Submitter : **Ms. Tammy Henry** **Date: 08/20/2007**

Organization : **Ms. Tammy Henry**

Category : **Individual**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Dear Ms. Norwalk:

As an individual whose has parents of Medicare age and requiring anesthesia services, 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. James Jeter** **Date: 08/20/2007**

Organization : **Dr. James Jeter**

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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Submitter : Dr. Donald Walker **Date:** 08/20/2007

Organization : Dr. Donald Walker

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Re: Proposed CMS 1285-P

The proposed legislation we feel will be a detriment with patients being able to access newer less risky surgical care.
Equipment like Lithotruipters and Green light prostate lasers are specialized high priced equipment that are not utilized in enough volume at any one facility to make it profitable enough to cover the overhead cost associated with the equipment. Physician's have banded together forming portable units which have allowed access to updated tech knowledge that would otherwise be not available.
This legislation will effect Urologist heavly as it is targeting an area that they have chosen to invest in for the well being of their patients. Be for these partnerships were formed the accessiblity of these procedures was very limited. Even in Boise Idaho we are still not able to offer Green Light PVP in the hospital setting. The two largest hospitals in the state of Idaho do not believe that they will see enough cases done to cover the cost of buying and running the equipment. We proposed a physician run partnership that would make the equipment available on a cost per case basis with no minimum number and they were all for this until this proposed legislation came out. Now all negociations have stopped.
Both Lithotripsy and Green light laser procedures are better and safer procedures for any patient, especially those that have many co-mobid health conditions. Some of these patient are very sick but need surgery. For us to do the PVP in the office setting is far too risky in not having the equipment and staff back up a hospital can offer. Yet this procedure is much safer and offers the patient a treatment for their problem over no treatment at all.
With the Green light PVP laser performing more than half the TURP type procedure in the US for the last 2 years, it shows that physician believe this is the new standard of care. Most of these cases are done in the hospital setting, as many moble units backed by physician investment, are suppling a laser that most hospitals will not purchase individually since the cost is too high and difficult to recoupe investment costs.
Some of us (4 clinics across the US) have taken the time to set up surgical suites in our office at great expense to offer this treatment (PVP). But with the great reduction in reimbursement over the past 4 years for this procedure we will no longer be able to offer it in the office setting as our costs will be greater than planned reimbursement in 2008. Thus we must take all these cases to the hospital setting, but no hospital in the Capital of Boise will invest in the machine. We were in the process of negociations for a lease to help the hospitals with their need and help us cover the cost of our equipment when this porposed legislation came out and killed all contracts until it is finalized.
It is frustrating that you contunue to penalize physicians who band together for the purpose of bring higher quality tech knowledge into communities that would otherwise be denied this level of care. The fact that physicians have hired companies to run these units, and these companies have done an excellednt job in making the equipment highly utilized thus profitable is the bonus they (the physician and companies) should receive. The profit these physicians see from their investment is not high as the value of the equpment is nothing when the tech knowledge becomes outdated or the equipment becomes outdated. The investment goes to the junk heap with no value, so the investment is recouped by the profit seen during the life of the equipment.
In Idaho one Lithotripsy unit services the southern half of the state including the two largest hospitals in Idaho. Even these hospitals do not see enough cases per year to warrent them buying their own unit.
Again please do not compromise patient care just to stop a few physician from gaining some profit. They have invested in the betterment of patient care options.

Submitter : **Mr. Robert Selden** **Date: 08/20/2007**

Organization : **AANA**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

Anesthesia payment boost of 32% is critical to our profession. Please strive to accomplish this boost.

Thank You,

Robert A. Selden CRNA

Submitter : Dr. Kurt Riegner **Date:** 08/20/2007

Organization : Anesthesia Consultants of Indianapolis

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-6751-Attach-1.DOC

#6751

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,

Kurt A. Riegner, MD

Submitter : **Dr. Kenneth Stone** **Date: 08/20/2007**

Organization : **Bridgeport Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Robert Arbeene** **Date: 08/20/2007**

Organization : **CRNA member of AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Robert Louis Arbeene, CRNA, CH, MA
Name & Credential
109 Murville Court
Address
Jacksonville, NC 28546
City, State ZIP

Submitter : **Bradley Meyer** **Date: 08/20/2007**

Organization : **Bradley Meyer**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Bradley Meyer

Submitter : **Date: 08/20/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Andrew Ross** **Date: 08/20/2007**

Organization : **Peak Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern:

The current loophole in the Stark law that allows physicians to bill for physical therapy services as in-office ancillary services violates the intent of the law. Under this exception, it is not necessary for a physician to employ a licensed physical therapist to perform the services. If the phsyician does employ a licensed Physical Therapist, the physician has the ability to control the volume of services provided and billed for based on the physician's financial concerns. In either case, the patient does not necessarily receive the services that would be most beneficial to them. In addition, the integrity of Physical therapy as a health care profession suffers when untrained providers or providers who might be controlled by outside influences, such as their employer's financial interest, are allowed to bill for services thaty require the skills of an independent, licensed Physical Therapy professional.

Thank you for considering changing the enforcement of the Stark Laws to reflect the original intent of the law.

Sincerely,

Andrew L. Ross, MPT, OCS, CSCS

Submitter : **Date: 08/20/2007**

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am concerned regarding the potential for fraud and abuse that exists when physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutlization of physical therapy services under the Medicare program, and enhance the quality of patient care.

As a physical therapy provider, I have experienced physicians acting in manners that are not consistent with valuing patient outcomes over financial gain. I specifically remember one particular patient whom I was seeing prior to her requiring knee surgery. She carefully selected her surgeon when it became apparent that surgery was needed, even though that surgeon was 2 hours from her home. After surgery, her physician recommended she see the physical therapist in his office, even though it was a significant distance to travel. The patient reported to me that she was reluctant to disregard her physician's instructions and decided to discontinue physical therapy in my facility. In this case, I actually happened to know this physician and his protocols from a period of time when I had worked with his patients in another facility. I telephoned to advise him of this and to report that it was a significant burden for the patient to drive 2 hours for physical therapy instead of receiving it near her office on a regular basis. He did not return my call. I do not believe this physician behaved in a way that was consistent with placing patient needs above financial gain.

