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CMS-1392-P

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Submitter : **Ms. kristen heinbaugh** **Date: 07/27/2007**

Organization : **emery medical solutions**

Category : **Health Care Professional or Association**

Issue Areas/Comments

OPPS: Packaged Services

OPPS: Packaged Services

I oppose all changes for the bundling of services in echocardiography. The components are billed in 3 seperate parts because 3 seperate functions are utilized for the evaluation. 2D and m-mode are utilized to evaluate atrial, ventricular and valvular structure and motion. Color Doppler is applied to assess for the presence of of valvular stenosis and or leakage. Pulsed wave and continuos wave Doppler are applied to quantify the stenosis or leakage detected by Color Doppler. From the perspective of an echocardiographer, I feel that it necessary to bill seperately for each component performed for the full evaluation.

#78

CMS-1392-P

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Submitter : Mr. George Miranda **Date:** 08/01/2007

Organization : DeKalb Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Payment for Therapeutic Radiopharmaceuticals

Payment for Therapeutic Radiopharmaceuticals

You list median costs for ibritumomab tiuxetan and tositumomab at between $8000 and $12000; however, we have to pay our radiopharmaceutical supplier somewhere between $18000 and $22000 for these drugs. I don't think hospitals are pricing these according to their cost-to-charge ratio, which is causing you to seriously underestimate the actual acquisition costs of Zevalin and Bexxar. This will effectively block access to both of these drugs for all lymphoma patients, since we won't be able to afford to provide it to teh 50% of clinically eligible patients who are Medicare recipients, and because we can't discriminate against Medicare patients with regard to access to treatments, we won't be able to offer the treatment to the other half of eligibile patients, either.

#80

CMS-1392-P

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

Organization : **Wood County Hospital**

Category : **Hospital**

Issue Areas/Comments

Blood Transfusions

Blood Transfusions

Hospitals should be able to charge for the number of units transfused per day, not just one transfusion per day.

#82

CMS-1392-P

Because the referenced comment number does not pertain to the subject matter for CMS-1392-P, it is not included in the electronic public comments for this regulatory document.

Submitter : **Dr. Wyman Lai** **Date: 08/01/2007**

Organization : **American Society of Echocardiography**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS--1385--P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008

Dear Sir or Madam:

I am writing regarding the CODING (ADDITIONAL CODES FROM 5-YEAR REVIEW) issues before your committee. I am a pediatric cardiologist practicing at an academic medical center in New York City. Approximately 1/2 of my practice is with patients on Medicaid, and the fees for the rest are significantly affected by the Medicare payment schedule.

I provide cardiac imaging services to children with congenital heart disease, most with echocardiography. The proposed CMS rule to "bundle" color flow Doppler (CPT Code 93325) with other echocardiography codes would reduce the reimbursement for an echocardiogram by approximately 30% in our group. This, quite literally, could put us out of business.

We use color Doppler to examine the heart for abnormal flow jets that result from valve abnormalities, holes in the heart, or abnormal blood vessels that children are born with. This is above and beyond the screening that we can do with 2D imaging and spectral Doppler evaluation. Not everyone needs this screening, and many providers are not performing this type of detailed screening on all echocardiograms.

One proposed solution would be to increase payment for the general echocardigoraphy codes. The amount would need to be significant to cover our costs for the expertise and time required to perform the color Doppler portion of the examination. Moreover, color Doppler is also used for fetal cardiac examinations and transesophageal echocardiogarms in my laboratory. The proposed "bundling" and elimination of a color Doppler code would severely affect our ability to perform these other services for the underprivileged population that we serve.

Most academic pediatric echocardiography laboratories are barely breaking even under the current system of reimbursement. The loss of color Doppler reimbursement would drive us to reduce our adoption of newer technologies that would benefit our patients.
Therefore, I ask that you please re-examine the negative effects of the proposed "bundling" of CPT Code 93325 on the care of patients.

