Submitter : **Dr. Christopher Williams** **Date: 08/09/2007**

Organization : **Dr. Christopher Williams**

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. It is imperative that this be passed if our nation's senior citizens are to be properly cared for in the future. 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. Without a change of course, this country's elderly population is going to face a huge shortage of available care.

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 continued access to expert anesthesiology medical care, it is urgent 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.

Chris Williams, M.D.

Submitter : Dr. Randy Lance **Date:** 08/09/2007

Organization : Anesthesiology Group Associates

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Thank you for your consideration of this serious matter.

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

Organization : **Professional Anesthetic Care**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-5479-Attach-1.DOC

#5479

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Theodore Burdumy** **Date: 08/09/2007**

Organization : **Anesthesia Medical Group of Santa Maria**

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

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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.

As I practice in a rural area, these changes will help us to recruit and retain professional staff to provide care to our patient population, many of whom are indigent.

Thank you for your consideration of this serious matter.

Sincerely,

Theodore James Burdumy, MD, MBA
Diplomate, American Board of Anesthesiology

CMS-1385-P-5480-Attach-1.PDF

#3480

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.

Because I practice in a rural area, this change will help us recruit and retain needed medical professionals to serve our growing population, many of whom are indigent.

Thank you for your consideration of this serious matter.

Sincerely,

Theodore James Burdumy, MD, MBA
Diplomate, American Board of Anesthesiology

Submitter : **Dr. Thomas Haas** **Date: 08/09/2007**

Organization : **Mercy Health Systems**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Janesville, Wisconsin as part of the Department of Laboratory Medicine of Mercy Health System.

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

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

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

Sincerely,

Thomas S. Haas, DO, FCAP
Mercy Health Systems
1000 Mineral Point Avenue
Janesville, WI
53548

Submitter : **Ms. Kathy Mottle** **Date: 08/09/2007**

Organization : **Cardiology Associates of Miami Beach, PLLC**

Category : **Other Technician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

As a cardiac sonographer who provides echocardiography services to Medicare patients and others in Dade County, Florida. 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 indcpendent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routincly 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,

Kathy Mottle
Cardiology Associates of Miami Beach, PLLC

Submitter : **Dr. Marc Kerman** **Date: 08/09/2007**

Organization : **Colorado Anesthesia Consultants**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

As an anesthesiologist with a large percentage of Medicare patients, 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.

Marc Kerman, MD

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

Organization : **American Society of Anesthesiologists (ASA)**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Mark Ceraso

Submitter : **Dr. Glenn Gall** **Date: 08/09/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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To ensure that our patients have access to expert anesthesiology medical eare, 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. Sandra Coleman** **Date: 08/09/2007**

Organization : **Retired Individual**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please grant the rate increase to Anesthesiologists under the proposed 2008 Physician Fee Schedule. Highly skilled in their field, Anesthesiologists deserve more than $16.19! I am a retired senior citizen. If we are to continue to have the best health care in the world, the growing Senior population will suffer without this justifiable increase. Thank you.

Submitter : Ms. ruth ginsberg **Date:** 08/09/2007

Organization : aano

Category : Pharmacist

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

yes i agree. pay them more.

Submitter : **Mrs. Krista Marie Schultz** **Date: 08/09/2007**

Organization : **Gulf-to-Bay Anesthesiology Associates, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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Krista Marie Schultz
Business Development & Contracting
Gulf-to-Bay Anesthesiology Associates, P.A.

Submitter : Dr. Reza Azar **Date:** 08/09/2007

Organization : Dr. Reza Azar

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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Sincerely yours,

Reza Azar, MD

Submitter : **Dr. Marsden Stewart** **Date: 08/09/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Marsden Stewart

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

Organization : **Dr. William Garrett**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter,

William M Garrett MD
Olympia, WA

Submitter : **Dr. Philip Wolok** **Date: 08/09/2007**

Organization : **Affiliated 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

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Thank you for your consideration of this serious matter.

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

Organization : **Anesthesia Services of Benton County**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-5493-Attach-1.DOC

#5493

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. Amy Backer **Date:** 08/09/2007

Organization : Incyte Pathology, Inc.

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 Year 2008". I am a board-certified pathologist and a member of CAP. I practice in Spokane, WA as part of an 18-member pathology group which both operates our own independent laboratory and practices in regional hospitals as medical directors.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from pathology services ordered and performed for their 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,

Amy Backer, MD

Submitter : Dr. Benjamin Kleiber **Date:** 08/09/2007

Organization : Dr. Benjamin Kleiber

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

I write to clarify the extra time and effort spent in acquiring and interpreting the echocardiographic color doppler examination, and state that this invaluable procedure is not part of the routine transthoracic echocardiographic examination. This procedure is entirely separate and and should not be bundled with standard 2D imaging. Trained technicians are needed to obtain multiple detailed images and extra physician time (and advanced training) is needed for interpetation; often the analysis requires time-consuming mathematical calculations and yields important information that determines how physicians manage patients, i.e. surgery vs medical therapy. Please feel free to contact me if I can be of further assistance in stating separate and critical role of color doppler.