I have owned my private physical therapy office for six years, and we receive virtually no referrals from orthopedists, who predominantly utilize in-office ancillary services. This exception has created a loophole that has resulted in the significant expansion of physician-owned arrangements that provide physical therapy services. Because of Medicare referral requirements, physicians have a captive referral base of physical therapy patients in their offices.

Physicians may argue that receiving services in the office is more convenient for patients, but many patients who are perfectly willing to go to a downtown office and park for a single physician visit are inconvenienced to make the same trip 2 or 3 times per week for physical therapy.

Physical therapy licenses do not require direct physician supervision for the administering of physical therapy services by physical therapists.

Thank you very much for considering my comments.

Submitter : **Jodie Greenwood** **Date: 08/20/2007**

Organization : **Jodie Greenwood**

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.

Jodie Greenwood

Submitter : **Dr. Richard Steinbrook** **Date: 08/20/2007**

Organization : **Dr. Richard Steinbrook**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : **Mr. Kenneth Somerville** **Date: 08/20/2007**

Organization : **Mr. Kenneth Somerville**

Category : **Individual**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Anesthesia Coding (Part of 5 Year Review)

Thank you for this opportunity to express my opinions regarding the review of anesthesia payments. I am glad that CMS has realized that the payments currently made for anesthesia are not indicative of the market value of such services. I beleive that Medicare and Medicaid patients deserve to receive competent services when required. Unfortunately, the current payments are forcing many top doctors to stop seeing Medicare and Medicaid patients. I am asking that you adjust the payment schedule to reflect todays pricing requirements. Thank you very much for your careful consideration of this matter.

Submitter : **Dr. John Morrow** **Date: 08/20/2007**

Organization : **Bostwick Laboratories**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 15, 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 [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.
Sincerely,

John F. Morrow, M.D.
Associate Medical Director

CMS-1385-P-6761-Attach-1.TXT

#6761

August 15, 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 [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

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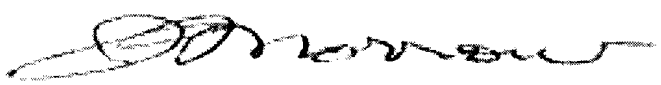
Sincerely,



John F. Morrow, M.D.
Associate Medical Director

Submitter : **Date: 08/20/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I've been a physical therapist for 9 years and am very concerned about the physician self referral law regarding physical therapy services. I believe it is in the best interest of the patient that they have the right to choose their therapy clinic. I disagree with physicians referring patients only to their clinic when they requested another facility. I don't believe patients should be bullied into a facility because physicians are receiving profit from that care. I believe it increases the risk for fraud and abuse. I'm concerned that patients will be taken advantage of because of this failed trust in their physieian. I believe that this "in office ancillary service" regarding physical therapy is unethical. I don't believe physicians should make profit off of other services besides their own. I believe that the bottom line is about profit and not patient care. The physician owned physical therapy clinics hide behind talk of better communication and care, but all physical therapy clinics should present with thesc attributes. I believe that the states of Indiana and the nation "in God we trust" need to protect the wellbeing of our current and future patients. I believe we need to take a stand as did South Carolina and not support physicians self - referral program.

Submitter : **Dr. Jorge Palacios** **Date: 08/20/2007**

Organization : **UAMS**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. 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,

Jorge Mauricio Palacios, MD

Submitter : Mr. Michael Reith **Date:** 08/20/2007

Organization : Mr. Michael Reith

Category : Occupational Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Dr. David Schultz** **Date: 08/20/2007**

Organization : **Dr. David Schultz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Yours truly,
David Schultz, M.D.

Submitter : Mrs. Mindy Paskiet **Date:** 08/20/2007

Organization : Smith Ambulance Service, Inc.

Category : Other

Issue Areas/Comments

Beneficiary Signature

Beneficiary Signature

Although I love the idea of being able to bill Medicare when we are unable to obtain a signature; it would be a huge delema for ambulance suppliers to obtain a contemporaneous stmt signed by the receiving facility. Most facilities are way under-staffed and would not be cooperative in providing us with this information to keep on file. If this were to be implemented, our amount of billable claims would decrease significantly causing a financial burden on our company due to uncooperative staff at hospitals and nursing homes. Most facilities could care less how we get paid, and if we get paid. Therefore, cooperation would not be expected. Due to competing ambulance companies we can not simply refuse to transport non-emergent patients to and from facilities that are not willing to give us a contemporaneous signature.
Thank you for your time!

Submitter : **Dr. Mark Sundet** **Date: 08/20/2007**

Organization : **Dr. Mark Sundet**

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)

To Whom It May Concern,

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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. This change will only help our patients.

Thank you for your consideration of this serious matter.

Submitter : Mr. Roger Schwartz **Date:** 08/20/2007

Organization : National Association of Community Health Centers

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-6768-Attach-1.PDF

#6768

National Association of
Community Health Centers, Inc.

August 20, 2007

BY ELECTRONIC MAIL
http://www.cms.hhs.gov/eRulemaking

U. S. Department of Health and Human Services
Att: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Attention: CMS-1321-FC

Re: Proposed Rule on the Tax Relief and Health Care Act of 2006 and Medicare Part B Payment Policy

Dear Sir or Madam:

I. Introduction

The National Association of Community Health Centers ("NACHC")[1], welcomes the opportunity to submit these comments regarding Medicare reimbursement to federally qualified health centers ("FQHCs") for diabetes self-management and training ("DSMT") services.[2] In light of the changes to DSMT service reimbursement made by the Deficit Reduction Act of 2005 ("DRA"), one of NACHC's current priorities is assuring accurate Medicare reimbursement to FQHCs for these services.[3] As health centers have begun to seek payment for DSMT services at the all-inclusive rate pursuant to the DRA, we have received conflicting advice as to whether services provided in a group setting trigger the all-inclusive payment rate, or whether this rate applies only to individual DSMT services.

