Submitter : **Candy & Lonny Carroll** **Date: 08/01/2007**

Organization : **Candy & Lonny Carroll**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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.

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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. Robert Alphin** **Date: 08/01/2007**

Organization : **Dr. Robert Alphin**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Robert S. Alphin, MD

Submitter : **Date: 08/01/2007**

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore, MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/01/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Sara Bachman, M.D.

Submitter : **Dr. Manivanh Keobounnam** **Date: 08/01/2007**

Organization : **Dr. Manivanh Keobounnam**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore, MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Brian Jones** **Date: 08/01/2007**

Organization : **Brian Jones**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1385-P-4851-Attach-1.TXT

Submitter : **Dr. Hemanth Baboolal** **Date: 08/01/2007**

Organization : **Mass General Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Submitter : Dr. GEORGE MOMANY **Date:** 08/01/2007

Organization : Dr. GEORGE MOMANY

Category : Physician

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

George M Momany M.D.

Submitter : Dr. Christel Carlson **Date:** 08/01/2007

Organization : Dr. Christel Carlson

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

re. I strongly encourage and support revision of the medicare payment for anesthesia services. Anesthesia services have been severly underpaid for years and the current looming further decreases will have an absolute effect on the ability to provide services. Under current planned reimbursement it would COST me money to provide services (reimbursement, overhead) to the patient. christel carlson md

Submitter : Dr. Manuel Pardo, Jr. MD **Date:** 08/01/2007

Organization : UCSF Department of Anesthesia

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-4855-Attach-1.DOC

4855

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

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

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Thank you for your consideration of this serious matter.

Manuel Pardo, Jr. MD
Professor of Clinical Anesthesia
University of California, San Francisco

Submitter : **Dr. Michael Jones** **Date: 08/01/2007**

Organization : **Dr. Michael Jones**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. long xu** **Date: 08/01/2007**

Organization : **anesthesia medical group of riverside, INC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Long Xu, MD

Submitter : **Dr. Daniel Castillo** **Date: 08/01/2007**

Organization : **University of Miami**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Daniel Castillo M.D.
Assistant Professor of Anesthesiology
University of Miami/VA Medical Center

Submitter : Dr. Henry Gonzalez **Date:** 08/01/2007

Organization : Dr. Henry Gonzalez

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1385-P-4859-Attach-1.DOC

#4859

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:

The letter below is a recommended statement from colleagues at the American Society of Anesthesiology. I've been in private practice since 1987 and I've taken care of many senior citizens on Medicare. It is way past the due time for our services to be fairly reimbursed by the Medicare system. I agree wholeheartedly with the following letter.

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.

Henry J. Gonzalez, M.D., Upland, CA—San Antonio Community Hospital

Submitter : **Dr. Michael Friedman** **Date: 08/01/2007**

Organization : **Dr. Michael Friedman**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Sincerely,

Michael J. Friedman, M.D.

Submitter : **Dr. Keith Ragsdale** **Date: 08/01/2007**

Organization : **Scott and White Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Keith Ragsdale, D.O.

Submitter : Dr. Catherine Lineberger **Date:** 08/02/2007

Organization : Duke University

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.

Submitter : **Dr. zachary bird** **Date: 08/02/2007**

Organization : **society of cardiovascular anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Resource-Based PE RVUs

Resource-Based PE RVUs

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Submitter : Dr. Andrew Katz **Date:** 08/02/2007

Organization : Duke University Medical Center

Category : Physician

Issue Areas/Comments

Background

Background

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

Submitter : Dr. kyla tremper **Date:** 08/02/2007

Organization : tremper healthcare systems

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

I am shocked that Medicare would even entertain this idea. There is no harm in having a Doctor of Chiropractic refer to a radiologist for x-rays. Who would of thought about removing this? I utilize this in my practicc and without it, it would increase the cost to the patient and potentially prevent them from receiving care. Sometimes without an x-ray, life threatening things will go undctected. Please do not change this provision and please do not limit Chiropractors even more.

Submitter : Dr. Stephen Kushins **Date:** 08/02/2007

Organization : Duke University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq. Acting Administrator Centers for Medicare and Medicaid Services 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.

