Submitter : **Mr. John Retzloff** **Date: 08/23/2007**

Organization : **Mr. John Retzloff**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:
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.
ı 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.
ı 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.
ı 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,

John Retzloff, RN, BSN
2334 Harwood St
South Bend, IN 46614

Submitter : **Mrs. Cynthia Retzloff** **Date: 08/23/2007**

Organization : **Mrs. Cynthia Retzloff**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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
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Sincerely,

Cynthia Retzloff
2334 Harwood St
South Bend, IN 46614

Submitter : **Dr. Jonathan Daitch** **Date: 08/23/2007**

Organization : **ASIPP**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 (the Proposed Rule) published in the Federal Register on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.
There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the all physicians crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as interventional pain physicians for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to all physicians for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services.

Jonathan Daitch, MD
6120J Winkler road
Fort Myers, FL 33919

Submitter : **Ms. Dawn Ragusa** **Date: 08/23/2007**

Organization : **ASe**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I do not support bundling of color flow doppler studies with a basic echo code.Color flow doppler is an advanced technique and requires additional training and time to perform and interprete. I do not use color flow doppler on all exams. It is a second complete exam,not a part of a basic echocardiogram.

Submitter : Andrea Batt **Date:** 08/23/2007

Organization : Andrea Batt

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am concerned about the rights of patients being affected by the self-referral of individuals to a for profit Physical Therapy outpatient clinic affiliated with a doctor's office. I work in a small outpatient clinic in a primarily rural area, and we have highly qualified staff with state of the art equipment, and yet we hear from patient's frequently that they were told they should go to their referring doctor's clinic which has staff who have less experience and no specific expertise, and it may mean many miles of unnecesary travel and hardship for the patient / families. The patient should have a right to choose where they receive services. Thank you!

Submitter : Dr. James Metzger **Date:** 08/23/2007

Organization : Metzger Chiropractic Center,LLC

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Please continue to reimburse for patients that Chiropractors refer for X-Rays. Firstly it saves you money in the long run and secondly it helps us to provide better more diagnostic care of the patient. This would harm the patient in a number of ways if we were not allowed to refer for radiology when needed. Thankyou.

Submitter : **Dr. Amy Reynolds** **Date: 08/23/2007**

Organization : **Dr. Amy Reynolds**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Amy Reynolds D.C.

Submitter : **Dr. Jeremy DiMartino** **Date: 08/23/2007**

Organization : **ACA**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Sincerely,

Dr. Jeremy DiMartino, D.C.

Submitter : Dr. Kevin Olson **Date:** 08/23/2007

Organization : ASMG

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

Dear Sirs: It is clear that the significantly high cost of practice in the San Diego area makes it diificult to attract new physicians to our group and retain the ones we already have. A lack of increase in the CMS anesthesia rates will only make this worse and cause more physicians to refuse to participate in the care of these patients.

Submitter : **Tami Ingham** **Date: 08/23/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:

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Sincerely,

Tami Ingham, CRNA_____
Name & Credential
720 Pilot Woods Road _____
Address
Covington, GA 30014/_____
City, State ZIP

Submitter : Dr. W A Forwood **Date:** 08/23/2007

Organization : Concord Medical

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

The idea that doctors of chiropractic can not order an X-ray directly or for that matter take the x-ray and have reimbersment is fullish and discriminatory. Studies show that when doctors of chiropractic are gatekeepers the costs for healthcare services are greatly reducted. Use of chiropractic should be encouraged not discouraged. This rule to further reduce patients use of chiropractic will increase overall costs to the government system. This is a very stupid rule change.

Submitter : **Ms. Nina Castro** **Date: 08/23/2007**

Organization : **Baylor College of Medicine SRNA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,
Nina Castro, SRNA Baylor College of Medicine
7550 Kirby Dr
Houston, TX 77030

CMS-1385-P-7521-Attach-1.PDF

CMS-1385-P-7521-Attach-2.PDF

August 20, 2007

Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244–8018

RE: CMS–1385–P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

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Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : Dr. vrajlal rajyaguru **Date:** 08/23/2007

Organization : advanced pain clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please continue all full time pain management physician under code 09, instead of 05. Thank you.