In practice, centers that are denied all-inclusive rate payment for group DSMT services often receive no reimbursement at all for these services. Interpreting the DRA payment changes as applying only to individual DSMT services directly undercuts Congress' intent in passing the statute. In this memorandum, we discuss the problems with this interpretation of the DRA, and we provide an alternative interpretation that would effectuate congressional intent.

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[1] NACHC is a membership organization that represents FQHCs nationally. At present, more than 1000 FQHCs with more than 5,000 sites serve approximately 16 million patients across the country. The vast majority of these patients are impoverished individuals living in medically underserved areas. More than one million of these FQHC patients are Medicare recipients.

[2] Due to the limited number of covered billable services under the Medicare FQHC reimbursement formula, many FQHCs provide care to their communities without adequate reimbursement. Because scarce financial resources threaten centers' ability to continue serving needy beneficiaries, NACHC is committed to helping centers gain appropriate access to revenues available to them under laws and regulations.

[3] P.L. 109-171, § 5114.

II. Congressional Intent Behind the DRA

As you know, § 5114 of the DRA amended the set of services for which FQHCs may be paid at their all-inclusive rate to include "services described in subsections (qq) and (vv)" (which are, respectively, DSMT and MNT services).[4] This provision also expanded the FQHC service set to include DSMT services furnished by a "health care professional under contract with the center."[5] With these statutory changes, Congress sought to increase beneficiary access to DSMT services. Congress viewed paying for DSMT services at the FQHC all-inclusive rate as more economically appropriate – and, thus, more likely to enable centers to offer these services – than merely permitting FQHCs to include these expenses in their allowable costs.

CMS itself has acknowledged beneficiary access as Congress' intent behind the DRA. In the final rule implementing the payment changes for FQHCs, CMS noted that not many centers were currently offering DSMT services and identified the purpose of Section 5114 as the provision of "coverage and adequate access to these services in the FQHC setting."[6] Moreover, CMS has taken steps to expand beneficiary access to DSMT services. For instance, the agency's current prevention and wellness initiative, "A Healthier US Starts Here," is designed to raise beneficiary awareness about – and to increase utilization of – preventive services, including DSMT services. In promoting this initiative, Acting Administrator Leslie Norwalk highlighted DSMT services as some of the most important preventive services that beneficiaries should be encouraged to use.[7] By thus committing to increased beneficiary utilization of DSMT services, the agency implicitly has committed itself to ensuring sufficient beneficiary access to these services.

Because regulatory limitations on the amount of individual DSMT services that are covered by Medicare essentially force the majority of these services to be offered in groups, interpreting the DRA as changing the payment methodology to allow DSMT billable visits only for individual services means not changing the status quo (i.e. inclusion in allowable costs) for most DSMT services.[8] Since the DRA-mandated change from the status quo to DSMT services as billable visits was intended to increase access to DSMT services, the change must be applied to group services – which comprise a high percentage of overall DSMT services – in order to effectuate this expansion of access.

III. FQHC Billing for DSMT Services Under Current CMS Policy

CMS' current interpretation of the DRA denies FQHCs per visit payment for group DSMT services. Although CMS guidance expressly allows FQHCs to bill under the HCPCS

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[4] *Id.* at § 5114(a)(1)(A). This provision of the DRA is codified at 42 U.S.C. § 1395x(aa)(3)(A).

[5] *Id.* at § 5114(a)(1)(C). Prior to the enactment of the DRA, FQHCs were permitted to treat the furnishing of DSMT services by certified registered dietitians or nutrition professionals as allowable costs.

[6] 71 *Fed. Reg.* 69624, 69665 (December 1, 2006).

[7] Remarks of Leslie V. Norwalk before the Administration on Aging (December 5, 2006).

[8] Under current Medicare regulations, Medicare Part B covers up to nine hours of initial DSMT training in a group setting, and only up to one hour of initial training individually; completion on an individual basis of the ten hours allowed for initial training is permitted only if group services are unavailable within the requisite timeframe or if the beneficiary has documented "special needs." After initial training is completed, up to two hours of individual or group training are covered as follow-up training in subsequent calendar years. 42 CFR § 410.141(c)(i), (ii).

codes for both individual DSMT services (G0108) and group DSMT services (G0109)[9], the agency's application of this guidance prevents the group code from resulting in payment to centers. The agency's current policy prohibits FQHCs from billing at the all-inclusive rate for group DSMT services and, instead, forces centers to continue accounting for these services solely as in allowable costs. Because many centers are already being paid at the cap amount[10], counting group DSMT services as allowable costs will not garner any additional payments for these centers.

In addition to increasing Medicare program expenditures, CMS' current policy also compromises patient care. Clinical research has shown that DSMT services help diabetic patients avoid adverse medical events by teaching these patients how to manage their condition.[11] These services are essential for diabetic patients, particularly those with lower incomes, since they experience a high number of chronic diseases and co-morbidities. Health center patients, in particular, are generally sicker and experience more chronic illnesses than office-based physicians.

In addition, health centers see a disproportionate share of patients with diabetes, as 6.3 percent of their patients are diabetic compared with the 2.8 percent of diabetic patients in office-based practices. Moreover between 2001 and 2005, health centers experienced 64 percent growth in their diabetic patient population. Because of the centrality of DSMT services to the provision of comprehensive, high quality health care to diabetic patients, and because of the relatively high concentration of these patients in health centers, it is imperative that health centers provide DSMT services to their patients in a method that is most effective and efficient for both the centers and their patients.