Submitter : Dr. David Martin **Date:** 08/02/2007

Organization : Dr. David Martin

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Submitter : **Dr. John Doyle** **Date: 08/02/2007**

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Francis Abdou** **Date:** **08/02/2007**

Organization : **Dr. Francis Abdou**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-4869-Attach-1.DOC

4869

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

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Stanford Plavin** **Date: 08/02/2007**

Organization : **Ambulatory Anesthesia of Atlanta Pc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Submitter : Matthew Njaa **Date:** 08/02/2007

Organization : Matthew Njaa

Category : Physician

Issue Areas/Comments

GENERAL

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Submitter : **Dr. Bradley Gawey** **Date: 08/02/2007**

Organization : **Dr. Bradley Gawey**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Joshua Dooley **Date:** 08/02/2007

Organization : Duke University Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq. Acting Administrator Centers for Medicare and Medicaid Services Attention: CMS-1385-P P.O. Box 8018 Baltimore, MD 21244-8018 Re: CMS-1385-P Anesthesia Coding (Part of 5-Year Review) Dear Ms. Norwalk: I am writing to express my strongest support for the proposal to inerease 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 all of your time and effort, Joshua Dooley, MD

Submitter : **Dr. Michael McCauley** **Date: 08/02/2007**

Organization : **Dr. Michael McCauley**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Michael McCauley, MD

Submitter : **Dr. Patrick Noud** **Date: 08/02/2007**

Organization : **ANESCO North Broward, LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

Patrick Noud MD
Medical Director, Department of Anesthesiology
Coral Springs Medical Center
Coral Springs, FL

Submitter : **Jean Fay** **Date: 08/02/2007**

Organization : **Dartmouth-Hitchcock Medical Center**

Category : **Other Technician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Mr. Kuhn:

As an American Registry of Diagnostic Medical Sonography-credentialed cardiac sonographer and Fellow of the American Society of Echocardiography who provides echocardiography services to Medicare patients and others at Dartmouth-Hitchcock Medical Center, I am writing to object to CMS s proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decision-making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS s proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler s role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. In our practice we routinely perform follow-up studies (such as for pericardial effusion) which do not include color flow Doppler. We also perform fetal echoes, stress echoes, and transesophageal echoes which may or may not include color flow Doppler. While most routine screening echoes done in our lab do include color flow Doppler as well as standard 2-D imaging, it is absolutely NOT TRUE that color flow Doppler has become intrinsic to the performance of ALL echocardiography procedures.

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

Sincerely yours,

Jean Belding Fay, A.B., R.D.C.S., F.A.S.E.
Senior Sonographer
Dartmouth-Hitchcock Medical Center
Lebanon, NH 03756

Submitter : **Dr. Lisa Reinke** **Date: 08/02/2007**

Organization : **Madison Anesthesiology Consultants, LLP**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Dr. Lisa Reinke, MD, Pharm.D

Submitter : **Dr. solur udayashankar** **Date: 08/02/2007**

Organization : **ccf**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Thank you for considering an increase in the Reimbersment for the Anesthesiologists.we have waited for this a long time.

Submitter : **Dr. Devang Patel** **Date: 08/02/2007**

Organization : **Greater Houston Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Submitter : **Michelle Gama** **Date: 08/02/2007**

Organization : **Dartmouth-Hitchcock Medical Center**

Category : **Other Technician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

As a cardiac sonographer who provides echocardiography services to Medicare patients and others in Vermont and New Hampshire, I sincerely object to CMS s proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS s proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have increased in our lab, as color flow Doppler s role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For some of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

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

Sincerely yours,

Michelle Gama, BA, RDCS, FASE
Dartmouth-Hitchcock Medical Center

Submitter : **Dr. James Beckman** **Date: 08/02/2007**

Organization : **Hospital for special Surgery**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Anesthesia reimbursements have been decreased for a decade and desperately need to be increased. In that tim Congress has received raises and fuel prices have tripled.
RE CMS 1385-P

Submitter : **Dr. gregg hirz** **Date: 08/02/2007**

Organization : **Dr. gregg hirz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Anesthesia Coding (Part of 5-Year Review)

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

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

Thank you for your consideration of this serious matter.

Gregg A. Hirz,M.D.
9730 Fieldcrest Dr.
Omaha, NE 68114

Submitter : Dr. Laverne Keizer **Date:** 08/02/2007

Organization : Calhoun Anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-4883-Attach-1.DOC

#4883

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

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

Dear Ms. Norwalk:

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

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Thank you for your consideration of this serious matter.

Sincerely,

Laverne Keizer, M.D.