CMS-1385-P-7522-Attach-1.PDF

CMS-1385-P-7522-Attach-2.TXT

please continue all full time pain management physician under code 09, instead of 05

Submitter : **Date: 08/23/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I believe that having ancillary physical therapy departments in doctors' offices is tantimount to a monopoly. They do not perform or oversee these services. An MD referal is taken very seriously by patients. As a physical therapist I am not suppose to advise patients on which doctor I believe does the best surgery, or has the least complications or the newest techniques. I am regulated to advise patients of 3 MD's in the area. Why should the MD be allowed to refer a patient to a PT that essentially works for them, so they can reap the profits. Their PT does not necessarily provide better care or services or even spend as much time as other PT's on a personal one to one basis with the patient. The MD's are supposed to advise the patients that they can go anywhere for their PT needs but do not always do this. Patients believe that because the service is in the MD's office that it must be better. It is unethical for the MD to steer a patient toward a specific PT whom that MD happens to gain finacially from, and it is not in the interest of the patient. A PT who works in their own business and has years of skill would not want to take a pay cut so the MD's could make money off of their skill! It is an unfair way for the doctors to fill their pockets with money. It is based on greed of a political base that has a lot of money to offer lobby groups and has no basis in better care or higher quality of care for the patient.
Please do not let MD's taint the physical therapy field by causing PT's to compete with them for the care of patients. Most patients trust their care to MD's without believing that the MD's are in it for the money. But this move to have PT's in their offices is just that; For The Money, not for the care of the patient.

Submitter : **Dr. David Hood** **Date: 08/23/2007**

Organization : **Wake Forest Univ School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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.

David D. Hood, MD
Professor of Anesthesiology
Wake Forest University School of Medicine
Winston-Salem, NC 27012

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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David D. Hood, MD
Professor of Anesthesiology
Wake Forest University School of Medicine
Winston-Salem, NC

Submitter : **Mr. Vince Buccellato** **Date: 08/23/2007**

Organization : **Mr. Vince Buccellato**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Administrator:

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

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Sincerely,

Vince A. Buccellato, RN, Student CRNA.

Submitter : **Mrs. Barbara Speer** **Date: 08/23/2007**

Organization : **Richfield Township Fire Dept.**

Category : **Other Health Care Provider**

Issue Areas/Comments

Beneficiary Signature

Beneficiary Signature

I am a licensed/practicing EMT and I live in rural northern Michigan. The population in this area is mainly elderly. Many of these individuals live alone with adult children/grandchildren living several hours or states away. In this area there is only one hospital per county (and some, like the county where I live, has no hospital and must transport beneficiaries 15-30 miles to the nearest hospital). These hospitals receive ambulance transports from many volunteer ambulance services.

While we always try to obtain a beneficiary's signature at the time of transport, in an emergency siutation there are times it is almost impossible to obtrain a signature either from the beneficiary or other authorized person. It is also not practical to ask the staff at the receiving facility to complete a statement showing the date & time the beneficiary arrived at the facility and why the beneficiary is unable to sign. In emergency siutations it is far more important that the ER staff treat the beneficiary than to complete a form as to why the beneficiary is unable to sign. With this being a rural area and the ambulance services all being volunteer, providers need to return to their area as soon as possible; this will not be possible if providers need to wait for ER staff to provide documentation regarding why the beneficiary was unable to sign a claim form.

Please review this proposed rule change for elimination in the beneficiary signature procedures.

Submitter : Mrs. Melinda Couch **Date:** 08/23/2007

Organization : Peak Performance Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would like to recommend closing the STARK loopholes to remove physical therapy from the in-office ancillary services of physicians. It is against the physical therapy practice act through the APTA for physicians to own a physical therapy practice.

Submitter : Mr. Mike Sechrist **Date:** 08/23/2007

Organization : ProTransport-1

Category : Other Health Care Professional

Issue Areas/Comments

Impact

Impact

Although well intentioned the rule would cause a greater hardship on the providers.