Sincerely,

Wyman W. Lai, MD, MPH
Divison of Pediatric Cardiology
Mount Sinai Medical Center
wyman.lai@mssm.edu

Submitter : **Ruth Broek** **Date: 08/02/2007**

Organization : **Ruth Broek**

Category : **Individual**

Issue Areas/Comments

Device-Dependent APCs

Device-Dependent APCs

I would like CMS to reconsider its proposal to make the radiologic supervision and interpretation (RS&I) codes for diagnostic angiography conditionally bundled beginning in calendar year 2008. Diagnostic angiography is an important diagnostic tool and has advantages over Computed Tomographic Angiography (CTA) and Magnetic Resonance Angiography (MRA) for anatomical areas that are prone to movement and calcium distortion such as the head, chest, abdominal and pelvic viscera. Calcium and patient motion can also substantially degrade extremity imaging in some cases. The proposal appears to be a move by CMS to push vascular diagnostic studies to CTA and MRA. This is currently not clinically feasible for many diagnostic studies.

The proposal states that the RS&I codes will be bundled into the related surgical procedure codes, however, in the case of angiography, this is the catheter placement codes. Catheter placement codes (36100 36248) are currently assigned Status Indicator N and not separately reimbursed. The number of catheter placement codes would indicate the complexity of the case however; they cannot be used for that purpose in their current status.

The number of diagnostic angiography procedures performed at one setting can vary greatly and the proposal to pay for only one study will cause most hospitals to lose money when performing diagnostic angiography studies. For example, when examining the vasculature of the head and neck, there may be imaging of one to four different vessels (two carotid and two vertebral arteries). To pay for imaging of only one of these vessels when each is injected and imaged separately would impose undue hardship on the hospital. In addition it doesn t seem financially sound to reimburse a simple abdominal aortogram (36200, 75625) the same as an arch and 4 vessel study of the head and neck (75650, 75671, 75680, 75685, 75685, 36215, 36216, 36217, 36218) with the inherent risks and difficulties potentially encountered. How can the value of the two procedures be the same?

Additionally, the proposed system would result in no payment at all for diagnostic angiography performed in the same session as an intervention (e.g., vascular stent placement, thrombolysis, etc.). It is often in the patient s best interest, especially in an emergency situation, to provide the diagnostic angiography and the subsequent intervention, when needed, in the same session. Your proposal tends to promote performing the sessions separately which is not convenient for the patient or clinically sound in many instances.

CMS indicates the proposal is to promote more efficient services. However, these are minor surgical procedures and how they are performed and the supplies used are at the physician s discretion. The hospital, without placing itself at significant liability risk, cannot dictate to the physician what procedures will be performed and the devices allowed. Until CMS places the same restrictions on physicians, there will be no change in practice, only monetary losses by the hospital.

I strongly urge CMS to rescind the proposed conditional bundling of the RS&I procedures for diagnostic angiography. However, if CMS is adamant that conditional bundling is the only option, it should be implemented for physicians at the same time or prior to implementation at hospitals. Unless the incentives are aligned, the hospitals have little chance of survival.

Thank you for your consideration of my concerns,

Ruth Brock, MBA, RT(R), CCS, CHC

CMS-1392-P-84-Attach-1.DOC

CMS-1392-P-84-Attach-2.DOC

CMS-1392-P-84-Attach-3.RTF

CMS-1392-P-84-Attach-4.DOC

CMS-1392-P-84-Attach-5.DOC

#84

OPPS: Device-Dependent APCs

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Thank you for your consideration of my concerns,

Ruth Broek, MBA, RT(R), CCS, CHC

Submitter : Ms. Cathy Smeed **Date:** 08/02/2007

Organization : Catholic Healthcare West

Category : Hospital

Issue Areas/Comments

Blood Transfusions

Blood Transfusions

CHW respectfully requests that CMS reconsider its decision to continue to reimburse CPT 36430 (Transfusion Blood & Blood Components)on a once/day basis. We request that you consider a structure similar to CPT 90765/66 or at a minimum, reimburse CPT 36430 on a per unit of blood product rather than a per day. Transfusion administration requires constant patient observation and frequent vital signs regardless of whether it is the first unit transfused or subsequent units. As you are aware, transfusion of more than one unit per day is very common. Thank you for your consideration of this request. We have 43 hospitals in our system, if we can provide you with any additional data or information, please contact Cathy Smeed at 602-307-2978 or cathy.smeed@chw.edu.
Respectfully,
Cathy Smeed

