Submitter : **Mr. Daniel Koontz** **Date: 07/09/2007**

Organization : **Mid-Atlantic Practice Management Services**

Category : **Individual**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

July 9, 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.

Yours Truly,

Daniel Koontz
President and CEO

Submitter : **Dr. Michael Quast** **Date: 07/09/2007**

Organization : **Medcenter One**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
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P.O. Box 8018
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Michael Quast, M.D., M.B.A.

Submitter : **Dr. Kevin Cregan** **Date: 07/09/2007**

Organization : **Wayne Radiologists, P.A.**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Committee Members,

I am a radiologist in practice in Goldsboro, NC. I urge you to amend the in-office services loophole that currently exists in the self-referral policy. It has been shown by many investigators (the foremost being Dr. David C. Levin from Thomas Jefferson University), that physicians with a financial stake in a piece of imaging equipment will order studies at a rate at least 4 times that of physicians without a financial conflict of interest. In our own community we have recently had a proliferation of in-office CT and MR scanners (within ENT, urology, and orthopedic offices). It is our contention that scanners of much lower quallity are being installed in medical offices such as these for financial reasons only. All of these services are available on state-of-the-art CT scanners in our office (on the same road as most of the physician offices) and at the hospital (across the street). The new state-of-the-art MR facility is across the street from the doctors' offices as well. These services are available on a "walk-in" basis in our office at no additonal inconvenience to the patient. The complete diagnostic work-up is still accomplished on the same day as the doctors' office visit and on a much better CT unit with interpretations by on-site board-certified radiologists.

It is way past time to update the self-referral provisions. Congress certainly did not intend the in-office exception for sophistatied expensive specialist services such as computed tomography and MRI. Nonradiologists are using these machines as "passive income" to offset other reductions in reimbursement. High-end imaging is complex abd requires supervision by trained specialists (radiologists). There are quality assurance and quality control issues and radiation dose issues that can only bc properly addressed by radiologists.

I am alarmed by what is currently occuring due to the loophole in the Stark legislation that permits in-office imaging and shameless, blatant self-referral. Medicare can save billions of dollars simply by closing this loophole. I urge you to close it now and not wait for next year.

Sincerely,
Kevin M. Cregan, M.D.
Wayne Radiologists, P.A.
2700 Medical Office Place
Goldsboro, NC 27534
919-734-1866

CMS-1385-P-28-Attach-1.PDF

#28

Radiology

Andrea J. Maitino, MS
David C. Levin, MD
Laurence Parker, PhD
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Jonathan H. Sunshine, PhD

Index terms:
Diagnostic radiology
Economics, medical
Radiology and radiologists, departmental management
Radiology and radiologists, socioeconomic issues

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Abbreviations:
NDI = noninvasive diagnostic imaging
RVU = relative value unit

[1] From the Department of Radiology, Thomas Jefferson University, Suite 3390, Gibbon Bldg, 111 S 11th St, Philadelphia, PA 19107 (A.J.M., D.C.L., L.P., V.M.R.); and American College of Radiology, Reston, Va (J.H.S.). From the 2001 RSNA scientific assembly. Received October 2, 2002; revision requested December 12; revision received December 30; accepted January 27, 2003. **Address correspondence to** A.J.M. (e-mail: *andrea.maitino@jefferson.edu*).

Author contributions:
Guarantors of integrity of entire study, all authors; study concepts, all authors; study design, D.C.L., L.P., V.M.R.; literature research, A.J.M.; data acquisition, J.H.S.; data analysis/interpretation, A.J.M., D.C.L., L.P.; statistical analysis, L.P.; manuscript preparation, A.J.M.; manuscript definition of intellectual content, all authors; manuscript editing, A.J.M., D.C.L., L.P.; manuscript revision/review and final version approval, all authors

Practice Patterns of Radiologists and Nonradiologists in Utilization of Noninvasive Diagnostic Imaging among the Medicare Population 1993–1999[1]

PURPOSE: To compare nationwide trends in noninvasive diagnostic imaging (NDI) practice patterns of radiologists and of nonradiologists among the Medicare population during the 6 years from 1993 to 1999.

MATERIALS AND METHODS: Medicare Part B claims files from 1993, 1996, and 1999 were analyzed for all procedure codes related to NDI. NDI codes were classified into 22 diagnostic categories within seven imaging modality groups. For each NDI code, physicians performing the services were classified as radiologists or nonradiologists by using the provider specialty code designated in claims in the files. The data were analyzed to determine the overall utilization rates and relative value unit (RVU) rate changes between 1993 and 1999 among radiologists and nonradiologists.

RESULTS: In 1993, the overall NDI utilization rate per 100,000 Medicare fee-for-service beneficiaries was 215,652 for radiologists and 79,942 for nonradiologists. In 1999, the rate was 207,270 for radiologists and 100,059 for nonradiologists, which is a 3.9% decrease among radiologists and a 25.2% increase among nonradiologists. In the 6-year interval from 1993 to 1999, the overall RVU rate increased 6.9% among radiologists and 32.4% among nonradiologists. The percentage of NDI performed by radiologists decreased from 73.0% in 1993 to 67.4% in 1999.

CONCLUSION: Overall, the utilization rate of advanced, high-technology imaging is increasing among both radiologists and nonradiologists. However, it is increasing at a considerably more rapid rate among nonradiologists.