Signatures are regulary not available due to the patients conditions.

Submitter : **Mr. Torrey Hawley** **Date: 08/23/2007**

Organization : **Independent Anesthesia Provider**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

RE: CMS 1385 P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

Dear Administrator:

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. Manuel Tolosa** **Date: 08/23/2007**

Organization : **Mr. Manuel Tolosa**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 23, 2007

Office of the 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

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ı 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.
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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,

Manuel Tolosa CRNA
11 Overlook Cir.
Euharlee, GA 30145

Submitter : **Sean Scribner** **Date: 08/23/2007**

Organization : **Sean Scribner**

Category : **Other Practitioner**

Issue Areas/Comments

Background

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RE: CMS-1385-P (BACKGROUND, IMPACT)

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Sincerely

Sean M. Scribner RN, BSN, SRNA
16530 Timberlane Dr
Omaha NE 68136

Submitter : **Mr. Michael A Parker** **Date: 08/23/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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
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Sincerely,

Michael A Parker CRNA,MSN, CPT, USAR

PO Box 4229

Chattanooga, TN 37405

Submitter : **Dr. Andrew Topf** **Date: 08/23/2007**

Organization : **Dr. Andrew Topf**

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,

Andrew Topf, MD

Submitter : **Date: 08/23/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

There have been so many cases where unsuspecting patients were deprived of immediate services of other PT clinics due to their physicians' misleading explanations/ justification on referring them in their own PT clinic. And most of the time they have been presented with false claims that usually sounds confusing to the patients, that their doctor's PT clinic is the only one that accepts their insurance.

One unfortunate experience shared by a former patient was having to wait due to the volume of patients seen in her doctor's office. There was a very long waiting list for her to start PT after undergoing shoulder surgery. This patient decided she couldn't wait and called a nearby facility, and when she started her treatment she already developed adhesive capsulitis. She returned to her doctor after a week of therapy (her prescription ran out and she was scheduled to be seen in 6 weeks) and was told she needed MUA. So instead of saving her the time and money, and possibly a better shoulder, her insurance (Medicare) spent more on something that was avoidable and worst she suffers for a prolonged period of time.

Another incident recently was a call I received from a patient asking if we are affiliated with a named institution because his doctor explained to him that only therapists/ PT's from that institution are "reliable". That physician is a leading member of that institution and giving his patient the impression that no other clinics can help the patient except his clinic is dishonest and just plain unacceptable. Bottom line is, patient suffers in the end. The wrong information he received has made him mistrust other clinics thus delaying his therapy because he keeps calling PT clinics in the yellow pages to find out which are "reliable" as his doctor explained to him.

Another case that I have encountered was a Medicare patient going to an OP therapy clinic for Achilles tendonitis. She was referred by her orthopedic doctor for 4 weeks of PT treatment, but unknown to the other doctor she also sees a podiatrist who was giving her PT in his office BUT the patient did not have a clue it was billed as PT treatment. The reason she found out was when her referring physician ordered the exact same modalities (which were WP, US). She told her therapist that she was already doing the same thing at her podiatrist's office.
That brought a conflict of interest. So which discipline will get covered by the patient's insurance?

These, alongside many more valid unfortunate events of abuse, are reasons why physical therapy services should be included in the in-office ancillary services exception.

CMS-1385-P-7534-Attach-1.DOC

There have been so many cases where unsuspecting patients were deprived of immediate services of other PT clinics due to their physicians' misleading explanations/ justification on referring them in their own PT clinic. And most of the time they have been presented with false claims that their doctor's PT clinic is the only one that accepts their insurance.

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That brought a conflict of interest. So which discipline will get covered by the patient's insurance?

These, alongside many more valid unfortunate events, are reasons why physical therapy services should be included in the in-office ancillary services exception.

Submitter : Selena Horner **Date:** 08/23/2007

Organization : None

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

CMS has reasonable data from outside sources that should question the cost-effectiveness/benefit to CMS and its beneficiaries of including physical therapy services as an 'in-office ancillary service.'

