Submitter : **Ann Pearson** **Date: 08/08/2007**

Organization : **Ann Pearson**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Norwalk: I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. The proposed changes will support the physician anesthesiologists in a fair payment for their important services. The anesthesiologists have been relatively underpaid under the present system. Thank you, Ann Pearson

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

Organization : Anesthesia Consultants of Central Florida

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.

Anesthesia Consultants of Central Florida
Jorge R. Villarreal, MD
Donald Nettlow, MD
Michael J. Simon, MD
Pablo J. Larrea, MD

Submitter : Mrs. MARJAN HESHMATI **Date:** 08/08/2007

Organization : THE METHODIST HOSPITAL

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Mr. Kuhn:

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

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

CMS s proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler s role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years. [Include additional examples from your practice of CPT codes that are rarely billed with color flow Doppler.]

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

Sincerely yours,

[Marjan Heshmati RCS
[

Submitter : Dr. GEORGE RIZK **Date:** 08/08/2007

Organization : CEDARS CARDIOVASCULAR, P.C.

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:

The Medicare cuts are extremely out of balance with the increased cost of living.

I have been informed that Medicare has proposed to bundle the color flow Doppler CPT code 93325 into all echocardiography services.
The color Doppler information is critical for the decision making process in patients with suspicion of heart valve disease as well as appropriate selection of patients for valve surgery or medical management. In addition, a color flow Doppler is important in the accurate diagnosis of many other cardiac conditions. When a color Doppler is performed extra time is necessary by both the Doctor and Technician over and above the general echo study process. This bundling will decrease each study reimbursement of about $100.00. This is a huge loss for our practice.

It is becoming increasingly difficult to satisfy staff salary and overhead as physicians like myself are being forced out of quality practice with ongoing Medicare cuts.

Please do not bundle code 93325 with all echocardiography.

Respectfully,

George T. Rizk MD FACC

CMS-1385-P-5423-Attach-1.DOC

5423

8/1/07

MERCY CARE INSURED PTS

1. HAVE M.R. PULL CHARTS & FILE WITH INACTIVE CHARTS
2. CHANGE PT STATUS TO INACTIVE

1. 779 – Man Reyes
2. 1298 – Christine Corson
3. 1522 – Harrison Breyer
4. 1743 – Angela Lamew
5. 2189 – Bobby Hays
6. 2349 – Andrew Kelley
7. 4503 – Hedy Bender
8. 6145 – Cheryle McGrew
9. 6246 – Peter Brown
10. 6466 – Richard Oxley
11. 6515 – Lawrence Medina
12. 6914 – John Velzka
13. 6930 – Francois Theroux
14. 7020 – Klara Abramova
15. 7048 – Elaine Talbot
16. 7075 – Derek Sanders
17. 7239 – Jane Frost
18. 8620 – Paul Gordon
19. 8666 – Carol Candlen
20. 9452 – John Beard
21. 9814 – Melvin Bird
22. 10577 – Rebecca Morris
23. 10620 – Judith White
24. 10785 – James Gianunzio
25. 11007 – Melvin Osier
26. 11011 – Steven Loredo
27. 11530 – Kathye Black
28. 11605 – Judy Meyer
29. 12248 – Jose Ayala
30. 12310 – Christen Pritchard
31. 12533 – Harry Lewis
32. 12593 – Marilyn Snyder
33. 12846 – Cynthia Burak
34. 13184 – Patricia Overstreet
35. 13417 – Romelia Biggsbrewster
36. 2862 – Susanne McMillan
37. 4834 – Jane Kohner
38. 8155 – Barbara Jackson

Submitter : **Dr. Matthew Grady** **Date: 08/08/2007**

Organization : **University of Iowa Hospitals 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
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. STEPHANIE AMERMAN **Date:** 08/08/2007

Organization : ST. LOUIS UNIVERSTIY HOSPITAL

Category : Other Health Care Professional

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

THIS IS REGARDING THE REIMBURSMENT OF COLOR FLOW DOPPLER IN ECHOCARDIOGRAMS. COLOR FLOW IS A SEPERATE PROCEDURE THAT IS NOT ALWAYS INDICATED. IT ADDS ADDITIONAL TIME FOR SONOGRAPHER AND PHYSICIAN IN A STANDARD ECHOCARIDOGRAM.