Submitter : **Dr. Todd Hickox** **Date: 08/09/2007**

Organization : **Thoracic Cardiovascular Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

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

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 appropriatc 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 arc 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 Medicarc 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 Amcrican College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT codc 93307. However, these data, which were prcviously 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 Codc 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 ovcr 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,

Todd G. Hickox, DO
Thoracic Cardiovascular Institute

Submitter : **Dr. Basaviah Chadnramouli** **Date: 08/09/2007**

Organization : **Pediatric Cardiology, P.C.**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

1. Children are not "Small Adults"
2. Congenital Heart Defects are different from Adult Cadiac Problems
3. To know anatomy, physiology and interventions required - need thorough knowledge that is possible by a detailed Echocardiographic study. Such study is not the same as a "adult echocardiogrphic study"
4. Previous mistakes made by CMS has resulted in significant drop in payments but the need for a thorough study has changed enormously; due to the increased number of complex pediatric cardiology diagnoses.
5. CPT 93325 should not be bundled with any other codes.
6. RUV's should be increased for the Pediatric Cardiac Echocardiology Study due to the amount of time that is required to review and make a diagnosis.

Pediatric Cardiology, P.C.
330 Laurel Street, Suite 2200
Des Moines, IA 50314

Basaviah Chandramouli, MD
Thomas E. Becker, MD
Stephen J. Mooradian, MD
John S. Lozier, MD

Submitter : **Dr. John Haworth** **Date: 08/09/2007**

Organization : **South Denver Anesthsiologists, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS:

Re: CMS-1385-P

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 thc 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 eonversion factor increase as recommended by the RUC.

Thank you for your eonsideration of this serious matter.

Cordially,

John M. Haworth, MD
South Denver Anesthesiologists, PC

Submitter : **Dr. Terry Hamilton** **Date: 08/09/2007**

Organization : **Dr. Terry Hamilton**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Terry Hamilton,D.C.

Medicare Telehealth Services

Medicare Telehealth Services

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

Re: TECHNICAL CORRECTIONS

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

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

Sincerely,

Terry Hamilton,D.C.

Submitter : **Dr. Larry Shirley** **Date: 08/09/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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. Keith Cromwell** **Date: 08/09/2007**

Organization : **Pinnacle Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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As the hospital population of my practice continues to age, and the demographics continue change unfavorably, I have been re-evaluating my desire to practice in such a challenging environment. I am in my early 40's. I am strongly considering other career options that would exclude care of the Medicare population. I am even exploring returning to non-medical graduate education and a new non-medical career.

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. There are system wide access and quality issues that need similar attention.

Keith T. Cromwell MD
13846 Creekside Place
Dallas, Texas 75240

Submitter : **Dr. Theresa FitzGerald** **Date: 08/09/2007**

Organization : **Rowena Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Re: TECHNICAL CORRECTIONS

I am writing to oppose the proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated.

I am a chiropractor of seventeen years working without my own x-ray lab. When Medicare patients need x-rays to identify a subluxation or to rule out any "red flags," or also to determine diagnosis and treatment options, or to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist, I will send my patients to the local radiology department like all the other healthcare professionals do.

By limiting a Doctor of Chiropractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Patients will suffer as result of this proposal.

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

Sincerely,
Theresa FitzGerald, DC
Rowena Chiropractic
2904 Rowena Avenue
Los Angeles, CA 90039

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

Organization : Dr. William Polsky

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir:

My comment concerns CMS 1385-P. Technical Corrections. As a practicing Doctor of Chiropractic I strongly urge you to eliminate the reccommendation 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 Medicare patients and it is ultimately the patient that will suffer should this proprosal become standing regulation. The x-ray can be a very important piece of information used to arrive in the diagnosis of the patient's condition. By limiting a Doctor of Chiropractic from referring directly to the radiologist for an X-ray study, the costs for patient care could go up due to the probability of a referral to another provider (family doctor, orthopedist, rheumatologist, etc.). With fixed incomes and limited resources, seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed, illnesses that could be life threatening may not be discovered creating more complications and possibly driving up the cost for care.

Submitter : **Dr. Dianne Ansari-Winn** **Date: 08/09/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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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,
Dianne Ansari-Winn, M.D.

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

Organization : **Meridian Laboratory Physicians**

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 Red Bank, NJ, and am a member of a 12 pathologists group serving three hospitals.

