Submitter : TRACY SMILES **Date:** 08/22/2007

Organization : ADVANCED PHYSICAL THERAPY

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P.
Dear CMS Representative,
I am writing to express my concern regarding the proposed Medicare Physician Fee Schedule revision that will dramatically affect the reimbursement of Physical and Occupational Therapy services provided to elderly patients in my community. I am concerned that patients will not receive the care in my community that they need to prevent higher cost interventions, such as surgery or long term inpatient care. I understand that the AMA, the American Physical Therapy Association, the American Occupational Therapy Association, and 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, Tracy Smiles

Submitter : **Dr. Daniel Kalbac** **Date: 08/22/2007**

Organization : **Orthopaedic**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I currently provide physical therapy to my patients in my office. This is only for those whose insurance we accept. Therefore a good 75-80% of my patients are sent elsewhere for their therapy.due to insurance reasons or distance concerns. Many of those are disapointed that they cannot perform their therapy at our facility which is right down the hall in my office. That way I am just a moment away in case any questions or issues arise from the patient or the therapist.Therefore, it is imperative that physicians like me be allowed to continue providing this most valuable asset to our practices for the betterment of our patients.

Submitter : Dr. Clinton Ewing **Date:** 08/22/2007

Organization : Central Jersey Pathology Consultants

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Edison, NJ as part of Central Jersey Pathology Consultants, a 7-member pathology group practicing in a hospital 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 groups' 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,

Clinton Alexander Ewing, MD

Submitter : Mr. Travis Wood **Date:** 08/22/2007

Organization : Cardiovascular Associates, P.C.

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-7085-Attach-1.DOC

#7085

CVA Cardiovascular Associates, PC

KINGSPORT
The Heart Center
2050 MeadowView Parkway
Kingsport, TN 37660
Phone 423.230.5000 or
800.322.4124
FAX 423.230.5010

BRISTOL
Bristol Regional Medical Center
One Medical Park Blvd., Ste. 458-W
Bristol, TN 37620
Phone 423.844.4975 or
866.741.6129
FAX 423.844.4987

ABINGDON
Tanner-White Medical Bldg.
273 White Street
Abingdon, VA 24210
Phone 276.739.0067
FAX 276.739.0069

NORTON
616 Park Avenue, NW
First Floor
Norton, VA 24273
Phone 276.679.6493
Fax 276.679.6498

www.theheartcenter.net

August 20, 2007

Herb B. Kuhn, Deputy Administrator (Acting)
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Proposed Revisions to Payment Policies Under the Physicians Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Mr. Kuhn:

On behalf of Cardiovascular Associates, PC and our 30 individual practicing cardiologists and cardiac surgeons, we are appreciative of this opportunity to submit comments to the CMS regarding the **"Resource-Based PE RVU's"** section of the above-referenced July 2, 2007, Proposed Rule. Specifically, our concerns lie with the 2008-2010 PE RVU's established for non-facility-based (freestanding) outpatient cardiac catheterization procedure codes and the major negative impact that would result for our practice and our patients should these values be finalized in the 2008 Physicians Fee Schedule.

As indicated above, Cardiovascular Associates, PC is a 30-physician cardiology and cardiac surgery group with offices in Kingsport and Bristol, Tennessee, and Abingdon and Norton, Virginia. We also provide outreach clinics in a number of communities in Northeast Tennessee and Southwest Virginia. We have a physician-owned, office-based cardiac catheterization laboratory and perform in excess of 1000 patient procedures per year.

Cardiovascular Associates, PC is an active member of the Cardiovascular Outpatient Center Alliance (COCA) and, as such, has continued to be actively involved in the work that COCA has accomplished this year to collect and submit direct and indirect cost data to the Practice Expense Review Committee (PERC) and the Relative Value Scale Update Committee (RUC). Unfortunately, and inappropriately, this process did not allow the entirety of COCA's data to be considered and resulted in PE RVU recommendations that are severely undervalued as to the direct and indirect costs associated with providing these procedures.

