MD

Submitter : **Ms. Sherlyn Hailstone** **Date: 08/07/2007**

Organization : **SSM St. Joseph Health Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

August 7, 2007

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

RE: CMS-1385-P Anesthesia Coding

Dear Ms. Norwalk:

I am writing on behalf of the many Medicare patients that SSM St. Joseph Health Center serves in St. Charles, Missouri. Currently, the Medicare payment for anesthesia services stands at just $16.19 per unit. It is my understanding that the proposed increase to anesthesia payments under the 2008 Physician Fee Schedule would result in an increase of nearly $4.00 per anesthesia unit. This would serve as a major step in correcting the long-standing undervaluation of anesthesia services.

We are very pleased that CMS has recognized this undervaluation of anesthesia services and are taking steps to address it. I am writing to express my strong support of this effort and encourage CMS to follow through with the proposal as recommended.

Thank you for your attention and consideration of my comments and support to move forward with this.

Sincercly,

Shcrlyn Hailstonc
President

Sh/ph

Submitter : **Dr. David Long** **Date: 08/07/2007**

Organization : **Critical Health Systems**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Thank you for your consideration of this serious matter.

Submitter : Dr. Ariel Soffer **Date:** 08/07/2007

Organization : Florida Institute For Cardiovascular Care

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : **Date: 08/07/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I am writing as a cardiologist in response to the proposed CMS bundling of color flow Doppler into all of the other echocardiogram base codes. It is unacceptable to not provide any additional payment for color flow Doppler. It is imperative the CMS understand the additional practice expense and physician work involved in the performance and interpretation of color flow studies. Please refrain from eliminating payment for color flow Doppler, as it will have a significant impact on the echocardiography community and on patient care and safety.

Submitter : **Dr. Alex Slucky** **Date: 08/07/2007**

Organization : **Colorado Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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To ensure that our patients havc access to expert anesthesiology medical carc, 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,

Alex V. Slucky, M.D.
President, Colorado Society of Anesthesiologists

Submitter : **Dr. Madhav Swaminathan** **Date: 08/07/2007**

Organization : **Duke University Medical Center**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others at Duke University Medical Center, 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 quantifying the severity of these lesions. In particular, color Doppler information is critical to the decision-making process in patients with heart valve disease undergoing valve surgery. It also allows us echocardiographers in the operating room to guide our surgical colleagues on the indication for valve surgery and immediately evaluate results of surgery. Each of these assessments is crucial to the short and long term outcome of our patients. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac eonditions.

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 physician time and equipment time that are required for a study; in fact, the physician 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 physician 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 acknowlcdgcs) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an indcpcndcnt consultant and submitted by the American Collcge of Cardiology and the American Socicty of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT codc 93307. However, these data, which were previously submitted to CMS, also indicate that an cstimated 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,

Madhav Swaminathan, MD, FASE
Periopcrative Echocardiography Service
Dukc Univcrsity Medical Center

Submitter : **Dr. Curt DeGroff** **Date: 08/07/2007**

Organization : **Childrens Hospital of Pittsburgh**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in Children s Hospital of Pittsburgh, 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, eolor Doppler information is critical to the decision making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions, ESPECIALLY IN OUR PEDIATRIC PATIENTS with congenital heart disease.

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 ESPECIALLY IN OUR PEDIATRIC PATIENTS with congenital heart discase. 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 servicc that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

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

Sincerely,
Curt DeGroff, MD
Director of Non-Invasive Cardiac Imaging
Children's Hospital of Pittsburgh