Submitter : **Dr. Diane Ellis** **Date: 08/08/2007**

Organization : **Dr. Diane Ellis**

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.

Diane S. Ellis, MD

Submitter : **Dr. Roland Miyada** **Date: 08/08/2007**

Organization : **Nevada Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Sincerely,
Roland W. Miyada,MD

Submitter : **Dr. Steven Saltz** **Date: 08/08/2007**

Organization : **ASMG**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Robert Friesen** **Date: 08/08/2007**

Organization : **University of Colorado**

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.

Robert Friesen, MD

Submitter : **Dr. Michael Kutner M.D.** **Date: 08/08/2007**

Organization : **Dr. Michael Kutner M.D.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

I am writing to support for the proposal to increase anesthesia payments. under the 2008 Physician Fee Schedule. I am thankful that CMS has recognized the undervaluation of anesthesia services, and that the CMS is taking steps to address this 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, my liability insurece 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,

Michael S Kutner M.D.

Submitter : Dr. Vincent Abbrescia **Date:** 08/08/2007

Organization : Delaware Heart

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

As a Board Certified Cardiologist who provides echocardiography services to Medicare patients and others in Dover, Delaware, 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.

Cordially,

Vincent D Abbrescia, DO, FACC
Vice President
Delaware Heart & Vascular Associates
567 South Governors Ave.
Dover, DE 19904
302-734-1414

Submitter : Dr. Michael Fraizer **Date:** 08/08/2007

Organization : Dr. Michael Fraizer

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Color flow doppler is not intrinsic to 2D echo performance. It takes additional physician and sonographer time to perform and interpret. With additional medical emphasis on diastolic heart function, this can take even longer. It should remain an additional code.

Submitter : **Dr. alexander nemirovsky** **Date: 08/08/2007**

Organization : **San Pedro 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)

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. Armin Wagman** **Date: 08/08/2007**

Organization : **Pediatrix Cardiology of Springfield, P.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment. I was not certain which was the correct issue area to select, but it relates to the bundling of CPT code 93325.

CMS-1385-P-5434-Attach-1.DOC

component and a lesser technology component.

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

In 1997 there were specific echocardiography codes implemented in CPT for congenital cardiac anomalies to complement the existing CPT codes for echocardiography for non congenital heart disease. "The codes were developed by the CPT Editorial Panel in response to the American Academy of Pediatrics and the American College of Cardiology's request to delineate more distinctively the different services involved in *assessing* and *performing* echocardiography on infants and young children with congenital cardiac anomalies." *(CPT Assistant 1997).*

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

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

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

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

Vignette 1 *(quoted from CPT Assistant 1997)* (example of Congenital Heart Disease)

"A three-day-old neonate with transposition of the great vessels was initially treated with an atrial septostomy with a planned arterial switch procedure at seven days. On the third day post Raskind balloon septostomy increasing cyanosis is seen with saturation dropping to the low 70s. A repeat transthoracic echocardiography (93304) with color flow Doppler study is performed *(color flow Doppler is coded in addition as a 93325).* The physician reviews the echocardiographic images and prepares a

report. The echocardiogram shows a closed patent ductus arteriousus and a small atrial septal defect. The child is returned to the cath-lab for a repeat septostomy and prostaglandin is restarted."