According to 2002 data from OIG Report on Physical Therapy billed by Physicians 91% of physical therapy claims billed by physicians did not meet requirements resulting in $136 million in Medicare overpayments.

The CSC Utilization and Edit Report contains interesting facts from 2004 claims. First of all, between 2000 and 2004 there was a 190.5% increase in physical therapists in private practice (PTPP). No interpretation of this increase was provided, but it cannot be assumed that a PTPP is not employed by a physician and is not reassigning benefits to the physician practice. Second of all, a few patterns are immediately apparent when looking at the overview of percentage of claim lines by setting. Three specific claim line percentages (HCPCS 97124, HCPCS 97530 and HCPCS 97035) and their threshold 98th percentile have substantial deviations between PTPP and physician settings. The example edits have an estimated impact of $17,590,538 for PT carriers. No interpretation within the report is provided as to the rationale for the variation in services provided.

Neither of the two reports provided by outside sources contains information involving the effectiveness or efficiency of the care provided to Medicare beneficiaries. Both reports suggest an increased burden of cost when care is provided in self-referral situations.

From my experience, I observed some of the same findings mentioned in the OIG report: very, very high volumes of patients treated per day by a single physical therapist (40-50 patients); lack of required supervision as outlined in 'incident to' (no physician within the building); lack of staff with appropriate qualifications providing care to patients (aides/techs providing care with no physician supervision); and very poor documentation with multiple CMS documentation requirements not being met. Complete disregard of CPT code definitions occurred. From my perspective self-referral has the propensity to create a win-lose-lose situation: physicians win by continuing to profit, Medicare beneficiaries lose by potentially receiving suboptimal care and CMS loses by reimbursing for services that do not meet defined requirements. The situation also continues because of the risk/benefit ratio. The actual risk of being audited combined with the costs to prove that day to day operations do not follow regulations are quite slim because of the lack of monetary funding to enforce the regulations.

As a professional in physical therapy, I do not view my role as an 'in-office ancillary service.' Physicians are not going to be current or knowledgeable in the growing evidence for effective physical therapy interventions. CMS rules and regulations are continually changing and physicians are generally inattentive to physical therapy regulations. Physical therapists do not require physician supervision to independently practice. Physical therapy is not a service that provides immediate information imperative to the medical management of the patient.

The reports created by outside sources indicate the reality of the issue: physicians own physical therapy clinics to increase profit. If that is not the case, then I ask you to ponder why 91% of physical therapy claims by physicians did not meet requirements? I also ask you to ponder why there could be such large differences in the provision of massage, therapeutic activities and ultrasound?

Thank you for the opportunity to comment on CMS-1385-P Physician Self-Referral. I wish you the best of luck in reviewing comments and potentially changing regulations to meet both CMS and Medicare beneficiary needs.

Submitter : **Brian Burney** **Date: 08/23/2007**

Organization : **Brian Burney**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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
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Sincerely,
Brian Burney, CRNA
1309 w. 35th Street
San Pedro, CA 90731

Submitter : **Steven Bartz** **Date: 08/23/2007**

Organization : **AANA**

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

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Sincerely,

Steven R. Bartz, CRNA
9259 Amsden Way
Eden Prairie, MN 55347

Submitter : Dr. Bernard Kirol **Date:** 08/23/2007

Organization : South Carolina Orthopaedic Association

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sirs:

I appreciate the opportunity to review some of CMS decision-making processes as it contemplates changes to the Stark self-referral regulations. I would like to submit comments and clarifications with regard to some of the self-referral provisions.

The fiscal and ethical integrity of the Medicare program is a goal shared by all who participate. CMS decision to focus on the billing of a particular diagnostic test performed by someone other than a full time employee of the ordering physician is appropriate. However, we request that CMS ensure that the payment level calculation under the anti-markup provision place no new administrative burdens on the billing physician or group.