Submitter : **Dr. michael kovarik** **Date: 08/02/2007**

Organization : **Sangamon Associated Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Michael F. Kovarik, M.D.

Submitter : Dr. Peter Roodhouse **Date:** 08/02/2007

Organization : Anesthesia Care Associates

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Paul Kim **Date:** 08/02/2007

Organization : NorthWest Children's Heart Care

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

See attachment

CMS-1385-P-4886-Attach-1.DOC

4886

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

To CMS:

I am writing regarding the proposed change to bundle CPT 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350 when provided together.

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

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

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

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

   This shift is reflected in the development of national standards such as those present in the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL) initiative to develop and implement an echo lab accreditation process. The focus of this initiative is on process, meaning work performed, and not on the technology associated with the provision of echocardiography services. This echocardiography accreditation initiative will be mandated by many payors within the next year.

   In 1997 there were specific echocardiography codes implemented in CPT for congenital cardiac anomalies to complement the existing CPT codes for echocardiography for non congenital heart disease. "The codes were developed by the CPT Editorial Panel in

response to the American Academy of Pediatrics and the American College of Cardiology's request to delineate more distinctively the different services involved in *assessing* and *performing* echocardiography on infants and young children with congenital cardiac anomalies." *(CPT Assistant 1997).*

Consistent with this, I have significant concern with the continued approach (of which this bundling proposal is an example) of placing adult and pediatric patients in the same grouping when it comes to evaluation of the work associated with providing care to these significantly different patient populations. Because the adult cardiology population is much larger than the pediatric population, the RVUs for procedures that are common to both are established exclusively using adult patients as the basis. The work and expense associated with providing care to pediatric patients is not considered. The inaccuracies that result from this approach can be linked to anatomical differences between pediatric and adult patients (size, development, etc. - see references from the CPT Assistant below) as well as the basic issue of getting a child to be still while performing complex imaging procedures.

CPT Code 93325 describes Doppler color flow velocity mapping. This service is typically performed in *conjunction* with another echocardiography imaging study to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow velocities.

Pediatric echocardiography is unique in that it is frequently necessary to use Doppler flow velocity mapping (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 for the pediatric population stating that Doppler color flow velocity is "... even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." It should also be recognized that Doppler flow velocity mapping is an essential medical service being provided to patients with congenital and non-congenital heart disease in the pediatric population.

The following vignettes will illustrate the importance of the Doppler color flow velocity mapping (93325) remaining as a separate and distinct medical service and as an add-on code (+) for pediatric echocardiography services. These are just a few examples of the many complex anatomic and physiologic issues that we as pediatric cardiologists face on a daily basis when performing echocardiograms on infants, children, and adults with complex congenital or non-congenital heart disease. These are not unusual cases for us.

Vignette 1 *(quoted from CPT Assistant 1997)* (example of Congenital Heart Disease)

"A three-day-old neonate with transposition of the great vessels was initially treated with an atrial septostomy with a planned arterial switch procedure at seven days. On the third day post Raskind balloon septostomy increasing cyanosis is seen with saturation dropping to the low 70s. A repeat transthoracic echocardiography (93304) with color flow Doppler study is performed *(color flow Doppler is coded in addition as a 93325).* The physician reviews the echocardiographic images and prepares a report. The echocardiogram shows a closed patent ductus arteriousus and a small atrial septal defect. The child is returned to the cath-lab for a repeat septostomy and prostaglandin is restarted."

Vignette II (example of non-congenital heart disease)

A two-month-old infant is referred by the pediatrician to a pediatric cardiologist for a persistent murmur in an otherwise healthy infant. The pediatric cardiologist is concerned about a patent ductus arteriousus as a possible diagnosis. A ductus arteriousus, connecting the pulmonary artery and the aorta, is an essential structure during fetal life. Normally, the ductus arteriousus closes in the first few days after birth in healthy term infants. A persistent ductus arteriousus can give rise to long-term complications and needs to be followed carefully to evaluate if further intervention is needed (medical vs. surgical). Echocardiography permits an accurate diagnosis of a patent ductus arteriousus with assessment of both the hemodynamic impact if there is a shunt. Estimated pulmonary artery pressure is obtained by Doppler imaging and can exclude other associated defects also. Color flow Doppler will be able to outline the flow of a patent ductus arteriousus from the aorta to the pulmonary artery. Color flow Doppler in this baby revealed no cardiac defects or patent ductus arteriousus and the murmur was determined to be innocent.

