Submitter : **Riva Lee Asbell** **Date: 11/05/2007**

Organization : **Riva Lee Asbell**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See above

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Comments on ASC Final Rule November 1, 2007
Riva Lee Asbell

RE: Classification of 0099T as an office based procedure

Insertion of intrastromal corneal ring segments is almost always done in the operating room. There are very few, if any, practitioners performing this procedure where the eye is open in the office due to the obvious risks.

RE: Classification of 68816 as an office based procedure (Probing of the nasolacrimal duct, with or without irrigation; with insertion of tube or stent

This is never done in the office. The supposition that was the case comes from the inaccurate and misleading vignette that was presented at the CPT meeting and refuted by Michael Repka, MD. This procedure is an extremely painful one, now usually performed in younger patients, and is always done in a facility under anesthesia. It is suggested you verify this with him at the American Academy of Ophthalmology.

Perhaps the confusion came from mixing 66816 with 66840 Probing of lacrimal canaliculi, with or without irrigation which is an office based procedure.

Thank you for your attention to these two items.

Riva Lee Asbell
Riva Lee Asbell Associates
333 Las Olas Way Suite 1406
Fort Lauderdale, FL 33301
954-761-1498
RivaLee@RivaLeeAsbell.com

Submitter : **Riva Lee Asbell** **Date: 11/06/2007**

Organization : **Riva Lee Asbell**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Please substitute my original comments with this version (there were some typos in the first one). Thanks.

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Comments on ASC Final Rule November 1, 2007
Riva Lee Asbell

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Insertion of intrastromal corneal ring segments is almost always done in the operating room. There are very few, if any, practitioners performing this procedure where the eye is open in the office due to the obvious risks.

RE: Classification of 68816 as an office based procedure (Probing of the nasolacrimal duct, with or without irrigation; with insertion of tube or stent

This is never done in the office. The supposition that was the case comes from the inaccurate and misleading vignette that was presented at the CPT meeting and refuted by Michael Repka, MD. This procedure is an extremely painful one, now usually performed in younger patients, and is always done in a facility under anesthesia. It is suggested you verify this with him at the American Academy of Ophthalmology.

Perhaps the confusion came from mixing up 68816 with 68840 Probing of lacrimal canaliculi, with or without irrigation which is an office based procedure. One is the duct (68816) and the other is the canaliculi (68840).

Thank you for your attention to these two items.

Riva Lee Asbell
Riva Lee Asbell Associates
333 Las Olas Way Suite 1406
Fort Lauderdale, FL 33301
954-761-1498
RivaLee@RivaLeeAsbell.com

Submitter : **Mrs. Kathy King** **Date: 11/06/2007**

Organization : **Surgery Center of Cincinnati**

Category : **Ambulatory Surgical Center**

Issue Areas/Comments

GENERAL

GENERAL

Submitted a add on code for ASC Fee schedule under Medicare B. Request to add G0289 for this is a CCI coding rule to use this instead of 29877. We have been approved for 29877 under Medicare B, but since this rule is in-effect we can't use this and get coverage.

Submitted paperwork and copies on 9/13/07. Just wondering do we ever hear anything back, or do we go into the site somewhere to see response?

How do we know this was rec in time?

Comment #210946, CMS-1392-P-T210946, and T210946

Email address is kathy.king@docsgroup.com if this helps?

Submitter : **Dr. william leeds** **Date: 11/06/2007**

Organization : **Dr. william leeds**

Category : **Physician**

Issue Areas/Comments

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Cutting further into the physician's fee schedule that hasn't been increased in real dollars in more than a decade, while at the same time,forcing physician's to invest in unproven programs like e-prescribing and electronic medical records is unrealisitic, and will definitely force doctors like me to severely limit the Medicare and Medicaid patients we accept. Why not pay for a fair fee schedule for physicians and the technology that everyone seems so convinced that we need by taxing the real beneficiaries of these policies, health plans, tech companies and pharma? Docotors are the only sector that is forced to pay for budget shortfalls. Hospitals, health care plans, drug companies, DME providers, etc. face no such cuts, yet they make up the vast majority of the costs. There is no more fat to cut or employees to let go. Physiscians need a compliance officer, a privacy officer, and now an IT officer just to be able to participate in the Medicare program. These all cost money.