It is readily apparent from the July 2, 2007, Proposed Rule that CMS accepted the RUC recommendations without considering the detailed cost information provided by COCA in May 2007. The PE RVU values set out in the July 2 Proposed Rule would result in severe cuts in reimbursement for cardiac catheterizations performed in the office setting. For example, if the 2007 conversion factor is applied to the technical component of the three primary CPT codes for a Left Heart Cath (93510TC, 93555TC, and 93556TC), the reimbursement in 2008 would be slashed by 32%. When the cuts are fully implemented, the total reimbursement would be reduced by 49%. Without a doubt, reductions this severe would result in the closing of the majority, if not all, non-facility outpatient cardiac cath labs in the country, thereby requiring that all patients who now benefit from the improved access and lower costs to have their procedures performed in the more acute hospital setting.

We respectfully request that CMS review the additional cost data provided by COCA and establish PE RVU's for outpatient cardiac catheterization procedures that more accurately and reasonably reflect the direct and indirect costs of providing these procedures. If these proposed RVU's are allowed to stand, this will result in additional cost to the Medicare program by way of direct APC payments and additional costs to Medicare patients in higher deductibles and co-insurance.

Thank you for the opportunity to provide comments on this very important issue.

Sincerely yours,

E. Travis Wood, CEO
Cardiovascular Associates, PC

Submitter : **Dr. James Barton** **Date: 08/22/2007**

Organization : **Dr. James Barton**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. David Huggins** **Date: 08/22/2007**

Organization : **Dr. David Huggins**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

David P. Huggins M.D.

Submitter : **Dr. Brett Schlifstein** **Date: 08/22/2007**

Organization : **Bay Area Anesthesia**

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.

Submitter : **Dr. Bryce Speer** **Date: 08/22/2007**

Organization : **UT - Houston Dept. of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Richard Cochrane** **Date: 08/22/2007**

Organization : **Twin Cities 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)

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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.

Richard Cochrane, M.D.
Adjunct Associate Professor of Anesthesiology
Twin Cities Anesthesia Associates

Submitter : Dr. James Arens **Date:** 08/22/2007

Organization : UT - Houston Dept. of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attached letter

CMS-1385-P-7091-Attach-1.RTF

7091

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.

Submitter : Dr. Matthew Wasco **Date:** 08/22/2007

Organization : University of Michigan

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a pathology resident and a member of the College of American Pathologists, United States and Canadian Academy of Pathology, and American Society of Clinical Pathologists. I am currently a resident (pathologist in training) at the University of Michigan and eagerly watch this issue as it impacts future training opportunities and my career.

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. As a resident who will soon be looking for a job, I am rather disgusted at how patient care is being treated by people looking for profit above all else, and using pathologists as witting and unwitting partners in these ventures.

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,

Matthew Wasco, M.D.

Submitter : **Dr. Michael McEachin** **Date: 08/22/2007**

Organization : **Gilbert Pathology, PC**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 2007

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

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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.
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Sincerely,
Michael D. McEachin, M.D., F.C.A.P.

Submitter : **Dr. Thomas Ockuly** **Date: 08/22/2007**

Organization : **Twin Cities Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.
Thomas Ockuly M.D.

Submitter : Dr. Ann Moriarty **Date:** 08/22/2007

Organization : AmeriPath Indiana

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Indianapolis Indiana as part of AmeriPath Indiana, a subsidiary of Quest Diagnostics. We have over 27 pathologists serving Indianapolis and the surrounding counties.

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

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

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Thank you for the opportunity to comment.

Submitter : Dr. Myra Wise **Date:** 08/22/2007

Organization : 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)

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The simple truth of supply and demand economics will dictate where qualified anesthesiologists will want to practice. High medicare populations will not be an attractive practice to a graduating anesthesiologist who may already be 150-200,000$ in debt for her education.

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.
Myra Clavier Wise, MD

Submitter : **Dr. Kimberly Helms** **Date: 08/22/2007**

Organization : **Dr. Kimberly Helms**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 2007

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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.

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Sincerely,

Kimberly M. Helms, M.D.

Submitter : Alan Crothers **Date:** 08/22/2007

Organization : Alan Crothers

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear CMS - Physician self referral is becoming a bigger issue every day. This situation needs to be corredted as it is costing the public significant extra dollars and leads to substandard care. I encourage you to look at the provision that allows physieians to provide therapy services, 'Ineident to' thcir practices. A GAO study has shown that these situations lead to morc 90% overutilization of therapy services!