We strongly challenge some of the characterizations articulated regarding the in-office ancillary exception of the proposed rule. The reference to hundreds of letters from physical therapists and occupational therapists encourages physicians to create physical and occupational therapy practices does not appear to be a satisfactory reason to consider change to this valuable in-office ancillary exception. CMS could just as easily construe this letter writing campaign as a self-serving strategy for some therapists to eliminate their competition from physicians. This strategy is supported by the APTA s own initiative of Vision 2020 (www.apta.org), as physical therapists are trying to distance themselves from physician oversight. Importantly, they are not properly trained in differential diagnosis and are not permitted by CMS to order diagnostic tests.

The physician must diagnose the particular musculo-skeletal condition, prescribe the therapy treatment plan and provide the ongoing review of that plan. The patient clearly benefits when there is daily collaboration between the overseeing physician and therapist, which allows for the ongoing and immediate fine tuning of the treatment plan. Only when the physician directly oversees this service can he/she truly control the quality of therapy provided for the patient. When this service is performed through the physician s office it is often more convenient and easily accessible for the patient. This in-office service also provides tremendous patient satisfaction and comfort knowing their physician is immediately available should a problem arise during therapy treatment. Additionally, cost savings can result with direct physician oversight as therapy treatments can be more timely discontinued when the desired result is achieved.

I request that CMS engage in discussions with stakeholders on this issue given the obvious importance of physician expertise, patient needs, clinical quality and the appropriate use of Medicare resources in the area of physical therapy.

Submitter : **Mr. Bruce Rioux** **Date: 08/23/2007**

Organization : **Mr. Bruce Rioux**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

Office of the 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

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Sincerely,

Bruce Rioux CRNA

23 Westwood Ave
Millinocket, Maine 04462

Submitter : **Dr. Ashok Krishnaney** **Date: 08/23/2007**

Organization : **Midwest Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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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.

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Thank you for your consideration of this serious matter.

Ashok Krishnaney, MD

CMS-1385-P-7540-Attach-1.DOC

#7540

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

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Ashok Krishnaney, MD

Submitter : **Mr. John Mitchell** **Date: 08/24/2007**

Organization : **Alaska Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Center for Medicare & Medicaid Services
Department of Health and Human Services

Dear Ms. Norwalk,

As a President of the Alaska Association of Nurse Anesthetists, I am writing to support the CMS proposal to boost the value of anesthesia work by 32%. Under CMS' proposed rule Medicare would increase the anesthesia conversion factor by 15% in 2008.
{72 FR 38122, 7/12/2007}If adoped,the CMS proposal would help to ensure the Certified Registered Nurse Anesthetists(CRNAs)as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia care.

The increase in Medicare payment is important for several reasons:

1. As the American Association of Nurse Anesthetists has previously stated to CMS, Medicare currently under-reimburses for anesthesia care, putting at risk the availability of anesthesia care and other healthcare services for beneficiaries, particularly in rural Alaska.

2. 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.

3. The CMS proposed change in 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 cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at an estimated rate of about 17% below 2006 payment levels, more than one third below 1992 payment levels (adjusted for inflation).

America's 36,000 CRNAs provide more than half of all anesthetics administered in this country. CRNAs are the predominant anesthesia providers in rural and medically underserved regions of our country. Medicare patients and the healthcare delivery in the U. S. depend upon our services. The availability of anesthesia care depends in part on reasonable Medicare payment. The CRNAs of the Alaska Association of Nurse Anesthetists are encouraged by 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 anesthesia payment.

Sincerely,

John F. Mitchell, CRNA
President//AKANA

8719 Mendocino Circle
Eagle River, Alaska
99577

Submitter : Dr. Dorming Wong **Date:** 08/24/2007

Organization : California Anesthesia Associates Medical Group,Inc

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-7542-Attach-1.DOC

7542

Dorming Wong, M.D.
26921 High Wood Circle
Laguna Hills, CA 92653
August 23, 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.