Submitter : **Dr. Aaron Morse** **Date: 11/06/2007**

Organization : **Central Coast Sleep Disorders Center**

Category : **Physician**

Issue Areas/Comments

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

I appreciate the opportunity to provide input regarding the proposed 10.1% reduction in the physician fee schedule. I am a specialist in sleep disorders, the only one in Santa Cruz County providing comprehensive diagnosis and treatment for all sleep disorders. I have been in practice for 26 years. Santa Cruz is one of the most expensive places to live in the country, and we are considered 'area 99' by Medicare. This results in about a 25 % reduction in gross reimbursement compared to San Jose, 15 miles away with an equivalent cost of living. I have 21 employees and our margin is always less than 25% of gross income at best. A 10% reduction will essentially put us out of business by halving our net and require me to either move my practice or retire early. Patients will then have to travel a dangerous road through the Santa Cruz mountains to receive inferior service at higher cost, both to them and Medicare. In combination with the area 99 designation, this would probably represent a fatal blow for our Center, which has been in Santa Cruz for 25 years.

Also, in Santa Cruz, very few primary care physicians are taking new Medicare patients due the the already poor reimbursement, and this reduction may make it virtually impossible for Medicare patients to access primary care here. In fact, an article in the Wall street Journal in August 2006 about health care in Santa Cruz advised seniors to think twice before coming here to retire because of the difficulty in accessing medical care.

I believe it would not be in the interest of patients, physicians or Medicare itself to implement this reduction. It would probably also result in increased costs as it would force patients to travel out of the area for care which more costly.

Thank you for your time.

Aaron B. Morse MD, FCCP, DABSM

Submitter : **Dr. Faruk Aydin** **Date: 11/07/2007**

Organization : **Palms Uropathology PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Medicare should terminate the option or exception that allows physicians to operate their own labs, does not matter in-office or remote location, centralized building, on the street, next to grocery store.

Pathologists are supposed to open and manage the labs. Not the physicians. 21 century mindset is not compatible with this system.

Do not let the big labs to buy the small ones. Quest and LabCor are monopolies. They enjoy so mush even Exxon Mobil, American Airlines, Microsoft cannot come close to them. Medicare has helped them to reach that size. Allow the competition. Thanks for giving me such an exceptional chance to speak the truth about my profession.

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

About self-referral rule, Medicare should decide first about the overall philosophy that it needs to create. As long as self-referral is not completely abolished, half measures as presented in CY2008 are not going to solve any of the problems.
I was a medical director of a lab owned by a gastroenterology group. Almost 100% of their patients underwent biopsy during endoscopy. Almost 99% of duodenal biopsies were normal. (I have record of it). Now I am working with a gastro group that send their cases to my independent lab. I have yet to see a duodenal biopsy. I have never seen a biopsy that is normal. I have seen so many gastric biopsy to rule out H pylori infection. 90% of them were normal in the previous group. In contrast, 90% of the latter group was positive. I am comparing 1.5 year data of one group to another group.

The rate of ordering immunostaining in prostate biopsy is another example. I rarely do it. In physician owned labs, they do it in almost in any small cancer. Why? Medicare pays $86.30 cent for one.

I can continue on forever based on my 10 years of experience in outpatient pathology service. I examined more than 60,000 prostate biopsies, 50,000 gastro-intestinal biopsies. 50,000 urine cytologies. I served to more than 2000 urologists. I worked at commercial labs. I also worked for physician groups. Finally I decided to open my own lab.

Absolutely, I protest the option of letting the physicians to operate their own labs. Such a system does not exist in the world. Look at the developed countries. None of them has it. Political pressures should not veer Medicare to get off the right path. Medicare rules the money collected from the people. It is Medicare's duty not to allow that money stolen.

Creating loopholes is not Medicare 's job. Pod labs is one example. In-office lab is one example.

This recent rule will not solve the problem. It will aggravate it.
First send your experts to major labs, let them observe what is going on. It is not possible to make decisions from Washington DC by reading comments. You need to have field personnel who will provide you actual but not anecdotal data.

I wish I had a position at Medicare so that I could serve my people better. I know of so many loopholes being abused everyday.

Submitter : **Diane Eisman** **Date: 11/09/2007**

Organization : **Diane Eisman**

Category : **Physician**

Issue Areas/Comments

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

The proposed Medicare pay cuts to physician are frightening. My expenses continue to rise, my staff needs a living wage. Many physicians can no longer afford to accept Medicare patients. Soon, the baby boomers will be seeking care.
Please, please, do not allow these draconian cuts to occur. We are losing so many good physicians and so many people will lose their access to care.