Vignette II (example of non-congenital heart disease)

A two-month-old infant is referred by the pediatrician to a pediatric cardiologist for a persistent murmur in an otherwise healthy infant. The pediatric cardiologist is concerned about a patent ductus arteriousus as a possible diagnosis. A ductus arteriousus, connecting the pulmonary artery and the aorta, is an essential structure during fetal life. Normally, the ductus arteriousus closes in the first few days after birth in healthy term infants. A persistent ductus arteriousus can give rise to long-term complications and needs to be followed carefully to evaluate if further intervention is needed (medical vs. surgical). Echocardiography permits an accurate diagnosis of a patent ductus arteriousus with assessment of both the hemodynamic impact if there is a shunt. Estimated pulmonary artery pressure is obtained by Doppler imaging and can exclude other associated defects also. Color flow Doppler will be able to outline the flow of a patent ductus arteriousus from the aorta to the pulmonary artery. Color flow Doppler in this baby revealed no cardiac defects or patent ductus arteriousus and the murmur was determined to be innocent.

Vignette III (example of congenital heart disease)

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

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

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

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

There are many reasons that have been described above, but I want to stress that taking care of a child with congenital heart disease is very different and unique than the typical adult cardiology patient.

Thank you for your consideration of this serious matter.

Sincerely,
Armin J. Wagman, M.D.
Pediatric Cardiologist
armin_wagman@pediatrix.com

Submitter : **Mrs. Leticia Vasquez-Mendoza** **Date: 08/08/2007**

Organization : **St. Luke's Episcopal Hospita/ Texas Heart Institut**

Category : **Other Health Care Professional**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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

Dear Mr. Kuhn:

As a cardiac sonographer who provides echocardiography services to Medicare patients and others in Houston TX- St. Luke's Episcopal Hospital/Texas Heart Institute , 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 paticnts with suspicion of hcart valvc diseasc and appropriate sclection of patients for valvc surgcry or mcdical management. In addition, color flow Doppler is important in thc accuratc diagnosis of many other cardiac conditions.

CMS s proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer timc 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 werc 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,

Leticia Vasquez-Mendoza, RCS
St. Luke's Episcopal Hospital/ Texas Heart Institute

Submitter : **Dr. John Fiadjoe** **Date: 08/08/2007**

Organization : **Dr. John Fiadjoe**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Jose Goldar** **Date: 08/08/2007**

Organization : **Dr. Jose Goldar**

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
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To cnsure 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 Laur** **Date: 08/08/2007**

Organization : **University of Iowa College of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my strongest support for the proposal to increase anesthesiology payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross and might I add severe 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 anesthesiologist's work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesiology 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 anesthesiologist 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, your constituents, and your family and friends have access to expert anesthesiology medical care which is VERY important to their comfort and safety, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesiology conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Best regards,

John J. Laur, M.D.

Submitter : **Dr. douglas chapman** **Date: 08/08/2007**

Organization : **pikes peak anesthesia assoc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

If medicare dollars are decreased any further it will be dangerous. I will do everthing in my power to stop seeing these patients. I will not work for free. Long ago the best and the brightest competed to get into the medical field. No longer the case. For God's sake don't make it any worse.

Submitter : **Dr. Karthik Reddy** **Date: 08/08/2007**

Organization : **South Denver 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
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 Karthik T. Reddy, M.D.

Submitter : **Dr. Kevin Owen** **Date: 08/08/2007**

Organization : **South Denver Anesthesiologists, P.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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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, Kevin Owen, MD

Submitter : Dr. Catherine Chimenti **Date:** 08/08/2007

Organization : F.A.C.C., American Society of Echo

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

To CMS:

As a practicing cardiologist, I must request that you refrain from eliminating paymjent for color flow Doppler Exams. A color flow Doppler Exam is an echo exam which is focused upon the diagnosis and evaluation of a specific set of valvular pathologies. It is MORE than an intrinsic part of an echocardiographic exam. The performance of an adequate color flow study requires specific technological expertise, which is time consuming as it is mandatory to have accuracy . A sonographer may spend up to 20 minutes on this portion of the exam. It is both qualitative and quantitative when correctly recorded. When the physician interprets this color flow doppler exam, the interpretation is subject to quantification criteria as well. These criteria are time consuming to review, and time consuming to compare to previous exams. Accurate interpretation influences patient management, surgical decisions, and drug therapies. This test is a valid exam, a "stand-alone" examination, and should not be considered " intrinsic to the performance of an echocardiographic exam". To consider it as such, reflects an inadequate understanding on the part of CMS for a vital cardiac diagnostic study.