It has been previously shown that in the years between 1993 and 1999, the utilization of noninvasive diagnostic imaging (NDI) in the Medicare fee-for-service population increased 3.8% and the work associated with the imaging, as determined with relative value unit (RVU) rates per 100,000 Medicare fee-for-service beneficiaries, increased 14.6% (1). The increase in RVU rates was associated with the increased use of more complex, high-technology imaging examinations. Health policy planners have been concerned with the increase in utilization of diagnostic imaging and high-technology medicine, but the earlier study to which we referred suggested that the increase in diagnostic radiology work in a 6-year period was moderate (1).

Exploring these increases in relation to the relative shares of procedures that are performed by radiologists and nonradiologists is of interest because of the issues of self-referral and image quality. In two important studies by Hillman et al (2,3), a considerably higher utilization of imaging examinations was noted among physicians who had the

opportunity to self-refer than among physicians who referred their patients to radiologists. The same phenomenon was identified throughout the Florida Medicare population, as noted in a report by the United States General Accounting Office (4). It has also been reported that there are apparent quality problems among the images obtained by nonradiologists. For example, in a pilot project in which 98 chest radiographs were reviewed at Hershey Medical Center, inadequate image quality was found in 3% of images obtained by radiologists but in 28% of images obtained by nonradiologists (5). The purpose of our study was to compare practice patterns between radiologists and nonradiologists performing NDI examinations among the Medicare population during the 6 years from 1993 to 1999.

MATERIALS AND METHODS

The methods used in this study have previously been described (1). The nationwide Centers for Medicare and Medicaid Service Part B Physician/Supplier Procedure Summary Master Files (the Medicare Part B databases) for 1993, 1996, and 1999 were evaluated for all procedure codes related to NDI. The Medicare Part B databases are anonymous public files and are therefore ex-

TABLE 1
Numbers of Medicare Part B NDI Examinations Performed by Radiologists, Nonradiologists, or Multispecialty Groups

Physician Category	1993	1996	1999
Radiologists	71,812,070 (68.9)	67,747,021 (66.2)	69,539,392 (63.8)
Nonradiologists	26,620,918 (25.5)	28,479,523 (27.8)	33,569,932 (30.8)
Multispecialty*	5,798,065 (5.6)	6,063,549 (5.9)	5,920,098 (5.4)
Total volume	104,231,053 (100.0)	102,290,093 (100.0)	109,029,422 (100.0)

Note.—Data in parentheses are percentages.
* Multispecialty groups are listed as a separate category because some claims do not indicate the specialty of the physician.

TABLE 2
Nationwide Utilization Rates of Medicare Part B NDI Examinations among Radiologists and Nonradiologists

	Radiologists				Nonradiologists			
NDI Procedure	1993	1996	1999	Percentage Change 1993–1999	1993	1996	1999	Percentage Change 1993–1999
Conventional radiography and fluoroscopy								
Chest radiography	92,416	83,387	77,358	−16.3	15,483	12,717	10,865	−29.8
Skeletal radiography	38,398	37,373	35,883	−6.5	27,048	26,681	26,644	−1.5
Abdomen radiography	14,288	12,597	11,854	−17.0	1,305	1,265	1,671	8.1
Gastrointestinal fluoroscopy	8,337	6,353	4,954	−40.6	352	220	167	−52.5
All conventional radiography and fluoroscopy	153,439	139,710	130,049	−15.2	44,188	40,883	39,347	−11.0
Mammography	14,373	12,781	16,990	18.2	1,421	1,040	1,533	7.8
US								
General	9,302	9,089	8,805	−5.4	3,091	3,685	4,676	1.3
Vascular	3,013	4,189	4,953	64.4	4,600	5,309	6,443	0.0
Breast	469	723	1,113	137.6	35	65	120	247.5
Echocardiography	561	521	550	−2.0	23,398	29,590	36,424	55.7
Obstetric	41	31	26	−34.8	38	37	41	6.5
All US	13,386	14,555	15,447	15.4	31,162	38,687	47,705	53.1
CT								
Body	11,154	12,472	15,698	40.7	199	217	435	118.1
Cranial	8,435	9,058	9,866	17.0	262	234	285	8.6
Spine	1,140	1,021	943	−17.3	37	31	42	14.4
Musculoskeletal	119	132	166	39.2	3	3	5	75.5
All CT	20,848	22,684	26,672	27.9	502	484	767	53.0
Nuclear imaging								
General	6,487	5,727	5,296	−18.4	493	399	357	−27.7
Cardiovascular	2,686	2,712	3,681	37.1	1,881	3,083	6,956	269.7
All nuclear imaging	9,173	8,439	8,977	−2.1	2,375	3,482	7,312	207.9
MR imaging								
Cranial	2,065	2,586	3,198	54.9	110	130	268	143.4
Spine	1,590	2,044	2,665	67.6	67	93	274	307.9
Musculoskeletal	482	693	1,054	118.5	15	26	130	768.0
Body	216	221	327	51.3	5	6	20	294.6
Cardiovascular	3	4	44	1173.0	1	1	5	692.0
All MR imaging	4,357	5,549	7,288	67.3	198	255	697	252.1
Bone densitometry	78	586	1,847	2271.0	97	1,054	2,698	2689.0
Total	215,652	204,303	207,270	−3.9	79,942	85,885	100,059	25.2

Note.—Examination utilization rates are calculated per 100,000 Medicare fee-for-service beneficiaries for 1993, 1996, and 1999. Percentage change is calculated from these rates. Data in columns may not add to totals because of rounding.