Submitter : **Dr. Alberto Aran** **Date: 11/11/2007**

Organization : **Dr. Alberto Aran**

Category : **Physician**

Issue Areas/Comments

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

Refinement of RVUs for CY 2008 and Response to Public Comments on Interim RVUs for 2007

If you implement this fee cut I will not be able to pay my employees, rent, taxes etc.... for the first time in my 22 years of practice it is now a monetary loss to stay in business. If you implement this 10.1% cut I truly feel I will start firing employees and soon be out of business. There are a lot of patients out there that need experienced caring surcons like myself but it is not possible to stay in business with Taxes going up, insurance going up, employees getting annual raises,everything going up and a fee cut at the same time. You are truly crazy if you think phycisians can be cut any more.

Submitter : **Mrs. Candace Steiding** **Date: 11/12/2007**

Organization : **Cary L Dunn MD PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Medicare Administrator -

Re:Section II.E.2 Coding - Multiple Reduction Rule for Mohs Surgery

I would like to express my serious concern over the recent rule change to Medicare reimbursements for Mohs Surgery. As a business manager for a Mohs only physicians office, these cuts will directly affect our practice and the way our Medicare patients receive treatment.

Currently our physician will treat multiple cancer sites with the Mohs technique for our elderly patients, especially those who live in rural areas and drive to us for Mohs Surgery. For these elderly patients, having all cancers treated in one day means less stress, less transportation requirements and gives them the ability to make sure all cancer is treated in a timely fashion. With the implementation of the MPRR for Mohs Surgery we will be forced to limit the number of Mohs sites we treat on each patient per visit and thus require the patients to return to our office if they have mutlitple skin cancers sites. Many of our patients have let their skin cancer go for years and thus are referred to us with multiple skin cancer sites that require Mohs surgery. Currently our physician performs Mohs on as many sites and the patient would like done in one visit and then he does most of the reconstructive procedures himself. Unfortunately we will be forced to limit the number of cancers treated and also to refer our patients out to other specialists (plastic surgeons) for their closures. We will be forced to this because if we do the closures ourselves we will then reduce our Mohs charges by 50% These physicians we will refer to have fees that are generally more expensive then ours as many of these will be plastic surgeons and many do not accept Medicare. Unfortunately this ruling means a great inconvenience in care and time to our patients and also creates a potential increase in costs to Medicare, rather than the savings you are hoping for. While we would love to continue to treat our patients in the same manner in which we have for many years, the new ruling will force us to limit the services we provide to our patients on any given visit. We feel that the health and well being of all Medicare patients with skin caner is as stake.

CMS recognized the need for the Mohs procedures to be placed on the MPRR exemption list in 1992 and no efficiencies in the procedure have occurred from that time to present. In addition, each process of Mohs takes the same amount of skill, time and lab work to perform. There are no efficiencies gained by doing more than one Mohs site at a time. Each Mohs site speciman requires the same processing and amount of work. Thus it seems unfair that we will get paid at a higher level for the first site, yet get a 50% reduction for any additional site AND in addition we will also receive a reduction on the first site, if we do a closure.

At a time when Skin Cancer is the most common form of Cancer in the United States and comprises 40% of all cancer diagnosed on an annual basis, it seems hard to imagine that you would implement a ruling that will adversely affect Medicare patients treatment for skin cancer. If you look at the statistics, skin cancer in Floridians is increasing at an alarming rate. According to the American Cancer Society, one Floridian is diagnosed with a new case of melanoma skin cancer every two hours. Without sufficient funding to provide the most effective treatment, this epidemic will likely get mush worse.

We would like to urge you to maintain the Mohs exemption to the MPRR in the 2008 Medicare pysician fee schedule. We believe that it is essential to keep this reimbursement in place so that our patients and other Medicare care patients receive the best possible treatment in a timely fashion.

Thank you for time and consideration.

Candace C. Steidng
Business Manager
Cary L Dunn MD PA

Submitter : **Ms. Wanda Wilson CRNA PhD** **Date: 11/14/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

mmm

CMS-1385-FC-10-Attach-1.PDF

#10

November 13, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

ATTN: CMS-1385-FC

Re: Comments on Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 (http://www.cms.hhs.gov/PhysicianFeeSched/downloads/CMS-1385-FC.pdf, November 1, 2007)

Provisions:

VIII. Anesthesia and Physician Fee Schedule Conversion Factors for CY 2008
B. Anesthesia Fee Schedule Conversion Factor

II. Provisions of the Final Rule Related to the Physician Fee Schedule
S. Division B of the Tax Relief and Health Care Act of 2006--Medicare Improvements and Extension Act of 2006 (Pub. L. 109-432) (MIEA-TRHCA);
1. Section 101(b)--Physician Quality Reporting Initiative
b. MIEA-TRHCA Requirements for Measures Included in the 2008 PQRI