Vignette III (example of congenital heart disease)

An eight year-old child (or a 23-year-old young adult), with complex cyanotic congenital heart disease (functional single ventricle) is post-op completion of a fenestrated Fontan procedure several years ago. He has had a progressive decrease in saturations over the last year. There are several possible explanations and the pediatric cardiologist performs an echocardiogram to help determine the etiology. Color flow Doppler (93325) is essential to help elucidate the postoperative anatomy and blood flow patterns, but the process is complex and time-consuming involving assessment of the surgically constructed lateral tunnel or extracardiac conduit searching for a residual fenestration shunt or obstruction to flow, assessment of flow patterns through the previously surgically constructed Glenn anastomsis between the superior vena cava and pulmonary artery, assessment for obstruction to flow through the bulboventricular foramen, assessment for significant AV valve or semilunar valve insufficiency, and assessment for collateral vessels directing venous (desaturated blood) into the heart that may have developed over time. Any or all of these findings will then help dictate the next step in the care of this patient.

3. I am concerned that this change would adversely impact access to care for pediatric cardiology patients. Pediatric cardiology programs provide care not only to patients with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for pediatric cardiology services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to our patients will not be sufficient to continue to do so should the proposed change to bundle 93325 with other pediatric cardiology echocardiography codes be implemented.

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Paul Kim, MD, FAAP

Attachment C – CMS Guidelines for Communicating Comments

Deadline: Comments must be received at one of the addresses provided below, no later than 5 p.m. on Friday, August 31, 2007.

Address: When sending comments on this issue, please refer to file code CMS–1385–P, CODING—ADDITIONAL CODES FROM 5-YEAR REVIEW.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link "Submit electronic comments on CMS regulations with an open comment period." (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1385–P, P.O. Box 8018, Baltimore, MD 21244–8018. Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1385–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Submitter : Dr. Linda Ehlers **Date:** 08/02/2007

Organization : Moraine Valley Chiropractic Center

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

RE: The proposal calling for the elimination of the current regulation that permits reimbursement by Medicare for an X-ray ordered by a non-treating physician, such as a radiologist, and used by a Doctor of Chiropractic to determine a subluxation.

This change, if enacted will end the current coverage protocol, which permits the referral of a Medicare patient to a non-treating physician.

X-ray is still recognized as an option to identify subluxation (as well as the PART process) and the fact is that X-ray remains a covered service if ordered by a treating MD or DO. In the end, it is the beneficiary that is ultimately affected by this change in coverage.

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 subluxation, to rule out 'red flags,' or to determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing (e.g., MRI) or referral to an appropriate specialist.

By limiting a Doctor of Chiropractic from referring directly to the radiologist for an X-ray study, the costs for patient care could go up due to the probability of a referral to another provider (family doctor, orthopedist, rheumatologist, etc.). With fixed incomes and limited resources, seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed, illnesses that could be life threatening may not be discovered.

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

This proposal further eviscerates the Doctor of Chiropractic as a physician in the Medicare system. As a licensed Chiropractic Physician I believe that this is unreasonable and irrational in our era of increasing costs and need. Please do not allow this change to be enacted.

Submitter : Allen McGee DC **Date:** 08/02/2007

Organization : Dinuba Chiropractic Office

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

We are afraid for the patient's safety if we can not get an x-ray for an elderly patient with possible osteoporosis, disk degeneration, in addition to a subluxation. If we refer the patient to their MD for an exam and an order of a x-ray, that costs Medicare even more. Please reconsider your position of not paying a radiologist for an x-ray that helps speed the patient's recovery by showing the DC what not to do, as well as what to do. Thank you

Submitter : Dorothy Markuson **Date:** 08/02/2007

Organization : Houston Northwest Primary Care, P.A.

Category : Individual

Issue Areas/Comments

Impact

Impact

I am commenting on the proposed reduced Physician Fee Schedule for 2008 as an employee for a Family Practice & as a 56 year old, aging American. How is our practice going to stay in business & continue to provide quality medical care to our patients when you reduce our income this way? This does not make good business sense. Our practice expenses are not going down (ie: rent, good employee salaries, supplies etc). I am afraid our doctors (5) will have to consider no longer caring for or filing claims for Medicare patients if this actually comes to pass. How am I, as a future Medicare patient, going to be able to find a good doctor who will accept this kind of reimbursement? There has to be another way to make Medicare more efficient. Sincerely, Dorothy L Markuson 08/02/07

Submitter : **Dr. Thomas Booy** **Date: 08/02/2007**

Organization : **Dr. Thomas Booy**

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. Willie Quon **Date:** 08/02/2007

Organization : Dr. Willie Quon

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I support the CMS proposal to increase the anesthesia reimbursement factor to be on par with other specialty so that insures adequate financial renumeration for services provides by health providers. I hope you will support this proposal. Thanks.