TABLE 3
Nationwide RVU Rates of Medicare Part B NDI Examinations among Radiologists and Nonradiologists

NDI Procedure	Radiologists				Nonradiologists			
	1993	1996	1999	Percentage Change 1993–1999	1993	1996	1999	Percentage Change 1993–1999
Conventional radiography and fluoroscopy								
Chest radiography	27,480	25,007	23,062	−16.1	4,881	4,089	3,498	−28.3
Skeletal radiography	12,215	11,881	11,229	−8.1	7,684	7,625	7,594	−1.2
Abdomen radiography	5,789	5,222	4,753	−17.9	534	501	586	9.7
Gastrointestinal fluoroscopy	8,785	6,674	4,979	−43.3	374	239	175	−53.1
All conventional radiography and fluoroscopy	54,269	48,784	44,023	−18.9	13,473	12,454	11,853	−12.0
Mammography	11,672	10,175	12,882	10.4	1,467	1,073	1,651	2.5
US								
General	10,046	9,907	9,316	−7.3	3,133	3,555	4,557	5.5
Vascular	3,160	4,324	4,849	53.5	4,762	5,494	6,442	5.3
Breast	385	600	902	134.0	28	54	97	242.3
Echocardiography	668	595	557	−16.5	29,482	33,524	36,956	25.4
Obstetric	58	44	36	−37.4	50	49	52	3.2
All US	14,317	15,470	15,660	0.4	37,455	42,676	48,104	28.4
CT								
Body	20,540	23,110	28,354	38.0	365	401	787	115.4
Cranial	12,776	13,483	14,090	10.3	391	350	420	7.3
Spine	1,992	1,804	1,629	−18.2	65	54	73	12.8
Musculoskeletal	196	219	268	36.7	5	5	9	72.4
All CT	35,504	38,616	44,341	24.9	826	810	1,289	6.1
Nuclear imaging								
General	7,537	7,063	6,657	−11.7	508	450	401	−21.0
Cardiovascular	4,995	5,065	5,859	17.3	3,577	5,579	10,385	190.4
All nuclear imaging	12,532	12,128	12,516	−0.1	4,085	6,029	10,786	164.0
MR imaging								
Cranial	5,691	7,467	9,206	61.8	288	356	747	159.8
Spine	4,014	5,276	6,767	68.6	167	238	687	310.4
Musculoskeletal	972	1,399	2,120	118.1	30	53	260	752.4
Body	520	538	778	49.6	12	14	48	290.2
Cardiovascular	8	9	115	1279.0	1	2	12	755.8
All MR imaging	11,205	14,689	18,986	69.4	498	663	1,754	252.2
Bone densitometry	27	250	800	2860.0	32	460	1,114	3380.0
Total	139,526	140,112	149,208	6.9	57,836	64,165	76,551	32.4

Note.—RVU rates are calculated per 100,000 Medicare fee-for-service beneficiaries for 1993, 1996, and 1999. Percentage change is calculated from these rates.

empt from review by institutional review board. For each NDI procedure code in the Medicare Part B databases, we classified the physicians performing the services as radiologists or nonradiologists by using the provider specialty code designated in claims in the files. Those NDI examinations in which the specialty of the provider was classified as a multispecialty group (without further indicating the specialty of the physician performing the examination) were excluded from analysis, although the overall volumes and percentages of examinations were tabulated.

The overall utilization rates and Medicare total professional component RVU rates per 100,000 Medicare fee-for-service beneficiaries were calculated for 1993, 1996, and 1999 among radiologists and nonradiologists. NDI examinations were classified into seven imaging modalities, which were then further classified into 22 diagnostic categories. The seven imaging modalities and their component diagnostic categories were as follows: *(a)* radiography (chest, skeletal, abdominal, gastrointestinal fluoroscopy); *(b)* mammography; *(c)* ultrasonography (US) (general, vascular, breast, echocardiography, obstetric); *(d)* computed tomography (CT) (body, cranial, spinal, musculoskeletal); *(e)* nuclear imaging (general, cardiovascular); *(f)* magnetic resonance (MR) imaging (cranial, spinal, musculoskeletal, body, cardiovascular); and *(g)* bone densitometry.

Four of the investigators (A.J.M., D.C.L., L.P., V.M.R.) reviewed each of the CPT-4 codes in the 70000 series and the echocardiography and vascular US codes in the 90000 series. Each code that represented an NDI procedure was assigned to the appropriate category and modality. SAS 8e Release 2 for Windows (SAS Institute, Cary, NC) was then used to tabulate the number of procedures in each of the categories and modalities. The changes in percentage of NDI utilization and RVU rates among radiologists and nonradiologists during the 6-year period between 1993 and 1999 were calculated for each NDI modality and category. Since cardiovascular imaging is often self-referred (6), we then separately analyzed these trends for all cardiovascular imaging and compared them with those for all noncardiovascular imaging. For this purpose, cardiovascular imaging included four categories: echocardiography, vascular US, cardiovascular nuclear imaging, and cardiovascular MR imaging. The

1999 RVU scale was used to calculate the RVU rates for 1993 and 1996 rather than the RVU scale for those particular years. We used these "synthetic" RVU rates because the assigned RVUs for some codes change from year to year, and we believed it was important to use a single, consistent scale in order to ascertain changes in the relative amount of work. Since the Medicare Part B database contains information on a complete population, no inferential statistical analysis is required, which would have been the case if we had been trying to infer population statistics from sample data.