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

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

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

Submitter : Dr. Penelope Duke **Date:** 08/09/2007

Organization : Dr. Penelope Duke

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Medicare reimbursment does not begin to cover the expense of practice and relies on commercial payors to fill the void. Even a small increase in reimbursement will be beneficial to my practice.

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

Organization :

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

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

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

Sincerely,

Robert Clarke

Submitter : **Dr. Theodore Saylor** **Date: 08/09/2007**

Organization : **Dr. Theodore Saylor**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

As a matter of fact, radiology is a part of the curriculum of chiropractic physicians. We are trained about the safety and quality control of this diagnostic tool. It is ludicrous that the chiropractic profession is not reimbursed for this service provided to medicare recipients. Not only are they utilized for determination of pathology, but also, they do, indeed, assist in establishing accurate juxtaposition of subluxated joints. The fact that we currently do not enjoy that privilege reeks of restriction of trade, again, by the medical cartel.

Sincerely,

Theodore H. Saylor, B.Sc., R.Ph., D.C.
101 Cedar Rock Trace
Athens, GA 30605
706-548-8984

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

Organization : Dr. Mark Lipa

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS 1385 P will help to correct a current undervaluation of anesthesia services and hopefully help to maintain the exceptional level of expertise and dedication presently found in today's practitioners for tomorrow's patients.

Submitter : **Dr. Denham Ward** **Date: 08/09/2007**

Organization : **Uiversity of Rochester**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachemnt

CMS-1385-P-5510-Attach-1.DOC

#5510

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

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

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

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

Thank you for your consideration of this serious matter.

Denham S. Ward, M.D., Ph.D.
Professor of Anesthesiology and Biomedical Engineering
University of Rochester
Rochester, ny 14642

Submitter : **Dr. Kai Rodning** **Date: 08/09/2007**

Organization : **University of Alabama at Birmingham**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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,
Dr. Kai Rodning

Submitter : **Mr. Adam Hosmann** **Date: 08/09/2007**

Organization : **Mr. Adam Hosmann**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Adam Hosmann

Submitter : **Dr. Eric Weissend** **Date: 08/09/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Submitter : Dr. DAVID BIRDWELL **Date:** 08/09/2007

Organization : INNOVATIVE PATHOLOGY SERVICES

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I appreciate the opportunity to comment on the Physcian Self-Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008." I am a board certified pathologist and a member of the College of American Pathologists. I practiee in Knoxville, Tenn. as part of a 13 member pathology practice that covers multiple hospitals over several counties.

I commend your initiative in bringing an end to abusive self-referral practices in the billing and payment for pathology services. I am well aware of such a set-up in this community. Until about a year ago we interpreted large numbers of prostate biopsies. We began to see news of "pod lab" situations around the country developed by urologists to off-set medicare cuts. We had always had an excellent relationship with the urologists and were stunned when they proposed that we set up a lab, staff it anyway we wanted, process their biopsies as always but allow them to bill globally and pay us a fee. The fee would be reduced but we would make up for it in volume. We felt like this was blatant self-referral, totally unethical and declined the arrangement. Unfortunately a smaller group in neighboring Oak Ridge agreed to the arrangement, and now all the biopsies go to them. General surgeons have told us how the urologists boast about their enhanced revenues from captured pathology. This galls me to think that physicians would artificially and unethically gouge patients and their insurance carriers when the cost of medicine is already prohibitively high. Only in America!

These arrangements are sophisticated but blatant abuses of the Stark Law prohibition against physician self-referral, and I support revisions to close the loopholes that allow physicians to profit from pathology services they do not perform. I think it is imperative for CMS to act quickly because the longer these practices continue the more likely it is that they will become the norm. The more money the urologists and gastroenterologists make the harder they will try to justify their practices (lobbyists, legal battles, etc.).

A closely related situation is the practice of gastroenterologists sending all their biopsies to a far away lab which then allows the gastroenterologist to send the bill (client bill). Of course, there is a markup of the artificially low pathology bill which the referring gastroenterologist pockets. This practice is nothing more than kickback. A large G.I. practice here in Knoxville is the prototype of this type of client billing and is affiliated with a lab in Memphis. They were written up in the Wall Street Journal. The guise is that they get "better service" from that lab. That better service is $$. The G.I. client bill program has been allowed to proceed for years with minimal ineffectual legislation at the state level to slow them down. There is a very strong G.I. lobby, and this problem may never change if left to the whims of legislators.