This is obviously very costly and hurts patients and providers who are trying to provide high quality, cost effective treatment. Therapy services should be provided in scttings without pressure from owners who are driven by dollars and cents versus what is good for the patient.

Thank you for your consideration of this matter.

Alan Crothers, PT, SCS

Submitter : **Dr. Thomas J Mulhollan** **Date: 08/22/2007**

Organization : **Affiliated Pathologists, PA**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 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 twice board-certified pathologist (Anatomic and Clinical Pathology) and a member of the College of American Pathologists. I practice in Ardmore, OK as part of a solo practitioner at my hospital and I am part of a 8-member pathology group and practice in a hospital 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 know 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

1. The expansion of the anti-markup rule to purchased pathology interpretations and

2. The exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law.

These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

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

Sincerely,

Thomas Joseph Mulhollan, MD FCAP

Submitter : **Dr. Syed Mohsin** **Date: 08/22/2007**

Organization : **CORPath**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Columbus, Ohio, as part of a 17 pathologists hospital based group practice.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. Our practice is currently threatened by two large groups of physicians in areas of gastroenterology and urology, who are planning to open thier own POD labs. These ventures have a potential to reduce our income by 25% or more. I am also aware of marked up billing practices by some Gynecology practices in our area. 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 qualified for 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,

Syed Mohsin, M.D.

Submitter : **Dr. Allen Miranda** **Date: 08/22/2007**

Organization : **TCAA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Lori Miranda** **Date: 08/22/2007**

Organization : **Northwest Anesthesia**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Submitter : **sandra calderbank** **Date: 08/22/2007**

Organization : **sandra calderbank**

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.

Submitter : **Mr. Brian Smith** **Date: 08/22/2007**

Organization : **Pottawatomie County EMS**

Category : **Other Health Care Professional**

Issue Areas/Comments

Ambulance Services

Ambulance Services

August 22, 2007

TO: CMS
RE: Comments on CMS-1385-P
BENEFICIARY SIGNATURE

After reviewing the proposed changes for obtaining beneficiary signature, I am largely in support of the proposed changes with one exception.

We currently make every attempt to get a signature from the beneficiary or representative of the beneficiary. As stated in the proposal, many times our beneficiary is unable to sign documentation due to their condition and we commonly do not transport a representative with the patient, so obtaining a signature from a representative is difficult at best. Our service currently requires the paramedic or EMT to document the reason why the beneficiary or representative was not able to sign.

The largest concern arrives from the proposed rule that, in the event a signature cannot be obtained from the beneficiary or representative, a signature from a representative from the receiving facility would be obtained. Our service is opposed to this requirement for the following reasons:
1. Delays in locating a receiving hospital representative to collaborate the patient cannot sign (or a representative of the patient is not available) can be extensive and can cause significant concerns getting an ambulance back in service.
2. Collaboration with the hospitals can cause significant logistical difficulties if your ambulance service transports to many hospitals (as we do) and having a different procedure or contact point at each hospital to get a collaborating signature.
3. Additional paperwork requirements add yet another process (in an already heavy documentation environment) for emergency providers who work in a high paced, time sensitive, response environment. There will be times when an emergency call is holding and the response to that call is a higher priority than obtaining signatures from the patient you just delivered to the hospital.
4. Conflicts can occur between the EMS representatives and the hospital representatives in regards to whether a representative is available in a timely manner to sign in the event the beneficiary cannot sign.

I strongly encourage CMS to not add another logistical step in obtaining a signature from a hospital representative. The current documentation requirements are already extensive for an environment that necessitates rapid response and streamlined documentation.

If you have any questions feel free to contact our administrative offices at 785-456-9700.

Sincerely,

Brian Smith, MICT
Director
Pottawatomie County EMS

Submitter : Dr. VERNON PILON **Date:** 08/22/2007

Organization : Dr. VERNON PILON

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I wish to support the CMS effort to stop physicians who perform intraoffice biopsies from creating pathology as an in office procedure which they can bill for. I am a practicing pathologist in Albany, NY and recently a large urologist group decided to create a pathology lab in their office so they can bill the global fee for 88305 for prostate biopsies. This creates a situation where the urologists make money based on how many biopsies they perform. The incentive for them is to perform as many biopsies as possible and to find a pathologist willing to allow them to bill for the professional as well as the technical service. Physicians who perform intra office biopsies should choose a pathologist based on quality and perform biopsies only on those who need them and only as many as can be justified for arriving at a diagnosis, not based on how much pathology derived revenue they can generate. I hope your rules will address this expanding problem.