Sincerely yours,

Dorming Wong

Submitter : **Ms. Jennifer Cervantes** **Date: 08/24/2007**

Organization : **Sacred Heart Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:
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.
ı 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.
ı 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.
ı 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,

Jennifer C. Cervantes, RN, SRNA
5912 N. Loma Dr.
Spokane, WA 99205

Submitter : **Ansley Carter** **Date: 08/24/2007**

Organization : **Member of AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:
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Sincerely,

Ansley K. Carter, CRNA
720 Bridgestone Ct.
Anchorage, AK 99518

Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I hope you reconsider the provision to allow Doctors to have "in-house" physical therapists. I have seen this situation be abused in many situations. One doctor expects his patients to drive out of town (about 45 miles) for PT when there are 3 local offices that perform physical therapy. Often the patients I talk to state that they are not given a choice where to go, but that they are directed to the "doctor's therapist." When I was offered a job by a local MD the recruiter stated the Doctors should not have to lose that income by referring it out and it makes more sense to just hire their own PT. Again, currently the provision allows for unethical and abusive behaviors and I would strongly suggest the removal of the provision to allow doctor's to have self-referral for physical therapy services.

Submitter : g Patterson **Date:** 08/24/2007

Organization : g Patterson

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a Physical Therapist that has grave concerns regarding Physical Therapists working in Physicians offices and viloating Stark Referral for Porfits law. I have worked very hard in my practice over the last 17 years and remained ethical in all aspects of my work. As a therapist and consumer, it troubles me that some physicians and therapists are 'cheating the system' in order to just make easy money at the patients expense. Physical Therapists and Physicians should practice independent of one another and have done so for many years with great success for themselves and patients. Physicians are starting to monopolize the therapy market by operating therapy services out of their office which is breaking the law and lowering the quality of care. Quality of care of therapy services is much better outside the physician office due to competition in the free market; a basic rule of supply and demand. There are specific examples in my area where patients have been told by their physician that they have to use the therapy service in their office taking away their right of choice for medical services. This is also a violation of law. Unfortunatly, the patient is usually not aware of this law and feels powerless over the physician.
Please uphold the intent of this law, and do not allow any anacillary services to be billed within a physician practice. As a tax payer, I should be protected by your institution from such illegal actions. I follow the law of my practice act and provide ethical care with the patient as my focus, not money. Allowing physical therapy or any other service not specifically provided by the physician with the scope of their practice should not be allowed in order to protect the best medical and financial interest of the patient. This has been abused too long and public should be protected. There are two new large therapy programs being developed in my area that are physician owned and will be in violation of Stark laws. I also have been aware of a very troubling Athletic Trainer doing the same in a physician office, not only violating Stark laws , but providing sub-standard care because they and the physican can get away with it and steal money from the government.

Please protect the public and stop the 'in-office ancillary exception' to the Stark law.

Thank you.

Submitter : **Mr. Jay Strickland** **Date: 08/24/2007**

Organization : **St. Vincent's Blount Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

Jay Strickland, CRNA
8415 Old Highway 31
Morris, AL 35116

Submitter : Mr. Thomas Burkett **Date:** 08/24/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment:August 20, 2007
Office of the 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
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Sincerely,
Thomas Burkett CRNA,MS,BSN.

2502 Eaton Road.

Wilmington, DE 19810

Submitter : Mr. Patrick Jose **Date:** 08/24/2007

Organization : Mr. Patrick Jose

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Office of the 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
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Submitter : **Dr. Asokumar buvanendran** **Date: 08/24/2007**

Organization : **Rush Medical College, chicago, IL**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 (the Proposed Rule) published in the Federal Register on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.
There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the all physicians crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as interventional pain physicians for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to all physicians for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. Interve

Submitter : **Dr. Phillip Carnevale** **Date: 08/24/2007**

Organization : **AMA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am an anesthesiologist at a busy endoscopy center that employs many CRNAs. The medicare cut in reimbursement has drastically affected our facility. We have increased number of patients and are receiving less reimbursement. Please support the increase in reimbursement to insure increase quality of care to our patients. Thank you.