The RVU rates represent a proxy for the relative amount of work associated with each procedure. On the basis of an earlier recommendation by the American College of Radiology, we made the assumption that screening mammography should carry 80% of the professional component RVUs of diagnostic mammography.

RESULTS

Table 1 shows the overall volume of NDI performed by radiologists, nonradiologists, and multispecialty groups in 1993, 1996, and 1999. In 1993, a total of 104,231,053 NDI examinations were performed among the Medicare fee-for-service population. Radiologists performed 71,812,070 (68.9%) examinations and nonradiologists performed 26,620,918 (25.5%) examinations. In 1999, a total of 109,029,422 NDI examinations were performed. Radiologists performed 69,539,392 (63.8%) examinations, which is a 5.1% reduction in their share, while nonradiologists performed 33,569,932 (30.8%) examinations, which is a 5.3% increase in their share. The share of NDI examinations performed by multispecialty groups remained relatively constant in the 6-year period: 5,798,065 (5.6%) in 1993, 6,063,549 (5.9%) in 1996, and 5,920,098 (5.4%) in 1999.

Table 2 shows the nationwide NDI utilization rates per 100,000 beneficiaries among radiologists and nonradiologists in 1993, 1996, and 1999 by imaging category and modality; it also shows the percentage of change in utilization rates between 1993 and 1999. In 1993, the overall NDI utilization rate was 215,652 examinations per 100,000 beneficiaries by radiologists and 79,942 by nonradiologists. In 1999, the rate was 207,270 by radiologists and 100,059 by nonradiologists, which is a 3.9% decrease among radiologists and a 25.2% increase among nonradiologists.

TABLE 4
Percentage of Medicare Part B Examinations Performed by Radiologists and Nonradiologists in Different Categories and Modalities

NDI Procedure	Radiologists		Nonradiologists	
	1993	1999	1993	1999
Conventional radiography and fluoroscopy				
Chest radiography	91.6	87.6	8.4	12.4
Skeletal radiography	85.7	87.7	14.3	12.3
Abdomen radiography	95.9	96.7	4.1	3.3
Gastrointestinal fluoroscopy	58.7	57.4	41.3	42.6
All conventional radiography and fluoroscopy	77.6	76.8	22.4	23.2
Mammography	91.0	91.7	9.0	8.3
US				
Breast	93.1	90.3	6.9	9.7
Echocardiography	2.3	1.5	97.7	98.5
General	75.1	65.3	24.9	34.7
Obstetric	51.9	38.8	48.1	61.2
Vascular	39.6	43.5	60.4	56.5
All US	30.0	24.5	70.0	75.5
CT				
Body	98.2	97.3	1.8	2.7
Cranial	97.0	97.2	3.0	2.8
Musculoskeletal	97.5	97.1	2.5	2.9
Spine	96.9	95.7	3.1	4.3
All CT	97.6	97.2	2.4	2.8
Nuclear imaging				
Cardiovascular	58.8	34.6	41.2	65.4
General	92.9	93.7	7.1	6.3
All nuclear imaging	79.4	55.1	20.6	44.9
MR imaging				
Body	97.7	94.2	2.3	5.8
Cardiovascular	75.0	89.8	25.0	10.2
Cranial	94.9	92.3	5.1	7.7
Musculoskeletal	97.0	89.0	3.0	11.0
Spine	96.0	90.7	4.0	9.3
All MR imaging	95.7	91.3	4.3	8.7
Bone densitometry	44.6	40.6	55.4	59.4
Total	73.0	67.4	27.0	32.6

Changes in utilization rates by modality demonstrate a decline in the utilization of conventional radiography by both radiologists (−15.2%) and nonradiologists (−11.0%). Both groups demonstrated an increased utilization of bone densitometry (2271.0% by radiologists, 2689.0% by nonradiologists), MR imaging (67.3% by radiologists, 252.1% by nonradiologists), CT (27.9% by radiologists, 53.0% by nonradiologists), mammography (18.2% by radiologists, 7.8% by nonradiologists), and US (15.4% by radiologists, 53.1% by nonradiologists). Changes in utilization rates of nuclear imaging, however, demonstrated a decrease in utilization by radiologists (−2.1%) but an increase in utilization by nonradiologists (207.9%). This was largely attributable to a substantial increase in utilization of cardiovascular nuclear imaging examinations by nonradiologists.

The RVU rates per 100,000 Medicare fee-for-service beneficiaries for 1993, 1996, and 1999 are shown in Table 3. In 1993, the overall RVU rate was 139,526 for radiologists and 57,836 for nonradiologists. In 1999, this rate increased to 149,208 (an increase of 6.9%) for radiologists and 76,551 (an increase of 32.4%) for nonradiologists. Table 4 lists the percentage of NDI examinations performed by radiologists and nonradiologists by category and modality in 1993 and 1999. The overall percentage of NDI performed by radiologists decreased from 73.0% in 1993 to 67.4% in 1999. Their rate of participation decreased in 15 of the 22 imaging categories. Substantial reductions in percentage of imaging performed by radiologists were observed for general US (from 75.1% in 1993 to 65.3% in 1999), cardiovascular nuclear imaging (from 58.8% to

TABLE 5
Percentage of Medicare Part B RVUs Performed by Radiologists and Nonradiologists in Different Categories and Modalities