Submitter : **Mr. John Ungaretti** **Date: 08/22/2007**

Organization : **Missoula Emergency Services**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Ambulance Services

Ambulance Services

Regarding the component of CMS 1385-P that requires ambulance providers to get "contemporaneous signatures" from the receiving facility. It can be difficult to get patient signatures as it is. Asking someone in a busy emergency room to sign a paper at the same time as the patient is unreasonable.
Please do not penalize honest providers for others misdeeds. This will only add to the already difficult process of billing government payors. Thank you.

Submitter : asghar naqvi **Date:** 08/22/2007

Organization : Oswego Hospital

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Oswego and Fulton , NY as part of a 3-member pathology group.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give 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,

Asghar Naqvi, MD

Submitter : **Dr. Mark Kieckbusch** **Date: 08/22/2007**

Organization : **Idaho Pathology Society**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Boise, Idaho as part of an eight person pathology group practicing at St Luke s Regional Medical Center and St. Luke s Meridian Medical Center.

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.

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Sincerely,

Mark E. Kieckbusch, MD
President, Idaho Pathology Society

CMS-1385-P-7111-Attach-1.DOC

Submitter : **Dr. Richard Regan** **Date: 08/22/2007**

Organization : **Northwest Comm. Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Impact

Impact

Thank you for the convenient forum to submit comments. CMS is protecting the consumer when it considers expansion of the anti-markup rule and exclusion of anatomic pathology services from Stark law exceptions. The issue is plain and simple. Clinicians are simple appointing themselves middlemen and tacking massive charge increases to patients and insurers for NO VALUE ADDED! They want to be paid for doing absolutely nothing. Anatomical pathologists continue to work to interpret the specimens and remain responsible for their interpretations in perpetuity. The patients think the pathologist is ripping them off when it is their own doctor. We charge say $10 for our fee, and the gynecologist might charge the patient $50?

The POD lab issue is also a severe threat to quality of care and smacks of self referral and fee splitting. Many pathologists with unimpressive credentials are willing to work as an 'indentured' servant to a urology or GI group for a weekly salary.

This is a factory like environment where the connection and concern for the sick patient is lost.

Thank you again for this opportunity and for taking the time to read it.

Sincerely,

Richard Regan, M.D.
Chairman Dept. of Pathology
Northwest Comm. Hospital
Arlington Heights, Il 60005
847-618-6150

Submitter : **Dr. janet roepke** **Date: 08/22/2007**

Organization : **Dr. janet roepke**

Category : **Physician**

Issue Areas/Comments

CAP Issues

CAP Issues

August 23, 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,

Janet E. Roepke, MD, PhD

Submitter : Mr. Dwain Klostermann **Date:** 08/22/2007

Organization : WORK

Category : Occupational Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am in private practice employing physical and occupational therapists. We are not owned or employed a physicians and rely on referrals from physicians in our area as well as patients who want to come to see us. We have been successful for the past 31 years due to our reputations, ethics, and our outcomes. Over the last 5 years our community has seen physicians open their own physical therapy clinics and self refer and direct all their patients to their own rehab clinic next door and when the patient says they want to see us, the doctors tell them if they go to their own clinic, they can watch their care closer. We all know that is in far from the truth. It is because they can make more money. One doctor, who happens to be the Chair of the Texas Medical Licensing Board, is one of these doctors who self refers to their own rehab clinic in their building, but uses the loophole in the STARK Law. And her husband also is a physician in that group who does the same thing. We also have 2 groups of orthopedists who do the same thing and a Minor Emergency Care Clinic who does the same thing. This must be closed and employing physical and occupational therapists by doctors for their own financial gain should be illegal and not allowed to continue. Over time, overutilization of therapy services has been proven by physicians who own their own therapy clinics. This is why the Stark Law was enacted many years ago, but loopholes have made it continue and it must be stopped. Thanks for allowing me to submit my comments

Submitter : **Mr. Dennis O'Brien** **Date: 08/22/2007**

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.