Opponents of the proposed changes claim some vague patient benefit, but this is simply not true. The motives are completely transparent no matter how eloquently or passionately they plead. Client billing and pod labs exist to enhance the revenues of clinical phyicians by charging for services they do not perform. The unethical pathologists that are their callaborators reduce the prices of their services (kickback to the clinician) and make up the difference in volume. This arrangement causes the volume to increase (the greater the volume the more money), and overutilization occurs. With the old system there was no stimulus to overutilize: The urologist or gastroenterologist performed the biopsy, sent it to the pathologist and each billed for his own work. This is a time honored and honorable way of providing medical services that docs not encourage overutilization or dishonest kickbacks.

Sincerely,

David A. Birdwell, M.D.

Submitter : **Dr. Paul Kim** **Date: 08/09/2007**

Organization : **Beaver 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

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

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Thank you for your consideration of this serious matter.

Paul S. Kim MD

Submitter : Dr. Lloyd Marks **Date:** 08/09/2007

Organization : Lloyd Marks, MD, FACC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-5516-Attach-1.PDF

#5516 1

LLOYD MARKS, MD, FACC

Non-Invasive, Invasive & Interventional

PEDIATRIC & ADULT CONGENITAL CARDIOLOGY

Mailing Address: 1021 Minisink Way, Westfield, NJ 07090

PHONE: (908) 789-0512 PAGE: (800) 408-0471 FAX: (908) 789-0232

Essex County Office
36 Newark Avenue, Suite 220
Belleville, NJ 07109
phone: (973) 844-9700

Union County Office
940 South Ave., Suite A
Westfield, NJ 07090
phone: (908) 789-0512

Middlesex County Office
98 James Street, Suite 209
Edison, NJ 08820
phone: (732) 632-9499

August 9, 2007

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

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

To CMS:

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

My comments particularly pertain to **the practice of pediatric cardiology and adult congenital cardiology** I have practiced in this field for over twenty-seven years, the last ten as a private practitioner. I did my cardiology training at Johns Hopkins, where, as a fellow, I assisted in the first pediatric valvuloplasty, the use of a catheter to alleviate an obstruction in a pulmonary valve. I am a fellow of both the American College of Pediatrics and the American College of Cardiology, and served as the director of the pediatric cardiology catheterization laboratory at St. Christopher's Hospital for Children in Philadelphia, PA, and as chief of the division of pediatric cardiology of United Hospital in Newark, New Jersey.

As will be discussed in this letter, I recommend that:

(1) The proposal should NOT be implemented; and

(2) Any future modification to the current methodology with respect to pediatric cardiology practice be allowed to **go through the appropriate evaluation process to determine: (a) whether bundling of the 93325 is appropriate and if so, (b) what revision to the RVUs for the echo codes** with

which it would be bundled should occur to **ensure that the work and expense associated with the bundled CPT would be appropriate.**

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

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

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

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

   This shift is reflected in the development of national standards such as those present in the Intersocietal Commission for the Accreditation of

Echocardiography Laboratories (ICAEL) initiative to develop and implement an echo lab accreditation process. The focus of this initiate 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 groupings 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), and the basic differences in the problems of the two populations (pediatric diagnoses largely, though by no means exclusively, pertain to holes in the heart, anatomical obstructions, and faulty anatomical connections in the heart and the problems that result from these anatomical abnormalities). Furthermore, and by no means to be underestimated, the inaccuracies that result from this approach can be linked to the basic issue of getting a child to be still while performing complex imaging procedures; the TIME needed to perform this work, which itself is more complex than that performed on adult patients, is often hours in the case of babies and young uncooperative children.**

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 diagnosis purposes and it forms the basis for subsequent clinical management decisions. **It should 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.**

Examples

A brief description of the sequence and purpose of the 2-D echo and the Doppler color flow velocity mapping may help to illustrate these points. Because the first concern of the pediatric cardiologist is anatomy and abnormal anatomy, the 2-D echo is done first. Often it is the case that abnormalities are not seen until the Doppler color flow velocity mapping is done. A small ventricular septal defect (VSD) often is not seen initially using 2-D echo. After it is detected using the Doppler color flow velocity mapping, the pediatric cardiologist goes back, with the use of the new information, and sees the defect. This is done because if one measures the defect using the Doppler color flow velocity mapping, one can over estimate the size of the defect. Often one goes back and forth between the two studies, each having served important diagnostic purposes.

Another example of the need to perform each of these phases of the examination, and how they each serve a diagnostic purpose is seen with an atrial septal defect (ASD) as well as a VSD. The exam starts with the 2-D echo, but then one must know whether the shunt is unidirectional or in two directions, that is left to right, right to left, or bidirectional. The Doppler color flow velocity mapping is used to answer that question which has important treatment implications.