Submitter : **Mr. Anders Rosenquist** **Date: 08/08/2007**

Organization : **Mr. Anders Rosenquist**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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To cnsure 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. Bruce Brookens** **Date: 08/08/2007**

Organization : **South Denver Anesthesiologists, P.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attatchment below:

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
Ancsthcsia Coding (Part of 5-Ycar Rcview)

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.

Sincerely, Bruce R. Brookens, M.D.

Submitter : **Date: 08/09/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.
Thomas F. Ingersoll, MD

Submitter : Dr. Chad Pedley **Date:** 08/09/2007

Organization : asa

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Attached below is the letter I should be attaching, but here are my comments.

Right now anesthesia physicians are reimbused roughly at a rate of 64 dollars an hour. While that may seem like alot, for someone who has spent 1/3 of their life studying and going into debt to safely provide an anesthetic this doesn't even cover their costs.

Nurses providing anesthesia charge about 100 dollars an hour. So even with an anesthesiologist working for FREE to supervise a nurse, it still costs me 36 dollars and hour to care for a medicare patient. The proposed increase in rates can help reduce the loss experiences by anesthesia groups attempting to care for our aging population.

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.

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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. jaskamal kahlon** **Date: 08/09/2007**

Organization : **Tri-city cardiology consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

This is regarding latest decision to bundle color doppler with echo. Since we don't do color doppler with every study making it a bundled study will increase our eost of performing such studies. We will nedd to hire more staff and get new equipment. I strongly urge you to reconsider this decision as it impact our practice singnificantly.

Submitter : **Dr. Deborah Chung** **Date: 08/09/2007**

Organization : **Loma Linda University**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

Rc: CMS-1385-P
Ancsthcsia 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 concerned about the viability of teaching populations that servc largely Mcdicare/Medicaid patients and am in favor of this increase in reimbursement. 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.

Yours truly,

Deborah Chung, MD

Submitter : **Dr. James Carritte** **Date: 08/09/2007**

Organization : **Beaver Medical Clinic, Inc.**

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
PO 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.

Sincerely,

James Carritte, MD
Beaver Medical Clinic, Inc.

Submitter : **Dr. Bruce Reitman** **Date: 08/09/2007**

Organization : **Dr. Bruce Reitman**

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.

Submitter : **Dr. David H. Evans** **Date: 08/09/2007**

Organization : **Anesthesia Consultants Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Rc: CMS-1385-P

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

Thank you for your consideration of this serious matter.
Sincerely,

Dr. David H. Evans MD, MSW.
13 Woodmere Drive
Dothan, Alabama 36305

Submitter : Dr. Craig Dykgraaf **Date:** 08/09/2007

Organization : Dr. Craig Dykgraaf

Category : Chiropractor

Issue Areas/Comments

Impact

Impact

This will greatly inhibit good and appropriate health care of those that are in the Medicare system. I would like to know the reasoning behind this change. What kind of outcome is expected? Whom are the persons suggesting and or directing this proposed change? {Please respond to these questions>}

I have a number of family and patients that where stunted by this and feel that they are being short changed and feel that this type of direction should be stopped. In fact they would like to see that exams with x-ray be included with their medicare.

Submitter : **Date: 08/09/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

Paul Zelenkov MD

Submitter : Dr. Mark Cady **Date:** 08/09/2007

Organization : Anesthsia Group of Onondaga, PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please be advised that Medicare payments to anesthesiologists are so low that many medicare patients cannot obtain services. It costs more for me to treat Medicare patients than I am being paid. I cannot continue to spend more money for my Medicare patient's care than I am being reimbursed.

Please increase Medicare reimbursement for anesthesia services so that I will be able to provide Medicare beneficiaries with the quality services they deserve.