Submitter : **Ms. Janice Bauman** **Date: 08/02/2007**

Organization : **Physician Specialists in Anesthesia, P.C.**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my support for the porposal to increase anesthesia payments under the 2008 Physician Fee Schedule. The Medicare payment for anesthesia services, currently at $16.43 per unit in our area (Metro Atlanta GA) does not even come close to covering the cost of our services. The RUC has recommended that CMS increase the anesthesia conversion factor to offset a calculated 32% work undervaluation. This would result in an increase of nearly $4.00 per unit and would be a major step forward in correcting the long-standing undervaluation of anesthesia services. I am a Practice Administrator for an anesthesia practice, however, I havc also worked with radiology practices and emcrgency medicine groups. If you caluculated an average hour worth of work and the possible Medicare payment you would see how undervalued anesthesia has been. Please fully an as soon as possible implement the anesthesia conversion factor increase as recommcnded by the RUC.

Sincerely,
Janice E. Bauman, CPA, RN, CPC
Practice Administrator

Submitter : Dr. Mark Huth **Date:** 08/02/2007

Organization : The Heart Clinic of So. Oregon and No. Calif.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CODING - ADDITIONAL CODES FROM 5-YEAR REVIEW. The federal register citation is 72 Federal Register 38122 (July 12, 2007). Letter concerning Bundling of Color Flow Doppler is attached.

CMS-1385-P-4893-Attach-1.DOC

4893

heartclinic

SOUTHERN OREGON
NORTHERN CALIFORNIA, P.C.
520 Medical Center Drive #200, Medford, OR 97504
541-282-6600 (phone) 877-261-8072 (toll free)
541-282-6601 (fax) heart@the-heartclinic.com

Brian W. Gross, MD, FACC
Stephen J. Schnugg, MD, FACC
Mark M. Huth, MD, PhD, FACC
Bruce L. Patterson, MD, FACC
Kent W. Dauterman, MD, FACC
Eric A. Pena, MD, FACC
Jon R. Brower, MD
Thomas Norby, MS, FNP

August 2, 2007

To Whom It May Concern:

I am writing regarding CMS 1385.

HEADING: Additional Codes from 5-year Review with a Federal Register Citation 72, Federal Register 38122 (July 12, 2007)

I should like to comment upon the proposal regarding the provisions of payment policies under the physician fee schedules as regards to echocardiography. It is my understanding that the intent of this is to bundle color-flow Doppler into the other echo base codes, based on an argument that Doppler has become intrinsic to the performance of all echocardiographic procedures. This is simply not a fact. Many practices, including our own, do not do color-flow Doppler on every study. This proposal ignores the practice expense and physician and sonography time involved in both the performance and interpretation of color-flow studies, and such a proposal would be harmful in the extreme.

Sincerely,

MARK M. HUTH, MD, PhD, FACC
MMH/kmm

Submitter : **Dr. Paul Cass** **Date: 08/02/2007**

Organization : **Wentworth Douglas Hospital**

Category : **Physician**

Issue Areas/Comments

Background

Background

I asm th President of Health Patrtners of NH a PHO representing the interests of over 150 physicians and Wentworth Douglas Hospital Dover, NH
We are very concerned about the proposed reduction in physician payments for 1/2008.
The ability of many practices to survive in light of increased labor and office costs has become a significant issue in our area. We have many elderly patients that are practices see in both NH and Coastal communities in Maine. Many of these patients are not affluent and depend on the offices caring for them. We are concerned if the payment rates decrease offices may decrease the number of elderly they see or worse close their practices to Medicare.
The current payment rates to physicians are not by any means excessive. At a minumum there should be an increase consistent with the BMCPI(4.5%) which would keep offices at the inflation rate rather than a decline.
Paul R Cass DO
President HPNH,INC

Submitter : **Dr. Russell Harris** **Date: 08/02/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P
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(even less in Arkansas). 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. A large percentage of anesthesiologists must be subsidized by hospitals.