Prompt training is essential for diabetic patients, given the complications that can arise from delayed or improper treatment. The best way to ensure that these patients receive DSMT services that are time-sensitive enough to meet their medical needs is to offer regular group training sessions.[12] DSMT-certified FQHC staff can see more patients when they are not forced to schedule only individual appointments, thus increasing access to timely training for FQHC

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[9] For example, in light of the DRA payment change, CMS revised the Medicare Claims Processing Manual to describe FQHC payment for DSMT services as follows: "All-inclusive encounter rate with other qualified services. Separate visit payment available with HCPCS." This manual section further clarifies the billing change by explaining that "[e]ffective January 1, 2006, payment for DSMT provided in an FQHC that meets all of the requirements as above, may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed . . . with HCPCS G0108 or G0109." Medicare Claims Processing Manual, CMS Pub. 100-04, Ch. 9, § 181 (*available in* Transmittal 1148 (January 19, 2007)).

[10] Per regulation, each FQHC's all-inclusive billable visit rate is calculated by dividing its total allowable costs by its total number of billable visits; the center's per visit payment rate is the lesser of this amount or the Medicare cap amount (which is $115.33 for urban centers and $99.17 for rural centers in FY 2007).

[11] Rosenbaum et al. *Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role.* Kaiser Commission on Medicaid and the Uninsured. 2003. Center for Health Services Research and Policy analysis of 2004 UDS. Office-based physician data based on 2002 National Ambulatory Medical Care Survey.

[12] Importantly, group sessions provide the added benefits of enabling diabetic patients to hear a medical professional's answers to other group members' questions and of providing patients with an environment in which to discuss common challenges, share insights from their own experiences, and otherwise offer support to one another.

diabetes patients. By impeding centers' ability to be reimbursed for group DSMT services, then, CMS' reimbursement structure interferes with patient care.

The agency's current policy is, thus, counterproductive to protecting the Medicare Trust Fund and to providing quality patient care. To correct these problems, CMS must interpret the DRA as requiring at a minimum, one billable visit payment to an FQHC for each group DSMT session the center provides to one or more Medicare beneficiaries. Unless and until CMS adopts this interpretation, centers that provide these important services to beneficiaries will be forced to do so at an economic loss – a situation that is both unsustainable and that contradicts Congress' intent in passing the DRA.

IV. Supports the Current FQHC Medicare Billing Structure

As you know, an FQHC's all-inclusive per visit rate is determined by dividing its total allowable costs by its total number of billable visits.[13] In simple mathematical terms, increases to the number of visits (the denominator of the fraction) without a corresponding increase in the total allowable costs (the numerator) could cause the quotient (the all-inclusive rate) to decrease. Reducing the all-inclusive rate, in turn, would directly reduce the per visit payment rate for a center already below the cap, and it could push a center currently paid at the cap below the cap, thereby lowering its per visit payment. Given the small amount of allowable costs attributable to each additional group member, then, centers would not benefit financially from artificially increasing the number of group DSMT visits.

Accordingly, to the extent that CMS is concerned that reimbursing FQHCs for group visits at a portion of the all-inclusive rate would create incentives for FQHCs to ratchet up their Medicare visits, the agency can put this concern aside. The built-in safeguards in the FQHC reimbursement system would ensure that the payment change advocated above would not result in overbilling for group visits. Rather, this payment change would make it financially practicable for centers to provide group DSMT services, which would, in turn, increase beneficiary access and treat FQHCs equitably with other provider types.

V. Conclusion

Ensuring beneficiary access to medically necessary care is one of the Medicare program's central purposes. For many low-income, minority, rural, or otherwise medically underserved beneficiaries, access to care means access to FQHCs that provide a comprehensive set of services. Through the Medicare FQHC benefit, Congress has sought to ensure access to the specified set of "FQHC services." DSMT services have been included in this set since the passage of the DRA. Effectuating Congress' intent behind the DRA of increasing access to DSMT services requires that CMS reimburse an FQHC at the all-inclusive rate for each group DSMT session that the center provides to one or more Medicare beneficiaries.

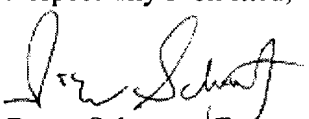
* * *

[13] If this rate is below the Medicare cap, the FQHC is paid at the all-inclusive rate for each visit; if the all-inclusive rate is at or above the cap, the center receives the cap amount for each billable visit.

Thank you for the opportunity to present our concerns about CMS' implementation of the DSMT payment provisions of the DRA. Please let us know if you would like to discuss this issue further with us or if we can provide any additional information. We have appreciated your recent attention to this issue, and we look forward to our continued work with the agency to ensure that our nation's most medically underserved beneficiaries have access to the health care services that they need.

We appreciate the opportunity to comment on the proposed regulations, and we would welcome the opportunity to further discuss these concerns. If you have questions, please contact, Roger Schwartz, Legislative Counsel and Senior Director of State Affairs, at 202.298.3800.