Submitter : **Dr. David Filipi** **Date: 08/03/2007**

Organization : **Physicians Clinic, Inc.**

Category : **Physician**

Issue Areas/Comments

Necessary Provider CAHs

Necessary Provider CAHs

Proposed OPPS Rules - Changes to Critical Access Hospital Provider-Based Requirements

As vice president of medical affairs for a 150 physician group affiliated with an Omaha system, I write in strong support of your proposal, which is actually a clarification of existing policy, on pages 682-684 from CMS-1392-P.

That clarification states that a provider based facility must be within 35 highway miles of a critical access hospital (CAH) and further that the provider facility must not be within 35 miles of another hospital.

A clear example showing the need for this policy occurred in Glenwood, IA, a bedroom community of the Omaha area within 35 miles of at least 4 metropolitan, non-critical access hospitals. Our clinic system owns and operates a 5 provider family practice in Glenwood, and 2 other providers have practices there. Using an FDA guaranteed loan for rural development, Grape Community Hospital a CAH in Hamburg, IA, within 35-miles, only as the crow flies, built a clinic directly across the street from our clinic, staffed with a nurse practitioner and occasional physicians. According to Grape board members, the hospital sponsored that initiative to increase market share as their population was dwindling. The administrator believed that the future was to extend their reach into a potentially growing population.

Our belief is that CAH s were financed and designed to serve the needs of the underserved, not to compete in the market against not-for-profit hospitals who are not subsidized by the federal government like the CAH.

Since the clarified rules and regulations are not in any sense new policy, we strongly believe that those institutions that violate this policy should not be grandfathered in. Grandfathering would only reward poorly thought out behavior contrary to public policy.

David H. Filipi, MD, MBA, FAAFP

Methodist Physicians Clinic

Omaha, NE

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

Organization : **Surgicenter of Murfreesboro Medical Clinic**

Category : **Health Care Professional or Association**

Issue Areas/Comments

ASC Impact

ASC Impact

I am very concerned about the reduction of payment to colonoscopy procedures. We do 300-400 per month at our asc and will likely have to shift a large volume to the hospital - as it will decrease our ability to do this procedure without a loss. If a physician utilizes a snare or other expensive equipment, it can cost as much as the current proposed reimbursement. This will enivitably drive the cost up for Medicare to pay the hospital reimbursement.

Submitter : Ms. Mary Nan Holley **Date:** 08/07/2007

Organization : Heartland Spine and Specialty Hospital

Category : Hospital

Issue Areas/Comments

Implantation of Spinal Neurostimulators

Implantation of Spinal Neurostimulators

This pass through has allowed our hospital to effectively treat patients suffering from chronic pain with rechargable neurostimulators. We feel if a seperate APC is not created for these systems our hospital will not be able to continue to offer this therapy as our costs will not be covered. CMS recognises there is a $6500 cost difference between non-rechargable and rechargable systems. This cost difference is significant for our hospital. We strongly encourage CMS to create seperate APCs for rechargable and non-rechargable neurostimulators on the basis of the substantial cost difference and the substantial clinical results provided by rechargable systems. As a hospital, we are willing to change our coding to accommodate new level II HCPS codes that would be required. While CMS mentions creating a new clinical APC is not justified due to the fact that retaining both rechargable and non-rechargable systems in APC 222 does not cause a two times violation, we encourage CMS to look at other examples where the two times violation did not occur yet seperate APCs were created. One example is APC 654 and APC 655. The clinical differences between rechargable and non-rechargable neurostimulators is tremendous, the main difference being able to implant two or more leads with eight electrodes each. The eight electrode leads span multiple vertebral bodies allowing greater relief of chronic pain. These leads require a larger power source that rechargable neurostimulators supply. If a seperate APC is not created for rechargable systems, our patients suffering from chronic intractable pain will not have access to this technology that has changed so many patients' lives over the past two years. Thank you for your consideration of these comments.