NDI Procedure	Radiologists		Nonradiologists	
	1993	1999	1993	1999
Conventional radiography and fluoroscopy				
Chest radiography	84.9	86.8	15.1	13.2
Skeletal radiography	61.4	59.7	38.6	40.3
Abdomen radiography	91.5	89.0	8.5	11.0
Gastrointestinal fluoroscopy	95.9	96.6	4.1	3.4
All conventional radiography and fluoroscopy	80.1	78.8	19.9	21.2
Mammography	88.8	88.6	11.2	11.4
US				
Breast	93.2	90.3	6.8	9.7
Echocardiography	2.2	1.5	97.8	98.5
General	76.2	67.2	23.8	32.8
Obstetric	53.7	40.9	46.3	59.1
Vascular	39.9	43.0	60.1	57.0
All US	27.7	24.6	72.3	75.4
CT				
Body	98.3	97.3	1.7	2.7
Cranial	97.0	97.1	3.0	2.9
Musculoskeletal	97.5	96.8	2.5	3.2
Spine	96.8	95.7	3.2	4.3
All CT	97.7	97.2	2.3	2.8
Nuclear imaging				
Cardiovascular	58.3	36.1	41.7	63.9
General	93.7	94.3	6.3	5.7
All nuclear imaging	79.4	55.1	20.6	44.9
MR imaging				
Body	97.7	94.2	2.3	5.8
Cardiovascular	88.9	90.6	11.1	9.4
Cranial	95.2	92.5	4.8	7.5
Musculoskeletal	97.0	89.1	3.0	10.9
Spine	96.0	90.8	4.0	9.2
All MR imaging	95.7	91.5	4.3	8.5
Bone densitometry	45.8	41.8	54.2	58.2
Total	70.7	66.1	29.3	33.9

34.6%), and musculoskeletal MR imaging (from 97.0% to 89.0%). The percentages of NDI RVU rates among radiologists and nonradiologists are listed by category and modality in Table 5. The radiologists' overall share of RVUs decreased from 70.7% in 1993 to 66.1% in 1999, which is a decrease of 4.6%. Radiologists' share of RVUs decreased in 16 of the 22 categories; the largest reductions were in cardiovascular nuclear imaging (from 58.3% in 1993 to 36.1% in 1999), obstetric US (from 53.7% to 40.9%), and musculoskeletal MR imaging (from 97.0% to 89.1%).

Tables 6–9 depict the effect of cardiovascular imaging on the utilization rates and RVU trends among radiologists and nonradiologists between 1993 and 1999. Table 6 demonstrates that between 1993 and 1999, nonradiologists' overall utilization of cardiovascular imaging per 100,000 beneficiaries increased from 29,880 examinations to 49,828 examinations (an increase of 66.8%), while radiologists' utilization increased from 6,263 examinations to 9,228 examinations (an increase of 47.3%). During this period, utilization of noncardiovascular imaging increased 0.3% among nonradiologists and decreased 5.4% among radiologists. The percentages of examinations performed by radiologists and nonradiologists are listed in Table 7. Nonradiologists' share of NDI examinations increased for both cardiovascular (1.7%) and noncardiovascular imaging (0.9%).

Table 8 shows that between 1993 and 1999, overall RVU rates for cardiovascular NDI increased 42.2% among nonradiologists, from 37,822 RVUs (per 100,000 beneficiaries) in 1993 to 53,795 RVUs in 1999; RVU rates increased 28.9% among radiologists, from 8,831 RVUs to 11,380 RVUs. During this same period, RVU rates for noncardiovascular imaging increased 13.7% among nonradiologists and 5.5% among radiologists. Table 9 lists the share of RVUs performed by nonradiologists and radiologists. Nonradiologists' share of cardiovascular RVUs increased 1.5%, and their share of noncardiovascular RVUs increased 0.9%.

DISCUSSION

Between 1993 and 1999, the overall utilization rates of NDI decreased 3.9% among radiologists but increased 25.2% among nonradiologists. During the same period, the overall RVU rates increased 6.9% among radiologists and 32.4% among nonradiologists. Results of a previous study showed that overall, the utilization of NDI increased only 3.8% between 1993 and 1999 (1). Our data reveal the somewhat surprising fact that the utilization actually decreased among radiologists but sharply increased among nonradiologists. This indicates that almost all growth in the utilization rates of NDI is attributable to imaging performed by nonradiologists.

Cardiovascular imaging procedures (echocardiography, vascular US, cardiovascular nuclear imaging, and cardiovascular MR imaging) constitute a considerable proportion of the increase in utilization of NDI by nonradiologists. Levin et al (6) showed that in 1998, 83.3% of all cardiovascular NDI was performed by nonradiologists and that 61.5% of this was performed by cardiologists. Most of this disparity was related to cardiologists' strong domination of echocardiography, in which they performed 79.8% of imaging. In our analyses, the rate of utilization of cardiovascular imaging by nonradiologists is so substantial that when other categories of NDI are analyzed separately from it, there is little change in the utilization of NDI by nonradiologists. Utilization of noncardiovascular NDI between 1993 and 1999 increased only 0.3% by nonradiologists and decreased 5.4% by radiologists. Examining the trends in RVU rates shows a substantially greater increase in the RVU rates among nonradiologists than among radiologists for cardiovascular NDI (42.2% among nonradiologists, 28.9% among radiologists) and noncardiovascular NDI (13.7% among nonradiologists, 5.5% among radiologists). Among nonradiologists, however, the rates of both cardiovascular and noncardiovascular NDI utilization and RVU remained relatively stable during the 6-year period.