Sincerely,

Mark D. Cady, MD

Submitter : Dr. Merete Ibsen **Date:** 08/09/2007

Organization : UIHC-Anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#3455

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 : Mr. Hunter Bowie **Date:** 08/09/2007

Organization : Rehabilitation Centers of Charleston

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I am concerned about the proposed cuts in reimbursement for physical therapy in CY 2008. Re-imbursement was cut 6% in the previous year and the proposals for CY 2008 will mean a 15% reduction in re-imbursement over the past 2 years combined. Being a small and independently owned clinic, reductions in re-imbursement can have a major effect on the day to day operations of our clinic and ultimately the service we are able to provide our patients. Please re-consider the proposed cuts in re-imbursement for the benefit of all Medicare participants.

Submitter : **Mr. Carl Schindelar** **Date: 08/09/2007**

Organization : **Franklin Square Hospital Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Carl J. Schindelar
President

Submitter : Dr. Barry Talesnick **Date:** 08/09/2007

Organization : Cardiology

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

We would like to comment on the proposal to bundle color flow Doppler into all other echo base codes without any additional payment for these base codes.(Federal register citation 72 Federal Register 38122) We strongly oppose this for the following reasons: 1. We do not use color flow Doppler for all echo procedures and 2. Color flow Doppler requires additional echo tech time and additional physician time. This budling would result in our remibursement level falling while our expenses remain unchanged or increase. Ultimately, as this trend of lower payments combined with rising overhead costs continues, patient care will be negatively affected.

Submitter : Dr. Sarah Titler **Date:** 08/09/2007

Organization : Dr. Sarah Titler

Category : Physician

Issue Areas/Comments

Medicare Economic Index (MEI)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Heriberto Gutierrez **Date:** 08/09/2007

Organization : Desert Cardiology of Tucson

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a cardiologist who regularly interprets echocardiograms, I can attest to the value of Color Doppler imaging in caring for patients. The technique continues to be challenging due to individual patient anatomy, which complicates the acquiring and interpreting of the Color Doppler data. This should justify continuing the seperate payment for Color Doppler rather than having it bundle into the other echo-related codes.

Submitter : Patrick Costello **Date:** 08/09/2007

Organization : Johnson City 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 Johnson City, TN as part of a 7 member private practice, Watauga Pathology Associates, that practices at the labs of Mountain States Health Alliance hospitals (TN/VA), Takoma Regional Hospital (TN), and Norton Community Hospital/Dickenson Co Community Hospital (VA).

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 medical specialy practices 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,

Patrick N. Costello, MD

Submitter : Dr. Joseph Vassallo **Date:** 08/09/2007

Organization : Cardiology

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

We would like to comment on the proposal to bundle color flow Doppler into all other echo basc codes without any additional payment for these base codes. (Federal register citation 72 Federal register 38122). We strongly oppose this for the following reasons: 1. We do not use color flow Doppler for all echo proccdures and 2. Color flow Doppler requires additional echo tech time and additional physician time. This bundling would result in our reimbursement falling while our expenses remain unchanged or increase. Ultimately, as this treand of lower payments combined with rising overhead costs continues, patient care will be negatively impacted as physicians may not be able to afford to continue their participation in the Medicare program.

Submitter : Dr. Jay Yedlin **Date:** 08/09/2007

Organization : Mid AMerican Surgical Institute

Category : Ambulatory Surgical Center

Issue Areas/Comments

Background

Background

Please find that I support the Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies that is being considered by CMS. This is being considered under Docket:CMS-1385-P.
Thank you for your consideration.
Jay H Yedlin

Submitter : **Date: 08/09/2007**

Organization : **American Chiropractic Center**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Dear CMS, I wanted to write today to say that we are strongly opposed to a section of your proposed rule dated July 12th that eliminates the reimbursement to a beneficiary for an xray taken by a MD or DO and used by a Doctor of Chiropractic to determine a subluxation. Xrays are very important for reasons other than just subluxations for manipulation; xrays allow doctors to see an array of potentially dangerous problems. While you may not think it appropriate to reimburse for chiropractic diagnostics, please do not place an undue burden on the patients. Chiropractic has seen a number of cuts this year across insurances even though it is the most inexpensive treatment option for pain management; we are asking that CMS continue to make chiropractic an available option for people in need. Chiropractic saves CMS millions of dollars each year by effectively treating pain without drugs and without residuals. Help us to continue to be able to give exceptional care. Thank you.