Respectfully submitted,



Roger Schwartz, Esq.
Legislative Counsel and
Senior Director of State Affairs

Submitter : Mr. Dave Knowles **Date:** 08/20/2007

Organization : Sonora Regional Medical Center

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

To whom this may concern,
My name is Dave Knowles. I am writing you in hopes of encouraging a resend on the "equivelency TRAINED" physical therapist assistant ruling. This measure eliminates these TRAINED therapists from treating Medicare patients in the outpatient/home health settings, etc. I would like you to understand that you are effecting my livelyhood as well as my life. I could loose my job and any future career possibilities that I might have. I have been in the field of physical therapy for 20 years in 2008. At that time Medicare and others accepted this certification and I went to work. I have a Bachelor's degree along with the strict prerequisite course work for this equivelency. I took the California State Board of Physical Therapy exam and passed the first time. I am a multi-facited Licensened Physical Therapist Assistant. I often help train both PTA and PT program graduates in the career of physical therapy. Too, my TRAINING has provided for my wide range of patients; from athletes, to ncuro/head injury victims and finally, the geriatric population. The latter two are at least 50% of my patient load. The consensus appears to be that I am pretty good at caring for Medicare's patients. The Medicare patients that I worked with do not understand why I cannot see them anymore. Most express discust or anger. This is because they are familiar with how I treat them as patients, not how I am seen by this umbrella ruling. I believe that this is an unjust ruling and should be overturned in November of 2007 during the voting on this matter.
A more just solution would be to set a date for the expiration of the process in which PEOPLE can challenge the state board for equivelency in the physical therapy profession, thereafter require that all physical therapist assistants graduate from an accredited program and finally, allow the previously licensed physical therapist assistant that have years of experience(in large part much better clinicians than the recent graduates from certified programs) to continue their careers.
It is my hope that the recipient of this letter will see the sum of this ruling's impact and too, the common sence approach to a conclusion of this topic.

Thank you for your attention on this matter,

Dave Knowles BA, PTA

Submitter : **Dr. Beth Ann Traylor** **Date: 08/20/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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,

Beth Ann Traylor M.D.

Submitter : Mr. Nick Weber **Date:** 08/20/2007

Organization : Advanced PT-Farmington Hills

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

The proposed method for reduction in payment for Physical therapy services will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery or long term inpatient care. I understand the AMA, APTA and AOTAas well as other orginizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these patients right to adequate and necessary medical care.
Thank you Nick Weber, MS, PT

Submitter : **Mrs. Marguerite Overton** **Date: 08/20/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

__Marguerite Overton, CRNA, MS_____
Name & Credential
___P. O. Box 4893_____
Address
___Boise, ID 83711_____
City, State ZIP

Submitter : Dr. Steven Hugenberg **Date:** 08/20/2007

Organization : Indiana University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

Steven Hugenberg, M.D.

Submitter : Mrs. Kate Blais **Date:** 08/20/2007

Organization : ASE

Category : Other Technician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

To CMS:

I am writing regarding the proposed change to eliminate CPT 93325 and bundle this code into other CPT codes. As a cardiac specialist caring for pediatric patients / adults with congenital heart disease, this is of particular concern to me because:

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.
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 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 effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

The surveys performed to set the work RVU s for almost all of the echo codes utilized specifically by pediatric cardiologists and adult cardiologists caring for patients with congenital cardiac abnormalities and affected by this proposed change were performed more than 10 years ago. As a result, particularly with respect to the 93325, the RVU s 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 those who care for this select group of patients, 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 initiative is on process, meaning work performed, and less so on the technology associated with the provision of echocardiography services. 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).

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.

Submitter : **Dr. Beth Ann Traylor** **Date: 08/20/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Beth Ann Traylor M.D.

Submitter : Mr. Bruce Weiner **Date:** 08/20/2007

Organization : Mr. Bruce Weiner

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

" First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
" Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
" Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Bruce Weiner, CRNA

Submitter : **Dr. James Loker** **Date: 08/20/2007**

Organization : **Bronson Methodist Hospital**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

I am a pediatric cardiologist in a small Children's Hospital. We have very detailed guidelines for our echo technicians for full studies, limited studies and those for cardiac function only. Not all of these studies require color doppler. In our full study 42% of the study is color flow doppler where in the limited study only 25% of the loops utilize color doppler and studies for function only do not use color doppler at all. There is a significant increase in technician time to obtain these images and for cardiology interpretation. These are definitely independant studies and it does not make sense to bundle them without additional reimbursement. This would have a negative impact on our ability to recruit an additional cardiologist to better serve our referral region. Right now we have over 60 day wait for new appointments and if reimbursement were to decline, I do not think I could get the hospital to approve another cardiologist. I am a salaried physician, so my concern is not for my own financial status, but rather my ability to see my patients in a timely fasion. Please reconsider your decision to bundle color flow doppler. Thank you.
Sincerely,
James Loker MD

Submitter : **Dr. Michael Moorman DO** **Date: 08/20/2007**

Organization : **ACI-LLC**

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.

Michael Moorman DO

Submitter : **Dr. Gerald Rogan** **Date: 08/20/2007**

Organization : **Rogan Consulting**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Comment to CMS-1385-P Practice Expense Relative Value Units (PE RVUs): (iii) Prothrombin Time, International Normalized Ratio (PT/INR) Allowance for G0249 Under current rules the capital cost of the INR testing device is reimbursed over four years (see practice expense table): captured in the reimbursement for G0249. If the capital investment reimbursement were moved to G0248 the capital risk to providers would be substantially less. Medicare would reduce its interest payment from 11% annual interest to 5.25% per annum: the 10 year treasury-bill rate. To offset CMS's risk of unrecovered amortized capital, CMS could limit the benefit to patients who are predicted to live four years or more (e.g. have no known short term terminal disease). SECOND COMMENT: Change the Benefit to DME: The benefit should be under DME. Under the PFS, the allowance is subject to the SGR and GPCI calculations. INR home test support company services contain no physician work component, and services may be coordinated nationally from one central location. The business plan of these companies requires a more stable and predictable reimbursement method than the physician fee schedule allows. A service that is provided across the nation from one central facility is easier for a CMS contractor to administer as a DME benefit. CMS will expose no vulnerability by changing the benefit administration to a DME contractor. Gerald N. Rogan, MD; Family Practice/Emergency Medicine; Former Medicare B Contractor Director; Disclaimer: Dr. Rogan is a consultant to an IDTF that provides home INR self-test and monitoring support.