Submitter : **Dr. Nathan Miller** **Date: 08/07/2007**

Organization : **Coastal Pain Medical Group**

Category : **Other Health Care Provider**

Issue Areas/Comments

Implantation of Spinal Neurostimulators

Implantation of Spinal Neurostimulators

I am writing in support of reversing the current proposal to combine and reduce the payments for rechargeable implanted neurostimulator. I am a physician provider who has placed neurostimulators for the past 14 years. The largest advance in this therapy occured several years ago when the rechargeable units became available. These units provide excellent pain and symptom relief to some of our most difficult patients; in some cases returning them to a normal life. The non-rechargeble units unfortunately require replacement every few years which not only is a medical liability but also adds serious costs to this therapy. If the proposed reduction goes through, it is likely that rechargeable therapies will no not be available to implant as the surgery centers will not be able to fund the shortfall.

Please reconsider,

Nathan Miller, M.D.

Submitter : **Dr. Marshall McCabe** **Date: 08/07/2007**

Organization : **Dr. Marshall McCabe**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Section 482.22 - I believe that the term anesthesia services should be better defined utilizing standard terminology such as moderate sedation, deep sedation and general anesthesia. Do you propose that the same requirements regarding history and physicals and post anesthesia evaluation apply for moderate sedation performed by the procedualist or surgeon and general anesthesia performed by an anesthesiologist?

Submitter :

Date: 08/08/2007

Organization :

Category : Individual

Issue Areas/Comments

Packaged Services

Packaged Services

see att

Submitter : Mr. Francisco Gomez **Date:** 08/09/2007

Organization : Pulmonary Physicians of South Florida

Category : Other Health Care Professional

Issue Areas/Comments

PET/CT Scans

PET/CT Scans

Further cut of the payments for PET/CT would be a disaster for the patients it would result in delays of treatment and increase of expenses. The dacronian that were implemented previously have made a negative impact on healthcare .Please do not make another mistake and further more reconsider and implement a moratorium retroactive to january.

#93

CMS-1392-P

Because the referenced comment number does not pertain to the subject matter for CMS-1392-P, it is not included in the electronic public comments for this regulatory document.

Submitter : Mr. Ken Goad **Date:** 08/10/2007

Organization : St. Vincent Health System

Category : Other Technician

Issue Areas/Comments

PET/CT Scans

PET/CT Scans

Dear CMS:

I am writing you in regards to Medicare s proposed payment for FDG PET procedures under the Hospital Outpatient Prospective Payment System for Calendar Year 2008. St.Vincent Infirmary Medical Center has been providing Positron Emission Tomography (PET) services since July 1995. We were the first institution in Arkansas to offer the service and had to have our radioactive glucose flown in daily from Vanderbilt University in Nashville, Tennessee. Having performed over 9000
PET procedures has made us one of the experts in the field.

In March of 2003 St. Vincent in a partnership with PETNET Solutions had the states first cyclotron installed on our campus. That machine now supplies radiopharmaceutical to almost the entire state of Arkansas.

I appreciate the hard work and careful consideration CMS put into developing the proposed rule and am aware of the rate and payment method for PET services that CMS has set forth in the Federal Register. In response to the agency s request for public comments on this issue, I would like to urge CMS to retain current Medicare payment for these critical services as a separate payment for the radiopharmaceutical and for the technical component. The proposed payment reductions for PET radiopharmaceuticals will have limiting effects on beneficiary access to PET services.

Proposed bundling of RP into the technical payment would drastically reduce the reimbursement rate for PET scans for patients with cancer and these reductions would significantly diminish access to PET for Medicare patients. We are very concerned that our PET program simply cannot sustain such a substantial reduction in Medicare payment again in a single year and still continue to provide high quality services. The potential result would be a significant reduction in access to PET for Medicare beneficiaries.