Submitter : **Mr. David Bertone** **Date: 08/22/2007**

Organization : **Marlboro Physical Therapy, PA**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

There should be a complete ban on referral for profit situations with only one exception - rural areas that are undersupplied by professionals. Physical Therapy has been used by many phsyicians as a way to generate revenue and they have sidestepped many of the self referral bans by using the existing loopholes, such as "in-office ancillary services". Physical Therapy should not be consider an ancillary service since 40+ states have direct access laws to PT services. Physican direction is not required. The excuse to keep everything in house for the good of the patient was invalidated by studies that prove overutilization in these situations. And the primary reason is money and greed, not convenience for the patient.
Therefore I am requesting that Physical therapy be treated with the respect and professionalism the field deserves by stopping runaway abuse for profit. Give the control back to the professionals that provide the care. In addition, Medicare should allow payment for direct access to PT services for patients since it would eliminate the cost of unnecessary physician visits. PT's are bound by our state practice acts to refer to the appropriate professional when something is outside out scope of practice. CMS can setup similar requirements.

Submitter : Dr. Mitchell **Date:** 08/22/2007

Organization : Dr. Mitchell

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician self-referral in physical therapy is truly running rampant in Oklahoma. It has worsened recently to the point that EVERY (and I mean every) orthopedist in the OKC area owns some part of and/or are receiving some sort of kick back for referrals. Several family practice physicians own and/or recieve kick backs as well. This loop hole needs to be closed. Physical therapy services should not be allowed under the in-office ancillay services exception.

It is a conflict of interest to a physician when he is referring a patient for therapy and he owns part of the practice.

Submitter : **Mrs. Theresa Soto** **Date: 08/22/2007**

Organization : **American Association of Nurse Anesthetist**

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,

Theresa Soto Student Nurse Anesthetist

Submitter : **Dr. Lucilene Tolentino** **Date: 08/22/2007**

Organization : **MLK-Harbor Hospital**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 2007
Centers for Medicare and Medicare Services
To Whom It May Concern:
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 Los Angeles, California as part of a 5-member pathology group that practice in a hospital.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. If some physician groups share 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,
Lucilene F. Tolentino, MD FCAP FASCP
Anatomic and Clinical Pathologist
MLK-Harbor Hospital
12021 S. Wilmington Avenue
Los Angeles, CA 90059

Submitter : **Dr. Joseph Lombardo** **Date: 08/22/2007**

Organization : **Allegiant Pathologists LLC**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in St. Charles MO as part of a 5-member pathology group in a hospital 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.

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Sincerely,

Joseph A. Lombardo MD

Submitter : **Mr. Andrew Wasely** **Date:** **08/22/2007**

Organization : **APTA**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-7123-Attach-1.DOC

7123

GEORGIA ORTHOPEDIC PHYSICAL THERAPY
3585 PEACHTREE INDUSTRIAL BLVD.
Duluth, GA 30096

Date: August 22, 2007

Mr. Kerry N. Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention:CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

Re: *Physician Office PT/OT Services*

Dear Mr. Weems;

I am writing this letter to express my concern regarding the in-office ancillary service arrangements that have impacted the delivery of quality Physical and Occupational Therapy.

I have seen physicians offices bonus their MDs based on the number of self referrals they make to their PT clinic. The productivity of the PTs in these offices is usually significantly higher than in free standing clinics. 20 to 25 visits per day verses 12 to 15. Quality of care and individual attention has to suffer with these high numbers.

I urge you to put measures in place to eliminate the ability of physicians to receive financial benefits from referring to such services as Physical and Occupational Therapy.

Thank you for considering these comments.