When we focused on noncardiovascular advanced imaging (US, CT, MR imaging, nuclear imaging, and bone densitometry), we found that radiolo-

TABLE 6
Utilization Rates of Medicare Part B Cardiovascular and Noncardiovascular NDI among Radiologists and Nonradiologists

	Radiologists				Nonradiologists			
NDI Procedure	1993	1996	1999	Percentage Change 1993–1999	1993	1996	1999	Percentage Change 1993–1999
Cardiovascular imaging	6,263	7,426	9,228	47.3	29,880	37,983	49,828	66.8
Noncardiovascular imaging	209,390	196,874	198,043	−5.4	50,061	47,903	50,231	0.3
Total	215,653	204,300	207,271	−3.9	79,941	85,886	100,059	25.2

Note.—Utilization rates are calculated per 100,000 Medicare fee-for-service beneficiaries for 1999, 1996, and 1999. Percentage change is calculated from these rates.

TABLE 7
Percentage of Medicare Part B Examinations Performed by Radiologists and Nonradiologists in Cardiovascular and Noncardiovascular Imaging

	Radiologists				Nonradiologists			
NDI Procedure	1993	1996	1999	Percentage Change 1993–1999	1993	1996	1999	Percentage Change 1993–1999
Cardiovascular imaging	17.3	16.4	15.6	−1.7	82.7	83.6	84.4	1.7
Noncardiovascular imaging	80.7	80.4	79.8	−0.9	19.3	19.6	20.2	0.9
Total	73.0	70.4	67.4	−5.5	27.0	29.6	32.6	5.5

TABLE 8
RVU Rates of Medicare Part B Cardiovascular and Noncardiovascular NDI among Radiologists and Nonradiologists

	Radiologists				Nonradiologists			
NDI Procedure	1993	1996	1999	Percentage Change 1993–1999	1993	1996	1999	Percentage Change 1993–1999
Cardiovascular imaging	8,831	9,993	11,380	28.9	37,822	44,599	53,795	42.2
Noncardiovascular imaging	130,695	130,119	137,828	5.5	20,014	19,566	22,756	13.7
Total	139,526	140,112	149,208	6.9	57,836	64,165	76,551	32.4

Note.—RVU rates are calculated per 100,000 Medicare fee-for-service beneficiaries for 1999, 1996, and 1999. Percentage change is calculated from these rates.

TABLE 9
Percentage of Medicare Part B RVUs Performed by Radiologists and Nonradiologists in Cardiovascular and Noncardiovascular Imaging

	Radiologists				Nonradiologists			
NDI Procedure	1993	1996	1999	Percentage Change 1993–1999	1993	1996	1999	Percentage Change 1993–1999
Cardiovascular imaging	18.9	18.3	17.5	−1.5	81.1	81.7	82.5	1.5
Noncardiovascular imaging	86.7	86.9	85.8	−0.9	13.3	13.1	14.2	0.9
Total	70.7	68.6	66.1	−4.6	29.3	31.4	33.9	4.6

gists perform far more examinations per 100,000 beneficiaries than do nonradiologists, but nonradiologists are increasing their utilization more rapidly. In 1993, the utilization rate of such examinations was 4,453 per 100,000 among nonradiologists and 41,577 among radiologists; radiologists performed more than nine times as many examinations. By 1999, the utilization rate had increased 110.0% to 9,351 among nonradiologists and had increased 22.7% to 51,003 among radiologists; radiologists performed more than five times as many examinations.

Aside from cardiovascular imaging, there are four other imaging categories in which nonradiologist participation is substantial. These are bone densitometry, skeletal radiography, chest radiography, and general US. Bone densitometry was a newly reimbursable technology in 1993 that gained popularity because of a new focus on osteoporosis screening. Consistent with this growth in popularity, large increases in utilization rates of bone densitometry were noted for both radiologists and nonradiologists, which indicates that the trends were not related to different

practice patterns. Utilization of skeletal and chest radiography are declining at about the same rate among radiologists and nonradiologists, which again suggests similar practice patterns. General US, by contrast, is a category in which utilization is decreasing among radiologists and increasing among nonradiologists. Given the relative absence of the cost and safety barriers that limit the use of other technologies, this increase in US utilization by nonradiologists most likely results from self-referral (2,3), although wider dispersion of technology and the establishment of new diagnostic uses for US could also help explain the increase. These latter two explanations seem unlikely as major causes. Such divergence in utilization trends between radiologists and nonradiologists suggests the need for further exploration.

There were limitations in this study. This was a secondary analysis of an administrative Medicare data set. We made the assumption that the specialty of the physician who billed for the service is the same as that of the physician who actually performed the service, but this may not always be the case. The data set contained only pure utilization information that applied to a restricted set of categories. There were no diagnosis codes in this data set, and we were unable to study individual patients during episodes of care. We cannot determine appropriateness with data sets like this, and, further, we cannot explore other areas of interest like quality or outcomes. Another limitation is that our database covers only the Medicare fee-for-service population and not those enrolled in the Medicare managed care plans. Some researchers believe that the healthier segment of the population has a greater tendency to migrate to managed care plans and that utilization rates for NDI performed on this population might therefore differ from those presented in this study. However, there is no firm evidence that this is the case.