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,
Russell Harris, M.D.
Little Rock, AR

Submitter : Dr. Natalie Wang **Date:** 08/02/2007

Organization : Dr. Natalie Wang

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Medicare had undervalued anesthesia services over the last twenty years. The undervaluation of anesthesia services had caused a nationwide shortage of anesthesiologists. The problem is particularly worse in high-cost of living areas.

Some physicians resort to providing anesthesia for cosmetic surgery because of cah payment, regular schedule--Banker's hours--, healthier patients and lesss demanding cases.

Other physicans may elect to opt-out the lower reimbursement Medicare or MediCal (CA) practice. Since these cases tend to be sicker, older patients, high risk emergencies and higher litigation potential.

Anesthesiology services are essential for all aspects of emergencies in Medicine: trauma, abdominal emergencies, neurologic emergencies, cardiac surgery, child-birth related emergencies and pediatrics emergencies. Outcome studies and complexities of specialty surgerics had necessitated 3 to 7 different anesthesiologists to be 'On Call' 24 hours a day, seven days a week, 365 days a year for each full service hospital.

While hospital often subsidize doctors to take emergency calls in specialty surgeries, anesthesiologist are less likely to successfully negotiate a subsidy. Any employer would understand the cost of providing seven professionals 24/7, 365 days a year to attend to emergencies intheir businesses.

The socio-economie reality of our country, includes aging of population, increase severity of illness, complexity of cases and yearly cuts in Medieare payment to anesthesiologists. All these reasons had discouraged medical students to choose anesthesiology. The field of anesthesiology had suffered slow down in research and soon will suffer in quality of care if things do not change.

Submitter : Dr. Julius Gardin **Date:** 08/02/2007

Organization : St. John Hospital and Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1385-P-4897-Attach-1.DOC

4897

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

Dear Mr. Kuhn:

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

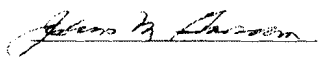
In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS's proposal to "bundle" (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler's role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography "base" procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is "intrinsic" to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography "base" codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

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

Sincerely yours,



Julius M. Gardin, MD
St. John Hospital and Medical Center

Submitter : **Mr. Anthony Belmont** **Date: 08/02/2007**

Organization : **Arkansas State University CRNA**

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.
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.

Submitter : **Dr. Juan Hernandez** **Date: 08/02/2007**

Organization : **Thoracic Cardiovascular Institute**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Dear Mr. Kuhn:

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

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS s proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler s role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

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

Sincerely yours,

Juan O. Hernandez, MD
Thoracic Cardiovascular Institute

Submitter : **Dr. George Kleiber** **Date: 08/02/2007**

Organization : **Thoracic Cardiovascular Institute**

Category : **Physician**

Issue Areas/Comments

Coding– Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

RE: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY2008.
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Sincerely yours,

George E. Kleiber, DO
Thoracic Cardiovascular Institute

Submitter : **Dr. Leslie Shrem** **Date: 08/02/2007**

Organization : **Dr. Leslie Shrem**

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.

Leslie Shrem, MD

Submitter : **Dr. Orville Wetzel** **Date: 08/02/2007**

Organization : **Dr. Orville Wetzel**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Orville Wetzel, MD

Submitter : Dr. Brian Colin **Date:** 08/02/2007

Organization : Duke University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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.

Submitter : **Dr. David Clark** **Date: 08/02/2007**

Organization : **American Society of Anesthesiology, Univ of MO:Col**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Donna Howe** **Date: 08/02/2007**

Organization : **VantagePoint HealthCare Advisors**

Category : **Health Care Industry**

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 pleased to have the opportunity to write this letter in support of the proposal for an increase in the work value of anesthesia services. 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.

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

Thank you for your consideration of this serious matter.

Sincerely,
Donna Y. Howe

Submitter : Mrs. Linda McGill **Date:** 08/02/2007

Organization : Western Communities Family Practice

Category : Health Care Professional or Association

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

I thought I added my comments on the last page, I am the administrator for a family practice and peds practice with 4 physicans, 4 nurse practitioners and 6 residents. My residents graduate and leave Florida for jsut about anywhere elsc where they can afford to live and make more money. The average medical assisant in our area makes $12.50 and hour or $25,000 a year if lucky. Thc avg family practicc doc makes $130,000 as an employee, thc median housc in Palm Beach county is $400,000, it is a wonder that anyone stays herc. Thc avg. reimbursent for an office visit is $69 for a levcl 99214, and you would like to cut that by 10%. You would also lilke me tp purchase an Electronic Health Record for aprox, $250,000.
If you choose to follow through on these cuts, you will not only but family praetice out of business, you will negatively influence those who are considering entering the field.