Submitter : **Dr. Phillip Carnavale** **Date: 08/24/2007**

Organization : **AMA**

Category : **Physician**

Issue Areas/Comments

Background

Background

I am an anesthesiologist in a busy endoscopy center that employs many CRNAs. The medicare cut has affected us all greatly as our number of patients has increased and reimbursement has decreased. This affects all patients. Please support the medicare reimbursemnt increase. Thank you.

Submitter : **Dr. Ben Stiles** **Date: 08/24/2007**

Organization : **Dr. Ben Stiles**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

By no means does this new proposed rule help the patient. As a treating physician I am consistently delayed in obtaining diagnostic tests because I cannot directly refer for testing. A recent patient was referred to her MD for imaging who referred her to an orthopedist without even seeing her. The orthopedist had a six week waiting list before she could be seen. She was in so much pain I encouraged her to ask her oncologist to order the imaging who did so reluctantly. A compression fracture was discovered on the imaging and she was advised to be admitted into the hospital. This was all done five weeks before her appointment with the orthopedist was available. Treating fractures is beyond my scope of practice but having the inability to order tests that would help diagnose such a problem should not be. This new proposal will only interfere with the patients ability to be properly diagnosed, treated and/or referred to the appropriate doctor.

Please reconsider and do NOT pass such a limiting and unfair rule. The next patient may be one of your loved ones and I am sure you would want them to have the best care possible. Chiropractors should have the ability to order imaging and be reimbursed for such care.

CMS-1385-P-7553-Attach-1.DOC

CMS-1385-P-7553-Attach-2.DOC

#7553

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

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Sincerely,

Ben Stiles, DC

Submitter : Dr. Ashwin Meta **Date:** 08/24/2007

Organization : AMA

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am a physician at a busy endoscopy center that employs many CRNAs. The reduction in reimbursement has drastically affected the entire facility. We have increased number of patients and yet are receiving less reimbursement. I would appreciate your support for the increase of reimbursement. Thank you.

Submitter : Miss. Leigh Ann Vanhove **Date:** 08/24/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am a nurse anesthetist that works in several facilities. the medicare cut has affected the facilities as well as my income. I am now receiving the same salary that I made in 1999. I would appreciate your support to increase medicare reimbursement. Thank you.

Submitter : Dr. Bruce Edgerton **Date:** 08/24/2007

Organization : AMA

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am a physician in a busy endoscopy center. The medicare cut has affected us all. Our numbers are soaring yet our reimbursement has greatly decreased. i feel this is punishment to everyone involved. Please support the increase reimbursemnt. Thank you

Submitter : Dr. David Shepard **Date:** 08/24/2007

Organization : AMA

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am a physician in a busy endoscopy center doing as many as 300 patients a week. The medicare cut has affected the facility in many ways as our numbers grow and the reimbursement is decreased. Please support the increase medicare reimbursemnt. Thank you.

Submitter : Dr. Lopez **Date:** 08/24/2007

Organization : AMA

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am a physician in a busy endoscopy center seeing approximately 300 patients a week. The medicare reimbursement cut has affected our entire facility as our number of patients has grown and the reimbursement has decreased. Please support the medicare increase. Thank you.

Submitter : Mrs. Laura Morgan **Date:** 08/24/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am a nurse anesthetist that works in a busy outpatient center. The medicare cut has affected us all, but as for myself I am now being reimbursed at the same rate I was in 1999. I would appreciate your support in increasing the medicare reimbursement increase. Thank you.

Submitter : Mr. Roque Covarrubias **Date:** 08/24/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am a nurse anesthetist at a busy outpatient center that sees approximately 300 patients a week. The medicare cut has affected us all but mostly I am now making a salary similar to 1999. I would appreciate your support increasing the medicare reimbursement bill. Thank you.

Submitter : Dr. David Heiman **Date:** 08/24/2007

Organization : AMA

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am a physician in a busy endoscopy center seeing approximately 300 patients a week. The medicare cut has affected the entire facility and I am now making a salary comperable to 1999. I would appreciate your support in increasing the medicare reimbursemnt. Thank you.

Submitter : Dr. John Porter **Date:** 08/24/2007

Organization : The Physicians' Pain

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Please see attached letter.

