Submitter : Dr. Louis Bojrab **Date:** 08/24/2007

Organization : Michigan Pain Specialists, PLLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Docket: CMS-1385-P - Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies; Revisions to Payment Policies for Ambulance Services for CY 2008;

CMS-1385-P-7733-Attach-1.DOC

7733

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

Re: CMS-1385-P

Dear Mr. Weems:

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

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

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

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

RESOURCE-BASED PE RVUs

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

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

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

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

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

CPT Code	Anesthesiologists - 05	Interventional Pain Management Physicians

	(Non-Facility)	- 09 (Non-Facility)
64483 (Inj foramen epidural l/s)	59%	18%
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64479 (Inj foramen epidural c/t)	58%	21%
62311 (Inject spine l/s (cd))	78%	8%

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Louis Bojrab, MD
18150 Peninsula Way
Northville, MI 48168

Submitter : **Dr. Sandra Bojrab** **Date: 08/24/2007**

Organization : **None**

Category : **Pharmacist**

Issue Areas/Comments

GENERAL

GENERAL

Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies; Revisions to Payment Policies for Ambulance Services for CY 2008;

CMS-1385-P-7734-Attach-1.DOC

7734

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

Re: CMS-1385-P

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Sincerely,

Sandra Ann Bojrab, PharmD
18150 Peninsula Way
Northville, MI 48168

Submitter : **Dr. Mark Janes** **Date: 08/24/2007**

Organization : **Dr. Mark Janes**

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 : **Bradley Shepherd** **Date: 08/24/2007**

Organization : **SACA**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Bradley Shepherd

Submitter : **Ms. Margaret O'Neal** **Date: 08/24/2007**

Organization : **AAAA**

Category : **Physician Assistant**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re:CMS-1385-P
Dear Ms. Norwalk,
I'm writing as an anesthetist with 24 years experience in providing quality anesthesia care to patients. In order to ensure this level of care going forward, I'm asking for your support in raising anesthesia payments under the 2008 Physician Fee Schedule.
The majority of anesthesiologists that I have had the honor to work with, are facing retirement. In order to attract the best and the brightest into medical specialties, it's imperative that they be able to make an equitable living. An anesthesiologist's involvement in a crisis can easily make the difference between life and death.
We are indeed facing a healthcare crisis in this country but cutting payments to specialty physicians is not the cure to this complex situation.
Please implement the conversion factor increase as recommended by the RUC.

Sincerely,
Margaret O'Neal AA-C

Submitter : Dr. Armin Porzig **Date:** 08/24/2007

Organization : Lawncrest Chiropractic and Rehabilitation Center

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

Eliminating this reimbursement will only make it more difficult, and expensive to perform nescessary procedures. If the drive is to keep Medicare costs down, why add an additional doctors visit to a process that is already effective. It would seem that this change would only add cost to the Medicare program.

Submitter : Dr. Gregory Frick **Date:** 08/24/2007

Organization : Dr. Gregory Frick

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Clinically, while x-rays are not a primary tool for identifying subluxation, they are necessary for ruling out any contraindications to care, as well as treatment options and protocols.

If doctors of chiropractic are limited in their ability to order x-rays, patients may be denied care (which adversely affects their health and well-being), and will be required to seek the care of other providers thus adding to the patient's expense. Chiropractic services are unique to doctors of chiropractic and are not duplicated by other providers.

Ultimately, the patient will suffer as a result of this proposal. If I am to provide safe and effective care to our seniors, this proposal must be tabled. I strongly urge you to table this proposal.

Gregory Frick, DC

Submitter : **Dr. Edson Parker** **Date: 08/24/2007**

Organization : **Dr. Edson Parker**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Edson O. Parker, MD

Submitter : **Dr. Kristin Chenault** **Date: 08/24/2007**

Organization : **Dr. Kristin Chenault**

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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Submitter : **Dr. Thomas Garetto** **Date: 08/24/2007**

Organization : **Dr. Thomas Garetto**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Submitter : **Dr. Jeffrey Maen** **Date: 08/24/2007**

Organization : **colorado blvd chiropractic center**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Colorado Blvd. Chiropractic Center
Dr. Jeffrey S. Maen DC
1325 S. Colorado Blvd #022
Denver, Co. 80222
303-759-8333

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

Dr. Jeffrey Maen DC

Submitter : Mrs. Linda Carey **Date:** 08/24/2007

Organization : North Suffolk Cardiology Assoc., P.C.