During gestation, there is a connection between the pulmonary artery and the aorta that is essential to development. But this connection normally closes in the first few days after birth. If it does not close, there can be serious long-term complications. A patent ductus arteriosus (PDA), may first be diagnosed using 2-D echo. However, sometimes it can only be seen on color flow. Once again showing the distinct diagnostic nature of the procedure. Then it is imperative that flow direction is determined. Left to right means one thing, while right to left often means a more serious condition, ductal dependence. This is determined using Doppler color flow velocity mapping, again a distinct diagnostic purpose.

Doppler color flow velocity is often needed to elucidate abnormal flow in patients with congenital heart defects.

93325 is used to determine turbulent flow which may indicate risk of bacterial endocarditis.

Conclusion

It is imperative that the bundling proposal not be implemented. The impact on pediatric cardiologists must be understood and addressed in an appropriate evaluation process, taking the time and care to insure considered judgment about these important issues.

Respectfully submitted,

Lloyd A. Marks, MD, FACC

Submitter : Ms. Cari Lausier **Date:** 08/09/2007

Organization : American Society of Echocardiography

Category : Other Health Care Professional

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Color flow doppler while intrinsic to an echocardiographic examination is a specialized part of the exam which requires time and patience to perform expertly. I spend a lot of time "mapping" with color flow when performing echo exams. Which means examining jets relating to valvular anatomy and the chambers of the heart to ensure that the stored images I take actually depict what I'm seeing so the physician can make an accurate diagnosis. Just today I performed a limited echo which took longer than the original echo because a physician wanted to examine the jet while he was in the room scanning with me to avoid having to submit the patient to a transesophageal echo. We did PISA with color flow on the mitral valve. As you can see while it is intrinsic to an echo exam, it is an extra step which takes a lot of time to do right. Please don't eliminate this reimbursement.

Submitter : **Ms. Elizabeth Murray** **Date: 08/09/2007**

Organization : **The Care Group, LLC**

Category : **Other Technician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

For echo proceedures to eliminate payment for color flow doppler.
We do not use color flow for all echo proceedures. Color flow takes more time for the tech to do, and more time for the physician to read. To eliminate payment for this proceedure would be detrimental to some labs. It takes time to do a complete study that is diagnostic, if payment is eliminated, many practices will be forced to do shorter quicker studies, that will not give adequate information that is needed. In order to have and maintain an echo machine and a tech, the reimbursement must be there. If practices are forced to shorten the exams to do more studies to be able to maintain a machine, the physician will not get edequate info, thereby forcing them to just do more testing on the patient thereby costing medicare more money. If bundling is needed to help medicare with payments, then you can not just eliminate the payment of color, but to incorperate that payment into the payment for 2D.
Liz Murray, Supervisor echo department, The Care Group, LLC

Submitter : **Dr. junjie wang** **Date: 08/09/2007**

Organization : **portsmouth anesthesia associates**

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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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. Anil Desai** **Date: 08/09/2007**

Organization : **Indian River pathology, P.A.**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018
Attention: CMS-1385-P

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 Fort Pierce, Florida as part of the Department of Pathology at Lawnwood Regional Medical Center and Heart Institute and as a solo practitioner at Indian River Pathology, an independent laboratory.

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

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

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

Sincerely,
Anil Desai, M.D.

Submitter : **Dr. Boris Aronzon** **Date: 08/09/2007**

Organization : **Dr. Boris Aronzon**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Sincerely,
Boris Aronzon, MD

Submitter : **Dr. Christopher Malik** **Date: 08/09/2007**

Organization : **Dr. Christopher Malik**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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

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Thank you for your consideration of this serious matter.

Sincerely,

Christopher J. Malik, M.D.

691 N. 1610 Rd.
Lawrence, KS 66049

Submitter : **Dr. Lincoln Nymeyer** **Date: 08/10/2007**

Organization : **Oro Valley Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Christopher Shadid **Date:** 08/10/2007

Organization : Northwest Anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-5524-Attach-1.PDF

#5524.

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Dr. Carson Johnson** **Date: 08/10/2007**

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

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
J. Carson Johnson, M.D.

Submitter : **Dr. Mark Mathis** **Date: 08/10/2007**

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

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Respectfully,
Mark D. Mathis, M.D.

Submitter : **Date: 08/10/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Being a small independently owned PT practice, Medicare participants are a large part of our patient population. Cutting benefits again will have a large impact on our clinic, and the care that we are able to provide our patients. Please consider the effect that this cut would have small clinics, and more importantly on the patients' well being. More cuts equals less therapy, directly affecting the quality of life of our elders!

Submitter : **Dr. gareth morgan** **Date: 08/10/2007**

Organization : **Dr. gareth morgan**

Category : **Physician**

Issue Areas/Comments

Background

Background

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

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Thank you for your considcration of this serious matter.