CMS-1385-P-7562-Attach-1.TXT

CMS-1385-P-7562-Attach-2.TXT

#7562

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

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I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, "Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008" (the "Proposed Rule") published in the *Federal Register* on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.

There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the "all physicians" crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians' ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries' access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as "interventional pain physicians" for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to "all physicians" for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. Interventional pain is an inter-disciplinary practice that draws on various medical specialties of anesthesiology, neurology, medicine & rehabilitation, and psychiatry to diagnose and manage acute and chronic pain. Many interventional pain physicians received their medical training as anesthesiologists and, accordingly, clinically view themselves as anesthesiologists. While this may be appropriate from a clinically training perspective, their Medicare designation does not accurately reflect their actual physician practice and associated costs and expenses of providing interventional pain services.

This disconnect between the Medicare specialty and their practice expenses is made worse by the fact that anesthesiologists have the lowest practice expense of any specialty. Most anesthesiologists are hospital based and do not generally maintain an office for the purposes of rendering patient care. Interventional pain physicians are office based physicians who not only furnish evaluation and management (E/M) services but also perform a wide variety of interventional procedures such as nerve blocks, epidurals, intradiscal therapies, implant stimulators and infusion pumps, and therefore have practice expenses that are similar to other physicians who perform both E/M services and surgical procedures in their offices.

Furthermore, the utilization rates for interventional pain and pain management specialties are so low that they are excluded from Medicare rate-setting or have very minimal affect compared to the high utilization rates of anesthesiologists. CMS utilization files for calendar year 2007 overwhelming report anesthesiologists compared to interventional pain physicians and pain management physicians as being the primary specialty performing interventional pain procedures. The following table illustrates that anesthesiologists are reported as the primary specialty providing interventional pain services compared to interventional pain physicians

CPT Code	Anesthesiologists - 05	Interventional Pain Management Physicians

	(Non-Facility)	- 09 (Non-Facility)
64483 (Inj foramen epidural l/s)	59%	18%
64520 (N block, lumbar/thoracic)	68%	15%
64479 (Inj foramen epidural c/t)	58%	21%
62311 (Inject spine l/s (cd))	78%	8%

The high utilization rates of anesthesiologists (and their extremely low practice expenses) drive the payment rate for the interventional pain procedures, which does not accurately reflect the resource utilization associated with these services. This results in payment rates that are contrary to the intent of the Medicare system—physician payment reflects resources used in furnishing items and services to Medicare beneficiaries.

I urge CMS to make a modification to its practice expense methodology as it pertains to interventional pain services such that its methodology treats physicians who list anesthesiology as their primary specialty and list interventional pain as their secondary specialty designation as interventional pain physicians for rate-setting. This pool of physicians should be cross-walked to "all physicians" for practice expenses. This will result in a payment for interventional pain services that is more aligned with the resources and costs expended to provide these services to a complex patient population.

I urge CMS not to delay implementing our proposed recommendation to see if the updated practice expenses information from the Physician Practice Information Survey ("Physician Practice Survey") will alleviate the payment disparity. While I believe the Physician Practice Survey is critical to ensuring that physician services are appropriately paid, I do not believe that updated practice expense data will completely resolve the current underpayment for interventional pain services. The accurate practice expense information for interventional pain physicians will continue to be diluted by the high utilization rates and associated low practice expenses of anesthesiologists.

II. CMS Should Incorporate the Updated Practice Expenses Data from Physician Practice Survey in Future Rule-Making

I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

III. CMS Should Work Collaboratively with Congress to Fix the SGR Formula so that Patient Access will be preserved.

The sustainable growth rate ("SGR") formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing

reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

Because of the flawed formula, physicians and other practitioners disproportionately bear the cost of providing health care to Medicare beneficiaries. Accordingly, many physicians face clear financial hardship and will have to make painful choices as to whether they should continue to practice medicine and/or care for Medicare beneficiaries.

CMS should work collaboratively with Congress to create a formula that bases updates on the true cost of providing healthcare services to Medicare beneficiaries.

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Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

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