In conclusion, although radiologists performed more than two-thirds of all NDI examinations in 1999, the utilization of NDI by radiologists has decreased 3.9% between 1993 and 1999, while utilization by nonradiologists has increased by 25.2%. Thus, virtually all increase in utilization rates of NDI was attributable to an increase in utilization by nonradiologists. Most of the discrepancy is due to the considerable increase in the number of cardiovascular imaging examinations performed by nonradiologists. Utilization of cardiovascular imaging increased 66.8% among nonradiologists and 47.3% among radiologists during the interval of this study. If cardiovascular imaging is excluded from the analysis, radiologists performed more than three-quarters of NDI in 1999; utilization by radiologists decreased 5.4% during the 6 years and utilization by nonradiologists increased by 0.3%. Overall, the rate of utilization of advanced, high-technology imaging is increasing among both radiologists and nonradiologists; it is increasing at a considerably more rapid rate among nonradiologists. Further research will be needed to assess the appropriateness of the accelerating use of NDI by nonradiologists and the image quality that results.

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1. Maitino AJ, Levin DC, Parker L, Rao VM, Sunshine JH. Nationwide trends in rates of utilization of noninvasive diagnostic imaging among the Medicare population between 1993 and 1999. Radiology 2003; 227:113–117.
2. Hillman BJ, Joseph CA, Mabry MR, Sunshine JH, Kennedy SD, Noether M. Frequency and costs of diagnostic imaging in office practice: a comparison of self-referring and radiologist-referring physicians. N Engl J Med 1990; 323:1604–1608.
3. Hillman BJ, Olson GT, Griffith PE, et al. Physicians' utilization and charges for outpatient diagnostic imaging in a Medicare population. JAMA 1992; 268:2050–2054.
4. Referrals to physician-owned imaging facilities warrant HCFA's scrutiny: report to the chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives. GAO/HEHS-95-2. Washington, DC: U.S. General Accounting Office, 1994; 1–61.
5. Hopper KD, Rosetti GF, Edminston RB, et al. Diagnostic radiology peer review: a method inclusive of all interpreters of radiographic examinations regardless of specialty. Radiology 1990; 177:335–339.
6. Levin DC, Parker L, Sunshine JH, Pentecost MJ. Cardiovascular imaging: who does it and how important is it to the practice of radiology? AJR Am J Roentgenol 2002; 178:303–306.

Submitter : **Dr. Chuck Jetton** **Date: 07/09/2007**

Organization : **University of Alabama at Birmingham**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Chuck A. Jetton, M.D.
Assistant Professor
University of Alabama School of Medicine
Department of Anesthesiology

Submitter : Melissa Kelley **Date:** 07/09/2007

Organization : Precision Ultrasound Imaging, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

IDTF Issues

IDTF Issues

Why are IDTF's being targeted again? IDTF's are not the reason for the over utitilization of imaging studies. Look into self referal of physicians who already own the equipment. I have seen over the last twenty years an explosion in the number of tests ordered by physicians in thier own offices purchasing equipment and profiting from these tests being offered by themselves. They have lost revenues for the fees from seeing patients so they raided radiology to get more revenue. Look back at when you only had radiology as imaging specialists. Now you have these miniture training courses in interpretation as well as weekend courses to learn how to perform tests. Now you have nonqualified persons performing exams by unproperly trained interpreting physicians. What happened to quality in America? In my field it takes several years to develop expertise in imaging as well as with the physicians who interpret. Now you have ER doctors attempting to do our exams with little or no training. Guess what? You are paying them for these limited exams. When they can't figure out what's what, they send it upstairs for a true exam. CMS gets two bills. At least with our entity, IDTF, we have rules and regulations to have qualified trained professionals providing the service. Then a properly trained qualified interpreting physician reviews the exams. In my IDTF, a board certified radiologist interprets all of our images except for echocardiograms. We have a board certified cardiologist read those exams. You should research all IDTF's before coming to these conclusions. I do not lease with any facility. If companies are leasing space, you should step in and do fraud and abuse checks on those entities. You are blanketing us all in to one group. I bill my facilities for what I actually do. I do not lease my techs or equipment. Please do more research on this issue with all registered IDTF's before you make this ruling take affect. You should also do more research into doctors who actually self refer all of thier exams. Cardiology is a huge practice that should be monitored. They have raided imaging services from radiologists by taking nuclear cardiology. They are now taking CT imaging as well. There is also increased utilization because of rampant lawsuits. Doctors feel like if they don't order tests that an attorney will rake them dry in court. Do your research fully before you target a small provider group. CMS has discriminated against IDTF's for years.

Submitter : Dr. Ted Ajax **Date:** 07/09/2007

Organization : Dr. Ted Ajax

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

I strongly urge CMS to adopt the RUC proposal regarding the payment for anesthesiology services.

Anesthesiology services have been egregiously undervalued compared to other physician services for many years now. In many cases, reimbursement by CMS does not cover the overhead of providing a given service. This trend is now jeopardizing access to surgical services that many of our Medicare eligible patients require.

I sincerely request that the RUC recommendation regarding revising the fee shcedule for the provision of anesthesiolgy services be adopted adopted by CMS. It is time to correct a worsening problem for which a solution is already long overdue.

Submitter : **Dr. kyle jones** **Date:** **07/09/2007**

Organization : **Dr. kyle jones**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-32-Attach-1.DOC

CMS-1385-P-32-Attach-2.DOC

#32

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

Re: CMS-1385-P
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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation—a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

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.