Submitter : **Dr. Jean Kwo** **Date: 08/02/2007**

Organization : **Dr. Jean Kwo**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Octav Constantinescu **Date:** 08/02/2007

Organization : Duke University Dept of Anesthesiology

Category : Physician

Issue Areas/Comments

Background

Background

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

Submitter : **Ms. Pam DiMuccio** **Date: 08/02/2007**

Organization : **Florida Orthopaedic Institute**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I am in support of the proposed change to the therapy certification period form 30 days to 90 days. I feel that, as a whole, we as therapists are managing utilization of therapy services and providing only medically necessary treatment.

Submitter : Dr. Jay Gooze **Date:** 08/02/2007

Organization : Solo Practitioner

Category : Physician

Issue Areas/Comments

Impact

Impact

I am a solo practitioner and my expenses go up 5-10% in my office every year for things like office products, plowing my parking lot, etc. The last 5 years of minimal payment increases(0.5% for me as an Ophthalmologist) have been devestating. I am close to retirement and will retire early if the kind of cut being proposed goes through!

Submitter : **Dr. Andrew Greenfield** **Date: 08/02/2007**

Organization : **Dr. Andrew Greenfield**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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 my hospital in South Florida we service a very high percentage of Medicare patients in our practice. We are having difficulty attracting and retaining anesthesiologists to our area based on the salaries we can afford to pay. The very low Medicare rate is a major part of this issue.

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

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Thank you for your consideration of this serious matter.

Sincerely,

Andrew J. Greenfield MD

Submitter : **Dr. Charles Hickok** **Date: 08/02/2007**

Organization : **Southern Maryland Anesthesia Assoc.**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Charles B. Hickok, MD
12200 Farm Rd.
Upper Marlboro, MD 20772
August 2, 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:

As an anesthesiologist residing and practicing in Maryland, 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.

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Thank you for your consideration of this serious matter.

Sincerely,
Charles B. Hickok, MD

Submitter : **Dr. William Lee** **Date: 08/02/2007**

Organization : **Anesthesia Consultants of New jersey**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Regarding CMS-1385P

To Whom It May Concern,

As a practicing anesthesiologist for many years I feel our services are undervalued for many years in the past. I write to support the increase in payments under the 2008 Physician Fee Schedule. Thank you for your time.

Sincerely,
William Lee M.D.

Submitter : **Date: 08/02/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Background

Background

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing in support of the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. It is good that CMS has recognized the gross undervaluation of anesthesia services. The Agency needs to take steps to address this complicated issue.

When the RBRVS was instituted, there was a significant undervaluation of anesthesia work compared to other physician services. 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 fully support implementation of the RUC s recommendation.

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.

Submitter : **Dr. Heath Higgins** **Date: 08/02/2007**

Organization : **Northwest Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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.

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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 : **James Ku** **Date: 08/02/2007**

Organization : **James Ku**

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 strongly support the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I greatly appreciate CMS recognition of the gross undervaluation of anesthesia services, and I am thankful 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.

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Thank you for your consideration of this serious matter.

Sincerely,

James C. Ku, MD

Submitter : **Ms. Colleen Joyner** **Date: 08/02/2007**

Organization : **Registered Ultrasonographer**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Mr. Kuhn:

As a cardiac sonographer who has provided echocardiography services for cardiologists thoughout the past 20 years, I have grown with this field. The echocardiogram study has evolved to include the additional performance of color doppler imaging. In conjunction with two-dimensional imaging, color Doppler tupically is used for identifying cardiac malfunction, and quantitating the severity of these lesions. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and apropriate selectin of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnsis of many other cardiac conditions.