Submitter : Mrs. Candace Hooton **Date:** 08/20/2007

Organization : University of Iowa Children's Hospital, Cardiology

Category : Other Practitioner

Issue Areas/Comments

Coding– Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am writing regarding the proposed change to eliminate CPT 93325 and bundle this code into other CPT codes. As a pediatric cardiac sonographer this is of particular concern to me for several reasons. 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. The performance of echocardiography in the population of patients with congenital anomalies 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. I am concerned that this change would adversely impact access to care for cardiology patients with congenital cardiac malformations. Programs caring for this select patient population do so not only for those with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for congenital cardiac services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to our patients will not be sufficient to continue to do so should the proposed change to bundle 93325 with other echocardiography codes be implemented. In order to ensure that labs are providing the most accurate and complete echocardiograms consistently, national standards dictate that Color Doppler echo be performed in conjunction with 2D/M-mode and PW/CW Doppler. Accrediting agencies such as the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL) encourage, in fact require that in order to achieve echo lab accreditation the echo lab must develop and implement an method of aquiring the most complete echocardiographic studies possible. If labs cannot be reimbursed for this it will become increasingly difficult to provide the best quality echocardiographic exams for our patients. I strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other 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.

Submitter : Debbie Ruiz **Date:** 08/20/2007

Organization : Cavalry Ambulance

Category : Other Health Care Provider

Issue Areas/Comments

Ambulance Services

Ambulance Services

The changes to the patient signature rules will be a hardship on maintaining quick and safe transport of patients. We do not want to see the changes implemented.

Submitter : **Dr. Andy Poritz** **Date: 08/20/2007**

Organization : **Worcester Surgical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Sincerely,

Andy H. Poritz, MD
Medical Director
Worcester Surgical Center
300 Grove Street
Worcester, MA 01605 tel.#508-754-0700

Submitter : **Dr. Beth Ann Traylor** **Date: 08/20/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

Beth Ann Traylor M.D.

Submitter : **Dr. Steven Hugenberg** **Date: 08/20/2007**

Organization : **Indiana School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

Steven T. Hugenberg, M.D.

Submitter : **Dr. Beth Ann Traylor** **Date: 08/20/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Sincerely,

Beth Ann Traylor M.D.

Submitter : Perry Perkins **Date:** 08/20/2007

Organization : BSA Health System EMS

Category : Other Health Care Provider

Issue Areas/Comments

Beneficiary Signature

Beneficiary Signature

The requirement to have a representative from the facility who received the patient is unduly burdensome. The need to return to service to respond to pending emergency calls demands that we spend as little time as possible at the receiving facility. Finding someone at the facility who is willing to sign will be virtually impossible. We will be spending literally hours and hours throughtout the year trying to track down people to sign this statement. A statement from the paramedic should be sufficient for all purposes. A secondary statement is overly duplicative and totally unnecessary. The information about what date and time the patient was received at the facility is already included in the patient care report.

Submitter : **Paul Beisser** **Date: 08/20/2007**

Organization : **Paul Beisser**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

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Sincerely,

Paul T. Beisser III, CRNA

930 Westwood Drive
Rexburg, Idaho 83440

Submitter : **Dr. David Columb** **Date: 08/20/2007**

Organization : **Dr. David Columb**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1385-P-6788-Attach-1.DOC

6788

Date: 8/20/2007
Re: **CMS-1385-P**

Dear CMS Representative:

I am writing this letter to express my concern regarding the proposed Medicare Physician Fee Schedule (MPFS) revision that will dramatically affect the reimbursement of Physical and Occupational Therapy services provided to elderly patients in my community.

I work with these patients everyday and see first hand the improvements in quality of life and function. With the average life expectancy increasing, we must **prioritize medical rehabilitation and the benefits it provides to patients as well as controlling the overall costs of healthcare.** This proposed method for reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that **prevents higher cost interventions**, such as surgery and/or long term inpatient care.

I understand that the AMA, the American Physical Therapy Association and the American Occupational Therapy Association, as well as other organizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these patients' right to adequate and necessary medical care.

Sincerely,

David J. Columb, DPT, MT(ASCP)

Submitter : **Mr. Daniel Kingsley** **Date: 08/20/2007**

Organization : **Physical Therapy**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern,

I do not understand why Physician's are allowed to own a Physical Therapy practice. How is this not a conflict of interest? Is it any different from a Physician owning their own Pharmacy?

In the current Physical Therapy referral system there is no accountability for quality care. A Physician-owned Physical Therapy Practice will get referrals due to their financial relationship regardless of whether the Physical Therapy is excellent or poor. On the other hand, a private Physical Therapist has to provide excellent care to stay in business. There have been cases where a quality private Physical Therapy clinic has closed because a large multi-Physician Practice opened their own PT clinic and only self referred.

Going back to the Pharmacy example, how would you like to be prescribed drugs based on whether the Physician had stock in that drug versus a drug that was more effective but they had no financial interest in it?

The MD s primary justification is that they can have better communication and control of the PT. How often does the MD pick up the phone and call the Therapist to see how their patients are doing? I have never once had a Physician call to get a check on their patient s status. Most communication is done via faxed reports, and when their is a problem that requires medical attention the patients Physician is immediately contacted via the phone. Even the referrals we receive from Physicians who own their own PT practice never check on their patients outside their clinic. That is incongruent and makes me doubt they really check on their own patients in their clinics.

Please clarify why these Physician Owned Physical Therapy practices continue to be legal?

Thank you for your time.