It is a battle to have our experts not flee to outpatient surgery centers for the "easy" patients. The patients that fall under the "Medicare" are at best a challenge for the complex surgeries that are needed for our "seasoned" citizens.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Robert Heflin** **Date: 07/09/2007**

Organization : **United Anesthesia Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It My Concern:

I am pleased to hear that CMS has proposed to accept the recommendation from the RUC to increase the reimbursement rate to anesthesiologist by $4.00 per unit. I believe this increase is fair after considering the 32 percent work undervaluation that was shown for our specialty. I encourage you to agree with the RUC and ASA and approve the positive payment update.

Thank you,

Robert E Heflin II MD

Submitter : **Jose Ruiz** **Date: 07/09/2007**

Organization : **Jose Ruiz**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

To curb potential Fraud. Require physical therapy services provided incident to a physician to be provided by LICENSED therapists and include their NPI in the form even if the money goes to the doctor practice. Right now the licensure requirement is not there, only graduation from accredited school. There should not be any difference in licensure requirements from setting to setting. Patients do not deserve diferrent requirements on the basis of practice setting.
Jose Ruiz PT MBA

Submitter : **Dr. Steven Scharf** **Date: 07/09/2007**

Organization : **Dr. Steven Scharf**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
Attention: 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 : **Mrs. Allison Charles** **Date: 07/09/2007**

Organization : **Physical Therapist**

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would like to see CMS investigate and place restrictions on physician owned physical therapy ofices. I have witnessed patients not be given a choice of where they would like to recieve therapy and in some instances told they could not go to a clinic that was not owned by them. The OIG issued a report recently that PT/OT services were overutilized in offices where physicians are able to self refer patients. If physician self referral is an issue in diagnostic imaging and CMS dollars are being overutilized then the Rehab offices owned by physicians are no different. The propsed fee schedule cuts will decrease revenues to all Rehab providers and I hate to think that those cuts have come about due to overutilization while the Physicians that own or have part ownership have profitied. It is a conflict of interest and I feel that it wil continue to be abused unless CMS acts now to prohibit reimbursement of PT/OT/ST services to clinics where physicians have a financial interest. Thank you for allowing this comment.

Submitter : Dr. Jeremy Roth **Date:** 07/09/2007

Organization : First Colonies Anesthesia Associates

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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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Thank you for your consideration of this serious matter.

Yours Truly,

Jeremy B. Roth, MD

Submitter : **Dr. Cheryl Jones** **Date: 07/09/2007**

Organization : **Duke University Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Karen Dugan** **Date: 07/09/2007**

Organization : **First Colonies Anesthesia Assiciates**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

July 9, 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

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Thank you for your consideration of this serious matter.

Yours Truly,

Karen M. Dugan, MD

Submitter : **Dr. Melvin Coursey** **Date: 07/09/2007**

Organization : **FCAA**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

July 9, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Yours Truly,
Melvin Coursey, MD

Submitter : **Dr. Melvin Coursey** **Date: 07/09/2007**

Organization : **FCAA**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

July 9, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
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Thank you for your consideration of this serious matter.

Yours Truly,
Melvin Coursey, MD

Submitter : Dean Monma **Date:** 07/09/2007

Organization : West Central 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.

Submitter : **Dr. Tim Robinson** **Date: 07/09/2007**

Organization : **First Colonies Anesthesia Assoc**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

July 9, 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 would like to express my profound support for the current proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am thankful that CMS has recognized the need to re-evaluate payment for anesthesia services, recognizing the current underpayment,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. A very significant part of that initial adjustment was a behavior offset, which clearly was not a realistic possibility, since anesthesiologist workload is determined by the caseload brought by surgeons, and in fact that behavior change did not materialize. Today, more than a decade after the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit, still down from over $19 (in non-inflation adjusted dollars). 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 continue to 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.

I cannot state strongly enough how important this change will be for the anestheia community and the future of anesthesiology.

Thank you in advance for your consideration and positive decision.

Yours Truly,
Timothy W. Robinson MD

Submitter : **Dr. Tamara Gabrielli** **Date: 07/09/2007**

Organization : **First Colonies Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

Thank you for your consideration of this serious matter.

Yours Truly,

Tamara Gabrielli, MD
First Colonies Anesthesia Associates
Maryland

Submitter : **Dr. Stephen Santangelo** **Date: 07/09/2007**

Organization : **Rocky Mountain Pediatric Anesthesiology, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

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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. Joshua Greenspan** **Date: 07/09/2007**

Organization : **PainClinics Inc**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Joshua Greenspan M.D.

Submitter : Dr. Perry Eisner **Date:** 07/09/2007

Organization : Dr. Perry Eisner

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Thank you for your consideration of this serious matter.

Perry Eisner, MD

Submitter : **Dr. Christopher Yarber** **Date: 07/09/2007**

Organization : **Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Christopher Yarber D.O.

Submitter : Mr. Nicholas Radov **Date:** 07/09/2007

Organization : Axolotl Corp.

Category : Health Care Industry

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

This proposal is an excellent idea. Fax is a dead-end technology. In order to realize the full benefits of electronic prescibing we need to get the entire industry following the NCPDP SCRIPT standard. Our physician customers have already been using it with excellent results since last year to send prescriptions to pharmacies and receive back refill requests. This is already saving them time and money compared to computer-generated faxes.

Submitter : **Dr. Ramani Peruvemba** **Date: 07/09/2007**

Organization : **First Colonies Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

First Colonies Anesthesia Associates

July 9, 2007

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Yours Truly,

Ramani Peruvemba M.D.