Sincerely,

Andrew P Wasely, PT

Submitter : **Dr. Deborah Ward** **Date: 08/22/2007**

Organization : **Greene Memorial Hospital**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sirs:
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 Xenia, Ohio as part of a 3-member pathology group covering two small hospitals.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of 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,
Deborah E. Ward, MD
Laboratory Director, Greene Memorial Hospital, Xenia, OH

Submitter : **Natalie Silva** **Date:** **08/22/2007**

Organization : **Community Regional Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Dr. Bharat Jhaveri** **Date: 08/22/2007**

Organization : **Atlanticare Regional Medical Center**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir,
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 the state of New Jersey as part of Atlantic Pathologists, PC , a hospital based group of six pathologists practicing at Atlanticare Regional Medical Center, serving the community of Southern New Jersey
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.
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Sincerely,
Bharat J. Jhaveri, MD
Medical Director & Chairman,
Dept of Laboratory Medicine & Pathology
Atlanticare Regional Medical Center
Atlantic City, NJ 08401

Submitter : **Dr. Thomas McQuail** **Date: 08/22/2007**

Organization : **Resurgens Orthopedics**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I think the proposed change to the self referral provisons in regard to Physical therapy would be a huge set back to patient care, and that is ultimately what all this should be about. There are multiple benefits to physician owned PT. First and foremost we can have a direct relationship with the therapist and take an active role in the process, I can't tell you how many times our therapist will stop me and give me an update on a patients progress so that we can modify accordingly. Second, we have a higher ratio of therapists to patients, the benefit there is obvious. Third, eliminating competition in health care will only drive up costs, and we all know what an issue that is today. Finally, increasing government regulation would be counterproductive for patient care and healthcare in general.

Submitter : **Dr. Wayne Cai** **Date: 08/22/2007**

Organization : **Dr. Wayne Cai**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 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 Pittsburgh, PA as part of 4-member pathology group at Mercy Hospital
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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Sincerely,

Wayne Cai

Submitter : **Dr. Anthony Natale** **Date: 08/22/2007**

Organization : **Dr. Anthony Natale**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 2007

Mr. Kerry N. Weems, Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: Physician Self-Referral Issues. Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

Dear Administrator Designate Weems,

I am a Physical Therapist in practice for over twenty five years. I have followed the evolution of the Stark Law regarding physician self-referral for profit for many years. I strongly support the goal of the Stark Law to eliminate referral for profit from the Medicare program.

The current in-office ancillary services exception for Physical Therapy services in the Stark Law has created a loophole that should be closed. The current rule allowing physicians to refer Medicare patients to physician-owned physical therapy services does not serve the best interests of Medicare patients, or the Medicare program.

Medicare requires a physician referral for payment for Physical Therapy services. Allowing physicians to own Physical Therapy practices via the in-office ancillary services exception creates an incentive for abusive referral arrangements. This results in over-utilization of Physical Therapy services, with increased costs to the Medicare program.

The current loophole does not serve the interests of Medicare patients. Physician direct supervision is not needed to administer physical therapy services. Most Physical Therapy interventions require multiple visits over several days or weeks. Due to this repetitive nature of physical therapy services, it is no more convenient for the patient to receive services in the physician s office than an independent physical therapy clinic.

I strongly support the removal of Physical Therapy from the services permitted under the in-office ancillary exception.

Thank you for your time and for your consideration of my comments.

Sincerely,

Anthony F Natale, PT, DPT

Submitter : Dr. Mack Thomas **Date:** 08/22/2007

Organization : Am. Society Of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Regarding CMS 1385-P. The decrease in reimbursment to teaching anesthesiologists needs to be changed to place payment in line with other teaching physicians. This inequity is creating significant negative economic on academic institutions.

Submitter : **Dr. Brian Adley** **Date: 08/22/2007**

Organization : **Midwest Diagnostic Pathology**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 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 Park Ridge, IL as part of large private practice pathology group covering 8 hospitals in Chicago, IL and its neighboring suburbs. The main hospital I work at has over 600 beds, accessions over 22,000 surgicals a year, and is affiliated with the University of Illinois Pathology Residency Program. Recently, over 30 urologists covering much of my practivce area formed their own independent Pathology laboratory and hired their own pathologists. As part of the arrangement, they are keeping a portion of the professional and technical component for all biopsies done on an outpatient basis, in essence creating a self-referral situation. As a result, we see very few prostate biopsies in our practice, even when a patient ends up having surgery at our hospital. We have even examined several prostatectomy specimens without residual cancer, without the ability to review the preoperative biopsy material. As a pathologist with fellowship training in Genitourinary pathology, I find our current situation very frustrating and alarming. Not only do I believe we compromise optimal patient care, but the current situation is also detrimental to our residency training program.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. The aforementioned 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,

Brian P. Adley, MD, FCAP
Advocate Lutheran General Hospital
Park Ridge, IL 60068
847-723-7361

Submitter : **Dr. Mahoney Cobb** **Date: 08/22/2007**

Organization : **University of Louisville Hospital**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-eligible pathologist and a member of the College of American Pathologists. I practice in Louisville, KY as a Transfusion Medicine fellow.