Daniel Kingsley, PT, CMPT, CSCS

Submitter : Dr. MO Eckel III **Date:** 08/20/2007

Organization : Mid-South Physical Therapy, Inc.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist and the owner of a private-practice physical therapy clinic in Tennessee. I have been directly impacted by the loopholes in the Stark Referral for Profit law. In 2003-04, a large orthopedic group, located in the professional building where my practice was located on the first floor, opened there own physical therapy clinic on the other side of the lobby from our suite. We had been in this location since 1992 and had provided care for this group's patients since opening. Following the opening of there clinic, we no longer received referrals from their office. In the ten plus previous years of providing care for their patients, we had no complaints about our service to the patients or the physicians.

After there PT clinic opened, on numerous occasions, I was contacted by patients and told that when the patient insisted on coming to my clinic, the referring physician would become upset and either change the frequency from three times per week to one time per week, or in a few incidence tear up the physical therapy order in front of the patient. Although these experiences are purely anecdotal, they were unsolicited on my part and frequent enough to demonstrate that "where there is smoke..."

Do to the significant decrease in our patient load and the fact that this particular orthopedic group is one of the largest groups in the area; I chose to close this office and continue my practice in an adjacent county. Not only did this referral for profit clinic have a direct fiscal impact on me, it also had a significant impact on my staff and patients.

There are many physical therapists in this country that are providing good professional care for their patients and their referral sources, there is no valid reason to have this conflict of interest, where the determination of a patient's care, frequency, duration, etc. be directly related to the physician's profit. I strongly urge CMS to remove physical therapy from the in-office ancillary services exception to the federal physician self-referral laws.

Submitter : **Dr. Shanaka Peiris** **Date: 08/20/2007**

Organization : **Dr. Shanaka Peiris**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Date: 08/20/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am currently a Physical Therapist who works in a private practice without any affiliations to a physician group. We are able to provide a superior service everyday to our patients, priding ourselves on the highest quality of care, low patient volume, evaluations within 24 hours, and excellent communication with referring physicians.

Unfortunelty, POPTS or referral for profit has created barriers for patients to gain access to our facility. I have heard from many individuals who would have preferred to come to our practice for physical therapy but did not. These patients either are unaware they have a choice or have been specifically told they have to go to the physician owned practice even when they have requested to see us instead. Some physicians are even claiming the outcomes of their surgery cannot be guaranteed if the patient does not attend rehabilitation at the physician owned practice.

In my opinion, no person should be able to refer to another professional for his or her own financial gain. This relationship creates an environment that lends itself to abuse. We are seeing the abuse in the form of over utilization, high patient volume resulting in poor quality, and patients being denied the choice of physical therapy providers.

Physicians who own Physical Therapy practices are claiming that physician ownership is a necessity to assure good communication among professionals. I currently have no physician ownership in my practice and frequently am given compliments by physicians on my communication of the patient plan of care and outcomes. I cannot understand why good communication and patient focused care cannot be achieved without an ownership relationship.

The reality is referral for profit relationships are strictly used for financial gain despite attempts to hide behind patient care needs.

Thank you for taking comments on this serious matter,

Respectfully,

Rob

Submitter : Mr. Thomas Valentine **Date:** 08/20/2007

Organization : Memorial Hospital

Category : Physical Therapist

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Close the Stark Referral For Profit Loophole

Submitter : Dr. Pamela Nagle **Date:** 08/20/2007

Organization : Wake Forest University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-6794-Attach-1.PDF

#6794

WAKE FOREST
SCHOOL of MEDICINE
THE BOWMAN GRAY CAMPUS

Department of Anesthesiology

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)

August 20, 2007

Dear Ms. Norwalk,

As an academic anesthesiologist, I am writing to share my strongest support for the recently proposed changes in the 2008 Physician Fee Schedule. I am convinced that this change will improve patient care and help us to recruit anesthesiologists to areas which serve higher proportions of the country's aging population.

As the reimbursement currently stands, anesthesiologists are struggling to recoup expenses when we care for this population. This is especially a problem in academic medical centers, such as where I work, because we cannot generate enough income to retain and pay anesthesiologists who will teach the rising generation of anesthesiology providers. We have been forced to try and obtain additional funding from the hospital to supplement our salaries and this creates ongoing tensions and difficulties that only impede our ability to guarantee the highest standards of care to our patients, a significant proportion of whom are the elderly.

The RUC recommended a $4/ unit increase and this will help immensely. (The current standards significantly undervalue the work of the anesthesiologist by about 30%, and we are thankful that CMS has recognized this issue and is attempting to address it.) I support full implementation of the RUC's recommendations and feel that it will ensure that our patients, now and in the future, will continue to have access to the expert anesthesiology medical care they need and deserve.

Thanks for all of your hard work and support and thanks for taking the time to read my letter.

Sincerely,

Pamela C Nagle, MD
Assistant Anesthesiologist
Wake Forest University School of Medicine
Winston Salem, NC 27157
(336)-716-4497

Submitter : **Bob Johnson** **Date: 08/20/2007**

Organization : **River Valley Orthopedics**

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

RE: In-office PT or OT services

It's my experience that in-office PT provides a great value to the patient and to the payor/insurance company.

The outcome for the patient is greatly enhanced due to:

1. Continuity of care
2. Physician oversight to ensure established protocols are followed
3. Access to and communication with the physician responsible for the patients care
4. Desired outcomes are frequently achieved with fewer visits

A basic financial question:
Who has a greater financial interest in abusing the system, a physician practice where PT accounts for 10% of their income or a private PT company where PT accounts for 100% of their income?

It's inappropriate to assume in-office ancillary services will be abused by a physician group and it's just as inappropriate to assume private PT companies would abuse the # of services needed by a patient. Appropriate high quality service can be provided by both. It can also be said that abusers of the system exist in both.

We ask that you NOT pass legislation that further restricts the ability to provide in-office PT services.

Thank you,

Submitter : **Date: 08/20/2007**

Organization :

Category : **Other Practitioner**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I am a cardiac sonographer and I would like to comment on the bundling of codes for Echo's. Using color flow is a specialized technique that we use on most echo's. It takes extra training to decipher it. I feel that it would be bad to bundle the code to all echos. We don't use it for all echos, it is an amazing tool that we use to enhance an echo. Thanks for your time!