Gareth Morgan

Submitter : **Dr. Gerard Costello** **Date: 08/10/2007**

Organization : **Dr. Gerard Costello**

Category : **Physician**

Issue Areas/Comments

Background

Background

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

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Thank you for your consideration of this serious matter.

Gerard Costello, MD

Submitter : **Dr. Desiree Carlson** **Date: 08/10/2007**

Organization : **Carlson Pathology Associates, P.C.**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 10, 2007

Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

Attention: CMS-1385-P

Dear Sir or Madam:
Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Brockton, Massachusetts as part of Carlson Pathology Associates, P.C., a subchapter S corporation consisting of five pathologists who provide anatomic and clinical pathology services at the Brockton Hospital, a community hospital in an underserved area, 20 miles south of Boston.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.
Sincerely yours,
Desiree A. Carlson, MD
Chief of Pathology
Brockton Hospital
President, Carlson Pathology Associates, P.C.
680 Center Street
Brockton, MA 02302

Submitter : Ms. Alice Forster **Date:** 08/10/2007

Organization : Trinitas Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Color flow doppler is an essential a part of an echocardiogram which requires time and skill of the sonographer and also interpretation by the cardiologist.

Submitter : **Dr. Fritz Andersen** **Date: 08/10/2007**

Organization : **Dr. Fritz Andersen**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

CODING ADDITIONAL CODES FROM 5-YEAR REVIEW

I would like to register my comment in regard to reduction of payments for COLOR DOPPLER examination when doing echocardiographic studies. This additional part of the examination is NOT done routinely and takes additional time by the recordnig technician and the interpreting cardiologist.

Sincerely. Fritz Andersen, M.D. The Cardiovascular Group, P.C.

Submitter : Mrs. Cynthia McMahon **Date:** 08/10/2007

Organization : Mrs. Cynthia McMahon

Category : Other Practitioner

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am a registered cardiovascular technologist with nine years experience in the field, so please, take these comments as relevant comment. Not all echocardiograms include colorflow Doppler. Colorflow is used when diagnosing or following up on certain pathologies. The performance of colorflow takes additional time to image as well as time to interpret for the physician. Further, the expense of additional storage either on tape or electronically of the colorflow data (10 to 15 minutes standard VHS or approximately 2MB per image with an average of 20 images)must be considered.

Bundling of colorflow Doppler without an appropriate increase in reimbursement is not only penalizing the physician providers, but will impact the technologist providers. Pay levels will decrease, experienced technologists will leave for other work, and fewer new technologists will enter a field aready exeriencing personnel shortages.

High quality imaging, and therefore a high quality of medical service to our patients, costs the providers both time and capital. Please, if you feel you must bundle colorflow Doppler into another code, at least pay those of us doing the work for our time and effort.

Thank you.

Sincerely,
Cynthia L. McMahon, B.S., R.D.C.S., R.V.T.

Submitter : Dr. Thomas Capannari **Date:** 08/10/2007

Organization : Pediatric Cardiology of Michiana

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment please.

CMS-1385-P-5534-Attach-1.TXT

#5534

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

RE: File Code: CMS-1385-P, CODING-ADDITIONAL CODES FROM 5-YEAR REVIEW

Dear CMS,

I am writing regarding the proposed change to bundle CPT 93325 into CPT 76825,76826,76827,76828,93303,93304,93307,93308,93312,99214,93315,93317,93320,93321, and 93350 when provided together.

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

1. I do not believe the appropriate process has been followed with respect to this change. After significant research between the RUC and American College of Cardiology and the American Society of Echocardiography, the CPT editorial panel has recommended that a new code be established that would bundle 93325 with 93307 to begin 1/1/09. The CPT panel did not recommend that the list of above echo codes be bundled as well with the 93325.

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

The shift is reflected in the development of national standards such as those present in the Intersocietal Commission for the Accreditation of Echocardiography Labs initiative to develop and implement an echo lab accreditation process. The focus of this initiative is on process, not on the technology associated with the provision of echocardiography services. This 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 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 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.) 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. The 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.

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 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 payer groups, the resources available today that allow us to support programs that provide this much needed care to our patients will not be sufficient to continue to do so should the proposed change to bundle 93325 with other pediatric cardiology echocardiography codes be implemented.

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

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

Sincerely,

Thomas E. Capannari, M.D., F.A.C.C., F.A.A.P.
Diplomate of American Board of Pediatric Cardiology

Submitter : **Date: 08/10/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 10, 2007
Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Augusta, Georgia as part of four-physician pathology group that provides pathology services for a hospital laboratory and for an outside pathology laboratory.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exeeption to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.
Sincerely,
David L Booker, MD

Submitter : Dr. Terese Farrar **Date:** 08/10/2007

Organization : Dr. Terese Farrar

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

By limiting a Doctor of Chirpractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, ete.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as a result of this proposal.