PET s unique ability to provide physicians with information about the body s chemistry, cell function, and location of disease can eliminate unnecessary surgeries, reduce the number of diagnostic procedures and otherwise demonstrate to physicians the most effective mode of treatment. PET can evaluate tissue metabolism to determine the presence or absence of malignancy whereas anatomic imaging depends on size and location of lesions to determine likelihood of malignancy.

The clinical benefits of this technology are enormous, as are the costs of continuing to offer this service. They include the initial expenditure for the medical equipment, renovations to the facility, and the cost to employ highly trained dedicated staff that are increasingly difficult to recruit. The radiopharmaceutical FDG has a very short half-life and hospitals need to purchase sufficient quantities to administer to patients. The proposed bundling of RP into the technical component would represent a significant decrease in total reimbursement for FDG PET.

I believe that the Cost to Charge Ratio has only this year possibly begun to be utilized appropriately to accurately reflect the cost of supplying PET radiopharmaceuticals.

I appreciate the opportunity to submit and discuss these comments with you.

Sincerely yours,

Ken Goad, CNMT
Manager, Nuclear Medicine & PET/CT
St. Vincent Health System
2 St. Vincent Circle
Little Rock, AR 72205-5499
Ph: 501-552-2187
Fax: 501-552-8695
Cell: 501-690-6175
Email: kgoad@stvincenthealth.com

Packaging Drugs and Biologicals

Packaging Drugs and Biologicals

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Little Rock, AR 72205-5499
Ph: 501-552-2187
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Submitter : Mrs. Tammy Webb **Date:** 08/10/2007

Organization : shs

Category : Hospital

Issue Areas/Comments

Cardiac Rehabilitation Services

Cardiac Rehabilitation Services

The new codes are per hour, so if the patient is in Cardiac rehab less than one hour, does a modifier have to be added to show a reduced service to the new Gxxxx code.

Submitter : **Dr. Philip Blaustein** **Date: 08/11/2007**

Organization : **Dr. Philip Blaustein**

Category : **Physician**

Issue Areas/Comments

PET/CT Scans

PET/CT Scans

I am writing you in regards to Medicare s proposed payment for FDG PET procedures under the Hospital Outpatient Prospective Payment System for Calendar Year 2008. We have been providing Positron Emission Tomography (PET) services since 2002.

I appreciate the hard work and careful consideration CMS put into developing the proposed rule and am aware of the rate and payment method for PET services that CMS has set forth in the Federal Register. In response to the agency s request for public comments on this issue, I would like to urge CMS to retain current Medicare payment for these critical services as a separate payment for the radiopharmaceutical and for the technical component. The proposed payment reductions for PET radiopharmaceuticals will have limiting effects on beneficiary access to PET services.

Proposed bundling of RP into the technical payment would drastically reduce the reimbursement rate for PET scans for patients with cancer and these reductions would significantly diminish access to PET for Medicare patients. We are very concerned that our PET program simply cannot sustain such a substantial reduction in Medicare payment again in a single year and still continue to provide high quality services. The potential result would be a significant reduction in access to PET for Medicare beneficiaries.

PET Imaging has the unique ability to provide physicians with information about the body s chemistry, cell function, and location of disease can eliminate unnecessary surgeries, reduce the number of diagnostic procedures and otherwise demonstrate to physicians the most effective mode of treatment. PET can evaluate tissue metabolism to determine the presence or absence of malignancy whereas anatomic imaging depends on size and location of lesions to determine likelihood of malignancy.

The clinical benefits of this technology are enormous, as are the costs of continuing to offer this service. They include the initial expenditure for the medical equipment, renovations to the facility, as well as the cost to employ highly trained and difficult to find staff. The radiopharmaceutical FDG has a very short half-life and hospitals need to purchase sufficient quantities to administer to patients. The proposed bundling of RP into the technical component would represent a significant decrease in total reimbursement for FDG PET.

I believe that the Cost to Charge Ratio has only this year begun to accurately reflect the cost of supplying PET radiopharmaceuticals.

I appreciate the opportunity to submit and discuss these comments with you.

Sincerely yours,

Philip A. Blaustein, MD

#97

CMS-1392-P

Because the referenced comment number does not pertain to the subject matter for CMS-1392-P, it is not included in the electronic public comments for this regulatory document.