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.

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Sincerely,
Mahoney Cobb, MD

Submitter : **Dr. Mack Thomas** **Date: 08/22/2007**

Organization : **Am. Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Comments regarding teaching rule and academic anesthesiologists.

Submitter : **Dr. Zhuowen Zeng** **Date: 08/22/2007**

Organization : **Dr. Zhuowen Zeng**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Aug 22, 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 Munster, Indiana as part of 10-member pathology group in a hospital 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.

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Sincerely,

Zhuowen Zeng, MD

Submitter : **Dr. Richard Bauer** **Date: 08/22/2007**

Organization : **Trover Health System**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Trover Clinic
200 Clinic Drive
Madisonville, KY 42431
August 22, 2007

Department of Health and Human Services:
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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.
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Sincerely,
Richard C. Bauer, M.D.

Submitter : **Mrs. Carolyn Lapierre** **Date: 08/22/2007**

Organization : **Blair County Anesthesia, PC**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

August 22, 2007

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.

Very truly yours,

BLAIR COUNTY ANESTHESIA, PC

Carolyn A. Lapierre, CMM
Practice Administrator

Submitter : **Dr. Donald Drew** **Date: 08/22/2007**

Organization : **Kaiser Southern California**

Category : **Physician**

Issue Areas/Comments

Background

Background

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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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. My previous practice at Eisenhower Medical Center in Rancho Mirage CA consisted of a high percentage of Medicare patients. Hence our reimbursement was considerably below the rest of the country due to the Medicare component dragging down our overall 'unit value'. This was one of the major determinants in my choosing to leave my prior practice.

Thank you for your consideration of this serious matter.

Capt. Donald Drew MD
USNR

Submitter : **Date: 08/22/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 2007

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Sincerely,

Angela L. Byrd-Gloster, M.D.

Submitter : **Dr. Jill Coleman** **Date: 08/22/2007**

Organization : **Dr. Jill Coleman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

Jill P. Coleman, M.D.
3 Westlyn Lane
Montgomery, TX

Submitter : **Dr. duc nguyen** **Date:** **08/22/2007**

Organization : **resurgens orthopedics**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

bill s 1385P. The bottom line is this ban would negatively affect patient care

Submitter : **James Qualkinbush** **Date:** **08/22/2007**

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
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Thank you for your consideration of this serious matter.

James Qualkinbush,M.D.

Submitter : **Dr. Daniel Fram** **Date:** **08/22/2007**

Organization : **Capital Health System**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-7142-Attach-1.DOC

CMS-1385-P-7142-Attach-2.DOC

714

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

Department of Radiation Oncology
Daniel K. Fram, MD
Director
Rachana Singh, MD

August 22, 2007

Kerry N. Weems
Administrator Designee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: Comments to Proposed Rule [File Code: CMS-1385-P]

Dear Administrator Weems:

As the Medical Director of the Capital Health System Cyberknife Center in Trenton New Jersey I provide image guided robotic stereotactic radiosurgery. I thank you for the opportunity to comment to the Centers for Medicare and Medicaid Services (CMS) on CMS-1385-P RIN 0938-AO65 Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008.

Medical linear accelerators (LINACs) were developed in the 1960's and allowed physicians to deliver isocentric radiation treatments of tumors over several weeks to spare normal tissue. Advancements in computer and linear accelerator technology in the 1980's led to 3-dimensional conformal radiation (3D-CRT) and image-guided radiation therapy (IGRT) which combined CT imaging with LINAC technology to register the location of a lesion before and after a treatment session. In the 1990's, intensity modulated radiation therapy (IMRT) further customized the shape of the radiation field to better conform to the lesion.