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

Sincerely,

Dr. Terese Farrar

Submitter : **Dr. Christina Ylitalo** **Date: 08/10/2007**

Organization : **Dr. Christina Ylitalo**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

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Sincerely,

Christina J. Ylitalo D.C.

Submitter : **Dr. William Paslak** **Date: 08/10/2007**

Organization : **American Chiropractic Association**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

Submitter : **Dr. Glenn D. Goldman** **Date: 08/10/2007**

Organization : **Fletcher Allen Health Care/UVM College of Medicine**

Category : **Physician**

Issue Areas/Comments

Coding--Multiple Procedure
Payment Reduction for Mohs
Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Please see attached letter dated 8/10/07.

CMS-1385-P-5539-Attach-1.DOC

#5539

Vermont's Academic Health Center

Filed electronically at http://www.cms.hhs.gov/eRulemaking

August 10, 2007

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

Re: CMS 1385-P: 2008 Medicare Fee Schedule
Coding – Multiple Procedure Payment Reduction for Mohs Surgery

Dear Sir/Madam:

I am writing to offer my comments on section II.E.2 (P-122) of the 2008 Medicare Fee Schedule Proposed Rule, which proposes to change how Mohs surgery is reimbursed by Medicare.

I am a dermatologic surgeon at Fletcher Allen Health Care and an associate professor at the University of Vermont. I am also the immediate past Chair of the Scientific Advisory Committee of the American College of Mohs Surgeons. I have been performing dermatologic surgery in Vermont for 12 years at Fletcher Allen Health Care – the University of Vermont College of Medicine.

As a dermatologic surgeon I focus mainly on skin cancer removal. Over a million Americans per year are diagnosed with skin cancer, and over the last ten years the rate of new skin cancer diagnoses has increased dramatically. Substantial morbidity and mortality is associated with skin cancer.

Mohs micrographic surgery (MMS) is a common way of treating nonmelanoma and some melanoma skin cancers and is considered the gold standard among treatments for nonmelanoma skin cancer, allowing the physician to examine 100% of the cancer margin to insure complete removal of the cancer with loss of as little normal skin as possible. It provides the patient with the highest cure rate of any treatment for skin cancer. Mohs surgery is an outpatient procedure that utilizes onsite laboratory analysis of excised tissue while the patient waits for the results. In my 12 years as a Mohs surgeon at Fletcher Allen Health Care I have removed approximately 7500 skin cancers using MMS. During this time I have accomplished a cure rate of well over 99%, despite the fact that some were very challenging, with prior treatment having failed on multiple occasions.

The Issue:

The issue involves the application of the "multiple procedure rule" (MPR) to surgical procedures. The MPR is used by CMS when two surgical procedures are performed on the same day. With the MPR, the higher-value procedure is paid in full, and the lower-valued procedure paid at 50%. The rationale for the MPR is that face-to-face time for two procedures on one patient is generally less than that for two procedures on two patients.

There are a number of procedures that have always been exempt from the MPR, most notably those procedures for which the majority of the work effort does not involve time spent with the patient face-to-face. **MMS was exempted from the MPR in 1991 based on the fact that most of the work associated with the MMS procedure is laboratory work that does not involve face-to-face time with a patient.** As a result, since 1991, when two MMS procedures are done on the same day both are paid in full at the CMS rate. Similarly, once a tumor has been completely removed by MMS, the repair has been considered a separate encounter, since the patient actually leaves the operating suite while awaiting the results of pathology. This decision had been affirmed on several prior reviews of the code 17304, most recently in 2004.

Over the last ten years there has been a marked increase in the utilization of MMS. As a whole, the increased utilization of MMS has had a tremendous positive impact on skin cancer care. When I arrived in Vermont, there were many cases of recurrent skin cancers resulting in marked disfigurement. Now that MMS is available, these cases are much rarer, and most tumors are removed with cure.

Last year the Mohs codes were up for review by the Specialty Society Relative Value Update Committee (RUC), an American Medical Association committee designated to assign relative values to given procedures. The implicit goal of this review was to establish two sets of codes, one for MMS on the face, hands, genitalia, and feet, and the other for other locations, where MMS should rarely be utilized. With input from my professional organization, the American College of Mohs Surgery (ACMS), the RUC proposed new site-specific codes for Mohs surgery, namely CPT codes 17311, 17312, and 17313. These recommendations and associated Relative Value Units (RVUs) were proposed and accepted by CMS for MMS. At the same time, however, the RUC recommended and then CMS elected to apply the MPR to Mohs surgery for the first time. No explanation for this shift was made available. The ACMS protested this decision, which had been made without notice, in violation of CMS's policies. CMS agreed and temporarily restored the MPR exemption.