CMS's proposal to 'bundle'(and thereby climinate payment for) color doppler completely ignores the practicc cxpenses, the sonographer's additional time spent aquiring this information, and the Physician's work involved in interpretation of thesc studies. If anything, the resources involved have increased, as color flow Doppler's role in the evaluation of valvc disease and other conditions has become norc conplex. The sonographer and equipment time and the overgead required for the pcrformance of color flow Doppler are not included in the relative value unita for any ofter echocardiography 'base' procedurc. Thus, with the stroke of a pcn, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

The Color Doppler portion of an echocardiogram is a very separate and technical part of the study. It provides specific and indivdualized diagnostic criteria. For these reasons, I urge you to refrain from finalizing the proposed 'bundling' of color flow Doppler into other echocadiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,
Colleen Joyner RDMS

Submitter : Dr. Hsin Peng **Date:** 08/02/2007

Organization : Dr. Hsin Peng

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Thank you for your consideration of this serious matter.

Submitter : **Date: 08/02/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/02/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Elliott Greene** **Date: 08/02/2007**

Organization : **Albany Medical Center Hospital, Albany, NY**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. mark bodily** **Date: 08/03/2007**

Organization : **northwest anesthesia physicians**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Denise Mackler** **Date: 08/03/2007**

Organization : **Anesthesia Consultants of NJ**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Date: 08/03/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

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

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Thank you for your consideration of this serious matter.

Submitter : Mr. Michael Langenberg **Date:** 08/03/2007

Organization : University Radiology

Category : Individual

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician Self-Referral represents a clear loophole in the Stark I and Stark II regulations that, if nothing else, clearly works in opposition to the intention of the Stark laws. Further, physicians who are allowed to self-refer have been proven to order anywhere from 2 to 9 times more studies than those who do not self refer. Thus, the self referral system must be further modified to avoid these abuses. The "in-office ancillary exception" should NOT allow a non-specialist physician to use the exception to refer patients for specialized serviees that will be performed on equipment owned by the non-specialist physician. To the extent that self-referral is permitted to continue in any form, CMS should mandate that the ordering physician formally in writing disclose to the patient that the ordering physician has a financial interest by referring the patient to his/her own office. Similarly, the patient should have to sign this disclosure that acknowledges the ordering physician has a financial interest in referring that patient to the ordering physician's office. Self Referral and the in office ancillary exception are abused loopholes that have driven up utililization and costs to the Medicare programs. I urge CMS to address these issues.

Very Sincerely,
Michael Langenberg

Submitter : **Dr. Steve Lysak** **Date: 08/03/2007**

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

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Steve Lysak, M.D.

Submitter : **Dr. Wyllys Hodges** **Date: 08/03/2007**

Organization : **Cumberland Anesthesia and Pain Management, PC**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

I am a member of the group which provides anesthesia coverage for the Western Maryland Health System in Cumberland,MD. Our practice population includes approximately 45% Medicare, 11% Medicaid and 6% self-pay patients. Recruiting and retaining high-quality anesthesia personnel has never been easy in this area, and physician and CRNA payment packages have to be at least somewhat competitive with others in the region or we don't have much of a chance.

I have been in practice here for almost 34 years and plan to remain in the area when I retire. The proposed increase in anesthesia payments under the 2008 Physician Fee Schedule would be a major help to our group in its efforts to provide quality anesthesia care.

Sincerely yours,

W.Royce Hodges III, MD

Submitter : **Dr. Richard Knox** **Date: 08/03/2007**

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

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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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 immediatcly implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Respectfully,
Richard F. Knox, M.D.

Submitter : **Ms. Annitta Morehead** **Date: 08/03/2007**

Organization : **Cleveland Clinic**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Attachment

CMS-1385-P-4929-Attach-1.PDF

#4929

August 3, 2007

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

Dear Mr. Kuhn:

As a cardiac sonographer who manages a laboratory and provides echocardiography services to Medicare patients and others in Cleveland, Ohio, I am writing to object to CMS's proposal to "bundle" Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography "base" services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become "intrinsic to the performance" of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decision-making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS's proposal to "bundle" (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler's role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography "base" procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is "intrinsic" to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography "base" codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

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

Sincerely yours,

Annitta Morehead, BA, RDCS, CCRC, FASE
Manager, Cardiovascular Imaging Core Laboratory
Cleveland Clinic, JJ55
9500 Euclid Avenue
Cleveland, Ohio 44195

Submitter : **John Levoy** **Date: 08/03/2007**

Organization : **Nashville Anesthesia Services**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Sincerely,

John M. Levoy, M.D.
Nashville Anesthesia Services
P.O. Box 442
Goodlettsville, TN 37070-0442