Category : Other Technician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

To Whom It May Concern,

I am contacting you electronically today to protest and insist that you reconsider denial of payment for the color doppler technical component that is such an integral part of transthoracic echocardiography. As a registered sonographer and echocardiographer for the past 15 years, I have applied and appreciated the advancement of color doppler technology for my patients. It galls me to consider that perhaps this reduction is simply a bookeeping/accounting consideration on the part of a government insurance. I can assure you as someone who uses this application on every patient; you have not considered the well being of the patient in your rush to judgement of such an important component of echocardiography testing and interpretation. Are you even aware of of the time and extensive hands on experience that goes into understanding the physics of color doppler. Do you know that the average technologist spends 6 months to a year preparing for our credentialing exam which has it's own seperate 3 hour exam just for the applications of color doppler physics and instrumentation? The additional 3 hour exam is required for registry for the actual 2D exam anatomy, physiology, pharmacology, EKG principles and interpretation, etc. Doppler physics and principles as well as it's application of instrumentation is covered extensively in our medical textbooks as well as the opening section of every conference which I am required to attend to maintain my registry credential. There are numerous controls on every ultrasound machine just for color doppler which I and my colleagues are required to know how to apply effectively for accuracy in diagnosis. My extensive education, and continuing education has provided the background for me to apply color doppler accurately and effectively on every patient. Consider also, not only the knowlege that goes into the application of this tool but now, there is the actual interpretation of color doppler. It takes months and in some cases years to have an appreciation and competence to interpret the severity of regurgitant jets in the heart valves, septal defects with residual shunting of blood into the wrong chamber, congenital defects which allow shunting of blood from one chamber to the other with sometimes life threatening consequences to our patients, leakage of valve replacements also causing serious consequences to our patients and countless other conditions for the timely and integral use of color doppler. Without having spent extensive time, getting education, getting years of invaluable work experience, reading with our cardiologists I and my colleagues would just be pushing buttons. The application and interpretation of color doppler is time consuming but a necessary and valuable tool which we can use non-invasively to interrogate the heart and it's function. It is with the greatest concern and compassion for our patients that I insist you reconsider this revision. I implore you not to degrade the profession of echocardiography by making accounting/bookeeping slashes in reimbursing our cardiologists by eliminating the color doppler component of the medicare reimbusement fee. I respectfully request your reconsideration of this policy and that you continue to provide coverage for this valuable, time consuming and extrordinary technical advancement in our field of echocardiography.
Respectfully, Linda A. Carey, RCS

Submitter : **Dr. Randal Colquitt** **Date: 08/24/2007**

Organization : **Dr. Randal Colquitt**

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.

Randal Colquitt, MD
10201 Red Bridge Ave.
Las Vegas, NV 89134
randycolquitt@carthlink.net

Submitter : **Dr. Victor Dapkus** **Date: 08/24/2007**

Organization : **The Chiropractic Way**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Victor W. Dapkus D.C.

Submitter : **Dr. khaled sleik** **Date: 08/24/2007**

Organization : **ASE**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I do not use color flow Doppler with all echo procedures, and it is very important to have additional sonographer and physician time for better service

Submitter : Dr. Willem Bos, D.C. **Date:** 08/24/2007

Organization : Bos Chiropractic

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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I Have practiced chiropractic in Arizona for the past seven years and deal with a large number of medicare patients. As a medicare provider with significant experience, I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,
Willem E. Bos, D.C.

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

Organization : Adult

Category : Physician

Issue Areas/Comments

ASP Issues

ASP Issues

See attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Dr. Mark Gifeisman** **Date: 08/24/2007**

Organization : **Smith 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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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.

Mark Gifeisman.

Submitter : **Dr. Barbara Gold** **Date: 08/24/2007**

Organization : **Dr. Barbara Gold**

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.

Sincerely,
Barbara Gold, MD

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

Organization : **Dr. John Wendel**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Technical Corrections
I would like to express my opposition to CMS-1385-P. I am a chiropractic physician. This decision will adversely affect a large population of my patients as well as serve to add health care costs to those seeking chiropractic care.

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

Organization : american association of nurse anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

I am a Certified Registered Nurse Anesthetist in West Tennessee. I have been practicing for over 20 years and plan to continue to practice for quite some time.

I urge the support and passage of legislation that will increase Medicare payment for CRNA services. Many rural areas have elderly patients that can not easily travel or get transportation to larger cities. Frequently anesthesia care in these areas are provided by CRNA's who provide excellent care at an affordable rate but they too must make a competetive income to stay in an area where they are needed. I thank you for your support.