Submitter : **Dr. Edward Abraham** **Date: 08/20/2007**

Organization : **Kendall Anesthesia Associates**

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.

Edward C. Abraham, MD

Submitter : **Dr. Michael Lisch** **Date: 08/20/2007**

Organization : **Dr. Michael Lisch**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-6798-Attach-1.WPD

#6798

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.

Michael Lisch, M.D.

Submitter : Mr. Tony Sell **Date:** 08/20/2007

Organization : Mr. Tony Sell

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Tony Sell, SRNA

Submitter : **Mr. Charles Boyle** **Date: 08/20/2007**

Organization : **Rice County District One Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

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Sincerely,

Charles R. Boyle, CRNA, Maj. USAF (Ret.)
1311 Greenleaf Road
Faribault, MN 55021

Submitter : Dr. rashid CAJEE **Date:** 08/20/2007

Organization : STOCKTON ANESTHESIA MEDICAL GROUP

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
POBox 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 thc proposal to increase anesthesia payments under the 2008 Physican Fee Schedulc. I am grateful that CMS has recognized the gross undervaluaation of ancsthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a big payment disparity for anesthesia, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since it took cffect, Medicare payment for anesthesia (A) services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation's seniors, and is creting 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% work undervaluation- a move that would result in an increase of nearly $4 per anesthesia unit and serve as a major step forward in correcting the longstanding undervaluation of (A) services. I am pleased the the Agency accepted this much-needed recommendation in its proposed rule, and I support its full implementation.

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 Rcgister by fully and immediately implementing the anesthesia conversion factor as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Dr. Rashid Cajee MD

Submitter : **Dr. joshua farthing** **Date: 08/20/2007**

Organization : **mcgaw medical center/northwestern**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Ginette Gomez **Date:** 08/20/2007

Organization : Academic Heart

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in St. Clair Shores and Woodhaven, Michigan, 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 flow 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 flow Doppler information is critical to the decision-making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS s proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of 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 have 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 the data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirms that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include color flow Doppler approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

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

Sincerely,

Ginette Gomez, DO
Academic Heart & Vascular, PLLC

Submitter : Mrs. **Date:** 08/20/2007

Organization : Mrs.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist practicing in South Carolina. I've been practicing in the outpatient setting for the past five years. When we moved to South Carolina four years ago, I was suprised to find so many of the physical therapy offices owned by physicians. I interviewed at a clinic owned by a chiropractor and medical doctor with one of their benefits being incentives for number of patients seen. I, however, chose to work at a private outpatient clinic and have been here 4 years. Our clinic is in a suburb which is about a half hour drive from the major hospital and medical offices. I often hear from my patients that they had to attend physical therapy at their physician offices which are 30 mintues plus from their homes. Patients don't understand that they have a choice where they go. They also don't take the initiave to question their physicians. So, if their orthopedic doctor tells them to attend PT 30 minutes from their home in a clinic he/she has a financial interest in, they often do. I ask that you remove PT serveies from servcies permitted under the in-office ancillary exception. Thank you for your consideration.
Sincerely,
Dawn Waugh, MSPT

Submitter : Ann Barone **Date:** 08/20/2007

Organization : Armstrong Ambulance Service

Category : Other Health Care Provider

Issue Areas/Comments

Beneficiary Signature

Beneficiary Signature

The 2nd requirment of the new rule proposal which states: "a signed contemporaneous statement from a representative of receiving facility documenting date and time patient was received at facility" would be a burdensome addition for ambulance providers. First, the documenting of date and time patient is received at a facility is redundant work for ambulance crews; this information is already recorded on all ambulance transports completed by Armstrong crews. Crews are also already responsible for obtaining a signed Physician's Certification Statement on the originating end of an ambulance call to comply with Medicare guidelines. Obtaining another signature at the receiving end will affect ambulance response times for subsequent calls.

Submitter : Mr. Terry White **Date:** 08/20/2007

Organization : Altamont Ambulance Service

Category : Other Health Care Professional

Issue Areas/Comments

Beneficiary Signature

Beneficiary Signature

While the proposed change to section 424.36 is needed, the change under section (6) article (ii) subarticle requirement (C) will be nearly impossible to comply with. (section states: A signed contemporaneous statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the date and the time the beneficiary was received by that facility) Most hospitals, etc. have trained their personnel to NOT sign documents under any circumstances on behalf of the patients. We service an area that is "interstate traffic" heavy and see a percentage of our calls generated by citizens that do not live in our service area. These patients may be incapable of signing for themselves for a variety of reasons and many times have no family member present. When they are sent documents to sign after the fact we often find ourselves calling numerous times, mailing numerous times to get billing authorization. Is this fair to the ambulance services that have "a duty to act" and have no choice in many cases of who they do or not transport under any or all medical circumstances? Our request would be to remove subarticle (C) under (ii) as it will be a great cause of arguments among pre-hospital and hospital staff and accomplish nothing. The bottom line is.... (a) We have a call for service for a Medicare recipient, (b) we answer that call which is medically necessary or falls under the prudent laymen perception, and (c) we must be paid for this service if the US congress expects this service to remain viable financially in the future. Thank you for your time. Terry D White, EMS Director / Altamont Ambulance Service - Effingham, Fayette and Marion counties, IL.

Submitter : **Angelyn Thomas** **Date: 08/20/2007**

Organization : **AANA**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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Sincerely,

Angelyn Thomas,CRNA
2825 Windy Hill Rd SE
#2102
Marietta, GA 30067
City, State ZIP

Submitter : **Dr. Anand Dash** **Date: 08/20/2007**

Organization : **Northwestern Memorial Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore , MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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