#918

CMS-1392-P

Because the referenced comment number does not pertain to the subject matter for CMS-1392-P, it is not included in the electronic public comments for this regulatory document.

#99

CMS-1392-P

Because the referenced comment number does not pertain to the subject matter for CMS-1392-P, it is not included in the electronic public comments for this regulatory document.

Submitter : Dr. W.L. Williams **Date:** 08/13/2007

Organization : Clinical Quality, Tenet Healthcare

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Acronyms found on page 42629 PPV is incorrectly labeled as "Pneumococcal pneumonia (virus)". The pneumococcus is a bacterium. What you are trying to say is PPV = pncumococcal pneumoniac vaccinc or vaccination. Not virus. WLW

Submitter : Ms. Claire Bartkewicz **Date:** 08/13/2007

Organization : Bayshore Community Hospital

Category : Hospital

Issue Areas/Comments

Implantation of Spinal Neurostimulators

Implantation of Spinal Neurostimulators

Please consider creating a separate APC for rechargeable neurostimulators. The rechargeable option translates into fewer stimulator replacements, an advantage to the patient and the healthcare system in the long run. Since the rechargeable stimulator has a higher price tag, creating a separate APC will help facilities continue to offer the advantage of clinical improvement without suffering a hardship by supplying the more expensive, but preferable neurostimulator. Using an individual HCPCS code for each type of stimulator is no different than choosing between hot biopsy forceps and snare technique for colonoscopy, and will have little to no adverse effect on hospital procedures, nor cause administrative burden.

Submitter : **Ms. Alyssa Delaney** **Date: 08/14/2007**

Organization : **The Delta Group, Inc**

Category : **Health Care Industry**

Issue Areas/Comments

Quality Data

Quality Data

We have been reviewing the proposed OPPS Rule that includes the addition of Hospital Outpatient Measure collection. We have a few questions regarding this initiative.

Questions:

What is the data source for these measures? Is it HCFA 1500 claims plus data collection?

When will the algorithms be ready for review? If current guidelines are in place then we would expect a manual 120 days prior to start date, which would be September 1st.

Will there be any reporting capabilities required in vendor tools?

Submitter : Dr. Michael Rock **Date:** 08/14/2007

Organization : Our Lady of the Resurrection Medical Center Pain C

Category : Physician

Issue Areas/Comments

Implantation of Spinal Neurostimulators

Implantation of Spinal Neurostimulators

I have a solo pain practice clinic within a community based hospital. I see a broad range of patients and get a lot of referrals to manage patients with intractable pain. I have been implanting Spinal Cord Stimulators for 5 years. The most common reasons for implanting SCS' are:

1. Severe spine pain from osteoarthritis.
2. Severe spine pain after spinal surgery (laminactomy or fusion).
3. Complex Regional Pain Syndrome.
4. Neuropathic pain (eg: Post Herpatic Neuralgia).
5. Cancer pain control.

I have placed over 100 SCS trial leads and implanted about 75 SCS permanenet leads / generators. The majority of those were made by Advanced Bionics.

As soon as the rechargeable gencrators were brought to my attention, I switched to using them instead of the non-rechargeable type. The advantages that I have found are:

1. Obviously, they last longer and most patients who get these devices will have them for the rest of their lives. The non-rechargeable units have a battery lifespan of 3 - 5 years. Rcachargeables can last as long as 20 years. Replacement is costly, painful and carries the risks of surgery (anesthesia and infection).
2. Complete freedom to use 'aggressive' settings on the stimulator because there is no need to be concerned about prolonging battery life. This translates into better pain coverage.
3. Rechargeable batteries can offer the ability to vary voltage output, thereby maintaining constant electrical outputs when impedance changes happen at the level of the electrodes. This keeps the pain control constant when the patient is active.

There is no doubt in my mind that SCS's are a godsend to many patients in dire straights from intractable pain. They are truly miraculous. Rechargeable SCS's represent a significant improvement and are a more than worthwhile choice, both in terms of efficacy and longterm cost over non-rechargeable ones.