Teresa Barsotti, CRNA

Submitter : Dr. ROOZBEH SAHRAI **Date:** 08/24/2007

Organization : ADVANCED BODY CARE

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

Sincerely,

Roozbeh Sahrai, D.C.

Submitter : **Dr. Timothy Beckett** **Date: 08/24/2007**

Organization : **Dr. Timothy Beckett**

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.

Timothy Beckett, MD

Submitter : **Dr. Adam Arita MD** **Date: 08/24/2007**

Organization : **Adam Arita MD 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
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Thank you for your consideration of this serious matter.

Adam Arita, MD

Submitter : Dr. George Pappas **Date:** 08/24/2007

Organization : Pappas Chiropractic Center LLC

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Dear Sirs

As a licensed chiropractic physician and in private practice in the state of New Jersey for the last 19 years, I am concerned as to the proposal to limit reimbursement for radiographic services ordered by a chiropractor.

Essentially all health insurance carriers recognise the need for imaging studies as both a means to rule out an underlying pathology which may be a contraindication to spinal manipulation, as well as to provide clinical information that may influence the method of care provided to a patient.

Especially considering that a majority of our Medicare patients are elderly this is not only an aid to the physician, but has tremendous benefit to protect the patient.

I know of no other carrier who denies reimbursement for radiographs whether performed by a radiologist or a chiropractor and whether or not ordered by a physician or a chiropractor.

Especially taking into consideration the intricacies of properly adjusting a persons spine, especially a senior it seems further troubling that you may be motivating patients and physicians from or obtaining imaging studies.

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a concerned physical therapy provider writing in regards to the July 12th proposed 2008 physician fee schedule rule. I intend to highlight the abusive nature of physician-owned physical therapy services (POPTS) and support the removal of physical therapy services from permitted services under the in-office ancillary services.

Firstly, I d like to explain my experience with POPTS. While in college, I had two clinical internships in the outpatient orthopedic setting: one physician-owned facility and one physical therapist-owned facility. After the two experiences, I quickly knew how the mentality of POPTS seriously provides a disservice to the patient, degrades the standard of physical therapy, wastes payer s money. After graduating, I quickly jumped at an opportunity to work for an extremely well respected, physical therapist-owned facility. It is the facility of choice for many physicians because it maintains the high standards of care. The true one-to-one treatments are unlike the competitors. In particular, one group of orthopedic surgeons was our primary referral source. This past January, this group of surgeons acquired a physical therapy facility. From that point on, there was sudden 80% decrease in the number of patients referred from this group.

As time goes on, I am learning of the blatant abuse involving this POPTS and it is not an isolated case. On a much more frequent basis, I am hearing how these surgeons insist their patients to attend their PT facility. To no surprise, the quality of care offered at their clinic is rather poor and the surgeons know this. This is apparent, as involved patients of these surgeons are specifically sent to our facility. In other cases, we treat the surgical patients that are doing poorly at the POPTS. Also, I continue to hear how these patients receive little if any PT supervised treatment. From what I understand, treatments consist of unattended modalities/exercise as the therapist hops between many patients. Ironically enough, it is likely that the billing records do not support this non-individual care they are not billing for group therapy. I realize this is something not specific to POPTS. However, I would that seems to be much more prevalent at POPTS.

In my opinion, you are concerned protecting the physical therapists the issue is the patient care and the money. Please consider the following points:

" With a financial interest in the POPTS, physicians will certainly self-refer. This certainly affects the patients with Medicare, as a referral/prescription is necessary. In this case the patient is not given free choice of practicioner.

" This financial interest encourages physicians to over prescribe therapy. This does not foster patient independence. I have witnessed patients of POPTS are frequently convinced that they need continued skilled therapy despite no functional limitations.

" This practice of over prescribing therapy promotes unnecessary spending of third-party payer s money. In the case of Medicare, interventions are provided excessively unnecessarily. In the same instance, physicians are more likely to use Medicare outpatient therapy cap-exempt codes and diagnoses in order to continue this abuse.

" Physician owned pharmacies are prohibited due to possible abuse with over prescribing medication. How is physical therapy different?

The continual defense to this that the physicians can closely monitor patient status. We need to get realistic. In my experience with POPTS, the patient-to-therapist ratio is so high that the therapist can t appropriately monitor patient progress. This defense also raises another question: if the patient receives PT somewhere other than the POPT, then are the physicians not monitoring their patient? Obviously, the answer is no. Just as importantly, physician direct supervision is not needed to administer physical therapy services.

Thank you for your time and consideration.