In the 1960's, frame-based stereotactic radiosurgery (SRS), was developed to deliver radiation with a high degree of accuracy to the brain and skull base. This intracranial treatment relies on placement and adjustment of an external head frame and manual adjustment of the patient. The accuracy afforded by this technology allows delivery of large, single, ablative doses of radiation. Then, in the late 1990's, image guided robotic stereotactic radiosurgery (r-SRS) proved significantly different from traditional radiosurgery in two ways: 1) no head or body frames are required, and 2) the flexibility of non-isocentric treatments allows for highly conformal treatments throughout the body together with significant decrease in normal tissue radiation.

Addendum B: 2008 Relative Value Units and Related Information Used in Determining Medicare Payments for 2008

In the CY 2007 PFS Final Rule, CMS revised the status indicator of level II HCPCS codes for image guided robotic linear accelerator-based stereotactic radiosurgery (G0339 and G0340) to indicate that they would be Carrier priced. We support CMS in maintaining these HCPCS codes for CY 2008 with the current status indicator so that Medicare beneficiaries may continue to have access to this treatment in the freestanding center setting, and providers may continue to bill for services using the most appropriate codes.

In summary, our center appreciates the opportunity to comment, and thank the agency for its decision to continue the use of Carrier-priced level II HCPCS codes for image guided robotic stereotactic radiosurgery in CY 2008.

Sincerely,

Daniel Fram, M.D.
Director, Penn Radiation Oncology at CHS
Medical Director, CyberKnife Center
Capital Health System
446 Bellevue Avenue
Trenton, NJ 08618
P 609-394-4244
F 609-394-4156

Submitter : **Dr. Arthur Mattingly** **Date: 08/22/2007**

Organization : **Austin Anesthesiology Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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,

Arthur T. Mattingly, M.D.
Austin, TX 78703

Submitter : **Dr. Mark Zahniser** **Date: 08/22/2007**

Organization : **Northcoast Anesthesia Providers**

Category : **Physician**

Issue Areas/Comments

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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.

If this matter does not pass, care of our seniors will become increasingly economically non-viable and will reduce their quality of care.

Submitter : **Dr. David Mehr** **Date: 08/22/2007**

Organization : **Central Utah Pathology, LLC**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 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 cytopathologist and a member of the College of American Pathologists. I practice in Utah County, Utah (HHS Secretary Leavitt's home state) as part of 3-member hospital-based pathology group. We work hard and diligently on behalf of our patients to provide the best pathology healthcare possible.

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.

NOTE: Our group has already been contacted by a local urologist to create such a pod-lab and he was wanting to know how much we would charge to read his prostate biopsies. He indicated that he was part of a group of '25 investors (? urologists)' that were interested in creating what amounted to be a pod lab-type arrangement. We indicated that we could not charge less than the Medicare rate for our area otherwise we felt this would be considered an inducement to obtain his business. The urologist scoffed at this and acted as if we pathologists owed it to our fellow physicians to somehow support his/their financial interests.

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.

Respectfully,

David S. Mehr, M.D.
Cytopathologist
Central Utah Pathology, LLC
A member of the College of American Pathologists

Submitter : **Mr. Allan Lammers** **Date: 08/22/2007**

Organization : **SMGSI-Centralia Campus**

Category : **Hospital**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

To whom it concerns, Using Color Flow Doppler is a very important part of an echocardiographic exam. To accurately demonstrate PW Doppler; or CW doppler we sometimes depend on Color Flow to find the best position that demonstrates this flow. ICAEL(International Commission for Accrediation of Echo Laboratories) also ask for color flow images for echocardiographic exams. most insurance companies want the echo labs to be ICAEL accrediated in order to receive payment. There is a definite need to use color flow in echo's, it also requires extra time for the sonographer to make adjustments to demonstrate color flow, and also extra time for the Cardiologist to interpret the color flow. I have been doing echo's for over 25 years. I remenber when we didn't have color flow or doppler. The test we not near as complete of an exam that they are now days, ie: high velocity jets in calcified valves of the heart would be inaccurately measured, this could lead to a very poor outcome for a patient. Another example for a pediatric echo would be not to see a hole in the heart muscle of a newborn baby and again a poor outcome could result. Color flow again is a GREAT compliment to any echo, and if needed it should definitely be utilized. Thank You,

ALLAN LAMMERS RT(R),RDMS,RDCS