Dear Administrator Weems:

On behalf of the 36,000 members of the American Association of Nurse Anesthetists, we wish to comment on two issues referenced in the final rule providing for physician fee services in 2008. We are concerned that the Centers for Medicare & Medicaid Services (CMS) may have miscalculated the national mean 2008 anesthesia fee schedule conversion factor (CF). Further, we request the agency reconsider its decision declining to include a measure for reporting perioperative temperature management among the 2008 PQRI list of approved measures for quality reporting.

American Association of Nurse Anesthetists Office of Federal Government Affairs
412 First St., SE, #12, Washington, DC 20003 // ph 202-484-8400 // fx 202-484-8408 // www.aana.com

VIII.B. Anesthesia Fee Schedule Conversion Factor

The agency calculates the 2008 anesthesia CF (Table 35, p. 895 of the final rule):

2006 anesthesia CF	$17.7663
Pre-TRHCA update factor	0.9495
2007 "combined adj for PE & BN"	0.9089
2007 Pre-TRHCA anesthesia CF	$15.3328
2008 Factor adjustments	
2008 MEI	1.0180
2008 Update adjustment factor	0.9300
2008 CF after MEI & UAF	$14.5162
2008 combined adj for PE & BN	1.1250
2008 CF after MEI & UAF	**$16.3307**

However, it is not clear from Table 35 the degree to which the agency has taken into account the agency's adoption of a 32 percent increase in the value of anesthesia work, which the agency states would have increased the anesthesia CF approximately 25 percent. An alternative calculation taking into account the factors referenced in CMS' narrative, especially those found on pp. 804, 806 and 895 of the final rule, yields the following result:

Alternative Calculation	
2006 anesthesia CF	$17.7663
Pre-TRHCA update factor	0.9495
2007 "combined adj for PE & BN"	0.9089
2007 Pre-TRHCA anesthesia CF	$15.3328
Factor adjustments (items from the narrative in *italics*)	
32% increase in value of work, p 804	*1.2500*
-1% BN adjustor for work, p 804	*0.9925*
-1% reduction in PE, p 804	*0.9975*
Proposed revised work adjustor, p 806	*0.8806*
2008 MEI	1.0180
2008 Update adjustment factor	0.9300
2008 CF after MEI, UAF and Work	$15.8192
2008 combined adj for PE & BN	1.1250
2008 anesthesia CF after all factors	**$17.7966**

You can see that such a calculation, which is based on CMS' final rule narrative and does not account for other information CMS may have at its disposal, yields an anesthesia CF of $17.7966, rather than CMS' published $16.3307, a substantial difference. Wishing to ensure CMS publishes and reimburses at the correct 2008 anesthesia CF, we request that the agency examine and spell out more fully its calculations, and publish an updated anesthesia CF as necessary to the *Federal Register* as scheduled November 27.

II.S.1.b. MIEA-TRHCA Requirements for Measures Included in the 2008 PQRI – Request to include "perioperative temperature management for surgical procedures under general anesthesia" measure in 2008 PQRI list

We request that CMS include a measure for reporting "perioperative temperature management for surgical procedures under general anesthesia" among the 2008 PQRI list of approved measures for quality reporting. As you may know, the AMA-Physician Consortium for Performance Improvement workgroup process developed the measure in 2007 with the extensive involvement and participation of the AANA.

We recognize that the measure's promotion by AQA October 26, 2007, evidently came late for CMS to incorporate it into the 2008 PFS final rule PQRI list published November 1 on pg. 714. However, we believe the evidence underscoring the measure's promise in reducing surgical patients' complications and optimizing care warrants the agency's further consideration. Promoting normothermia and preventing unintended hypothermia in surgical patients will save lives and quality of life, and reduce spending associated with treating surgical complications. We nonetheless appreciate the agency's ambitious timeline driven by necessary administrative processes, as we expect the agency appreciates the vigor and alacrity with which this and other quality measures were developed during 2007.

We thank you for the opportunity to comment on the final rule. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400.

Sincerely,

Wanda Wilson, CRNA, PhD, MSN
AANA President

cc: Jeffery M. Beutler, CRNA, MS, AANA Executive Director
Frank Purcell, AANA Senior Director of Federal Government Affairs
Pamela K. Blackwell, JD - AANA Associate Director, Federal Regulatory Policy