As of July 1st of this year, CMS again announced a planned change in payment policy. (The proposed payment revisions were published in the Federal Register on July 12; *see* 72 Fed. Reg. 38122, 38146.) The planned change would remove Mohs surgery from the longstanding exemption from the MPR. The change would decrease reimbursement by

50% for either the Mohs excision or for the associated repair, as well as for Mohs excision or repair of any additional cancers treated on the same day.

The implications of this decision:

This decision, if implemented, will negatively affect skin-cancer patients who need MMS procedures, as well as substantially reducing the revenues Mohs-trained dermatologists need to cover the cost of these services. In addition, if the intent of the change is to save Medicare money, the result will likely be the opposite - more money will be spent on more procedures, without the efficiency, cost-effectiveness, and patient-centeredness of today's practices.

To illustrate, at present the Mohs surgeon who removes a lesion and repairs the wound on the same day is paid at the Medicare rate for both procedures. MMS and repair tend to be done in an outpatient setting, and facility fees are not usually applied. If the repair (often a very challenging part of the surgery) is only paid at ½ value due to the MPR, many Mohs surgeons will refer the repair to a colleague in plastic surgery or ENT. This practice is already reasonably common in dealing with difficult cases as a collaborative effort, but it will become widespread if MMS and repair cannot be billed in full on the same day. Since both plastic surgeons and otorhinolaryngologists work exclusively in the operating room, an unintended result will be that the cost per lesion per patient will include not only the full repair amount but also the operating room costs along with anesthesia. This will actually result in an overall higher expenditure per given lesion. In addition, whereas Mohs surgeons will frequently remove two or more lesions on the same day, if they are only paid 50% for the second lesion, they will have no choice but to request that the patient come back on a second day. Although this is inefficient and not patient-care friendly, it will become the standard practice in order for Mohs surgeons to cover their costs.

Let me give you a real-life example of how it works now, and what will likely happen should this new rule take effect. I recently treated a woman with four skin cancers on her face. I was able to remove all four in a single session, and repaired the wounds appropriately. From the patient's perspective, she was happy to have all four spots taken care of in one sitting. She needed to make only one trip to the hospital, was able to minimize the disruption to her life, and was able to know that all four cancers had been taken care of simultaneously.

In terms of the actual procedure, four removals were done, and four pathology specimens were mounted, cut, stained, and analyzed. The patient was then returned to the operative suite and all four sites were repaired surgically. The patient was allotted a substantial time allocation and spent the majority of the morning in the outpatient suite.

Medicare reimbursement for all of this work was $4,281.49. This reflected payment in full for all four Mohs surgery removals (17311 - 4 units), payment for the largest repair in full, and - because the MPR is already applied to the other three repairs - 50% payment for each of them.

If the MPR were implemented for the Mohs code 17311, the reimbursement would have been $2,960.89 - a reduction of $1,320.60, or 31%. This amount would not have covered the cost of running my lab, paying my technician, my nurse, my medical assistant, the room time, the surgical instruments and supplies, and the remainder of my staff expenses.

If on the other hand the MPR were applied and we performed surgery for her four lesions on four separate days, Medicare would reimburse $3,879.95 - an overall savings to Medicare of only $401.54 from how it would be reimbursed today, but an increase to the physician of $919.06. Despite the enormous imposition on patients to treat them in this inefficient manner, the difference in payment to the physician will likely mean that lesions would start to be treated one at a time in order to ensure that the costs of the services are covered.

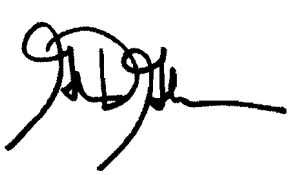
Furthermore, if these procedures were to be performed by plastic or general surgeons in the hospital, the costs would be even higher, since the pathology fees and facility fees would be multiple times that of the MMS and repairs as listed.

Similarly, if the MMS were done by an individual physician and the repair by a separate reconstructive surgeon, the overall cost would also be higher.

For the reasons stated above, I urge you not to adopt the proposal in section II.E.2 (P-122) of the 2008 Medicare Fee Schedule Proposed Rule, but instead to continue the longstanding exemption of MMS procedures from the MPR rule. The planned change in Medicare reimbursement policy will have a significant negative impact on the skin cancer care of U.S. citizens, and will likely end up increasing - rather than decreasing - overall expenditures for this health care service.

Thank you for the opportunity to express my concern. I would be happy to answer any questions you may have.

Sincerely,



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cc: Centers for Medicare and Medicaid Services (by mail, original and two copies)
The Honorable Patrick J. Leahy
The Honorable Bernard Sanders
The Honorable Peter Welch