Submitter : Mr. Joseph Finnerty **Date:** 08/09/2007

Organization : New York Presbyterian Hospital/Weill Cornell Medic

Category : Other Practitioner

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

I do not use color doppler for every patient. The use of color doppler increases the duration of the echocardiogram and also the time of interpretation by the physician.

Submitter : Dr. Sean Dwyer **Date:** 08/09/2007

Organization : Cardiology

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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We would like to comment on the proposal to bundle color flow Doppler into all other echo base codes without any additional payment for these base codess. (Federal register citation 72 Federal register 38122). We strongly oppose this proposal for the following reasons: 1. We do not use color flow Doppler for all echo procedures and 2. Color flow Doppler requires additional echo tech time and additional physician time. This bundling would result in our reimbursement falling while or expenses remain unchanged or increase. Ultimately, as this trend of lower payments combined with rising overhead costs continues, patient care will be negatively impacted as physicians may not be able to afford to continue their participation in the Medicare program.

Submitter : **Dr. Deborah Barbour** **Date: 08/09/2007**

Organization : **Cardiology**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Submitter : Dr. Harris Kenner **Date:** 08/09/2007

Organization : Cardiology

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Submitter : Dr. Morton Kavalier **Date:** 08/09/2007

Organization : Cardiology

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Submitter : Dr. Andrew Peters **Date:** 08/09/2007

Organization : Dr. Andrew Peters

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I strongly urge you to abolish the recommendation that reimbursement would no longer be allowed for X-rays taken by a non-treating physician such as a radiologist and used by a Doctor of Chiropractic to determine a subluxation. These X-rays, if needed, are integral to the overall treatment plan of the Medicare paticnts and it is ultimately the patient that will suffer should this proposal become standing regulation.

Submitter : **Dr. Stephanie Jones** **Date: 08/09/2007**

Organization : **Dr. Stephanie Jones**

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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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,

Stephanie B. Jones, MD

Submitter : **Dr. Jaime Llobet** **Date: 08/09/2007**

Organization : **Dr. Jaime Llobet**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in Miami,Fl 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 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 cchocardiographic studics, 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 becomc more complex. Thc sonographer and equipmcnt time and the associated overhead required for the pcrformance 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 Mcdicarc paymcnt for a service that (as CMS itsclf 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 thc provision of this important service.

Sincerely yours,

Jaime Llobet, MD

Submitter : Dr. William Doyle **Date:** 08/09/2007

Organization : Anesthesiology Associates of North Florida

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please support the increase in the Anesthesia conversion factor.
This longstanding inequity has definitely led to a reduction in the numbers of Medicare beneficiaries I choose to accomodate in my practice. If not for contractual obligations with some facilities at which I provide services, I would probably completely avoid Medicare patients because of the low reimbursement for anesthesia services. It is unfair for CMS to use anesthesiologists' medical ethics and sense of duty against us to force acceptance of below fair value for our services to senior citizens.

An immediate significant increase in the anesthesia conversion factor would help financially stabilize anesthesia practices across the country which have had to seek financial assistance from their hospitals. With your support of this increase, perhaps anesthesiologists like me may make room for additional Medicare patients in our practices.

Submitter : **Dr. Laima Pauliukonis** **Date: 08/09/2007**

Organization : **Dr. Laima Pauliukonis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Sincerely,
Laima Pauliukonis MD

Submitter : **Date: 08/09/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : **Dr. Jordan Sankel** **Date: 08/09/2007**

Organization : **South Denver Anesthesiologists, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Jordan H. Sankel, MD