CMS-1385-P-7759-Attach-1.DOC

77

Dear Mr. Weems

I am a concerned physical therapy provider writing in regards to the July 12th proposed 2008 physician fee schedule rule. I intend to highlight the abusive nature of physician-owned physical therapy services (POPTS) and support the removal of physical therapy services from permitted services under the "in-office ancillary" services.

Before I list some important points, I'd like to explain how this has struck close to home. I consider myself relatively new to the physical therapy arena. While in college, I had two clinical internships in the outpatient orthopedic setting: one physician-owned facility and one physical therapist-owned facility. After the two experiences, I quickly knew how the mentality of POPTS seriously provides a disservice to the patient, degrades the standard of physical therapy, wastes payer's money. Therefore, I knew what type of facility that I wanted to work for.

After graduating, I quickly jumped at an opportunity to work for an extremely well respected, physical therapist-owned facility. It is the type of facility that maintains the high standards of care despite the constant pressure to sacrifice quality of patient care brought about by the dwindling reimbursement of third-party payers. The true one-to-one treatments are unlike the "mill" competitors. For this reason, when I came on board, we were the physical therapy provider of choice for many of the area physicians—and still are. In particular, one group of orthopedic surgeons referred a large amount of patients to our facility. The majority of my case load was from this group. This past January, this group of surgeons acquired a physical therapy facility within the building that they practice. From that point on, I noticed a gradual decrease in the number of patients referred from this group. Currently, I have one patient from this group who is coming to our facility because they were happy with the care they previously received. According to the facility's records, referrals from this group dropped at least 80%--where previously they were our primary referral source.

As time goes on, I am learning of the blatant abuse involving this POPTS—and it is naive to think that this is an isolated case. On a much more frequent basis, I am hearing how these surgeons insist their patients to attend their PT facility in order to "monitor" the patient's status. To no surprise, the quality of care offered at their clinic is rather poor—and the surgeons know this. This is apparent, as involved patients of these surgeons are specifically sent to our facility. Obviously, involved patients require more intense, one-on-one treatment. Therefore, taking them on as a patient is not cost effective compared to the less involved counterparts. Furthermore, I have met and treated people that have been treated at the surgeons' facility. I continue to hear how these patients receive little if any PT supervised treatment. From what I understand, treatments consist of unattended modalities and exercise without detailed physical therapy assessment. Usually the therapist is hopping between multiple patients at one time, and care is sacrificed. Ironically enough, taking your perspective as a payer/consumer, it is likely that the billing history is not supported by the type of non-personal care—chances are they are not billing for group therapy. It is obvious why this occurs, and this is something not specific to POPTS. I have witnessed this type of practice with therapist-owned facilities. However, I would bet that it is much more prevalent at POPTS.

In my opinion, the issue that you are concerned with is not to protect the physical therapists—the issue is the patient care and the "bottom line." Without doubt, both these

are grossly abused in the POPTS that I have witnessed. Please consider the following points:

- With a financial interest in the POPTS, physicians will certainly self-refer, and even insist patients go to their facility. This certainly affects the patients with Medicare, as a referral/prescription is necessary. Without free choice of practitioner, how is not different from a socialized medicine model?
- Furthermore, this financial interest encourages physicians to over prescribe therapy—both in frequency and duration. This does not foster patient independence. My experience has shown that patients of POPTS are frequently convinced that they need continued skilled therapy despite no functional limitations.
- This practice of over prescribing therapy promotes unnecessary spending of third-party payer's money. In the case of Medicare where fees are based upon the services provided, interventions are provided excessively in order to maximize return. In the same instance, physicians are more likely to use Medicare outpatient therapy cap-exempt codes and diagnoses in order to continue this abuse.
- Physician owned pharmacies are prohibited due to possible abuse with over prescribing medication. How is physical therapy different?
- Physical therapy is a specialty focusing on movement dysfunction—separate from orthopedic surgery. How can physicians be allowed to provide such a service? Physicians that specialize in tempromandibular joint dysfunction do not self-refer patients to a physician-owned dental service for dental work. Why is physical therapy an exception?

The continual defense to this that the physicians can closely "monitor" patient status. We need to get realistic. In the case of the POPTS that I have witnessed, this is certainly not the case. In my experience with POPTS, the patient-to-therapist ratio is so high that the therapist barely has time to monitor patient progress. This then begs the question—how does the physician have time to do so? Furthermore, this defense raises another important question: if the patient receives therapy at a location other than the POPT, then are the physicians not monitoring their patient appropriately? Obviously, the answer is no. Just as importantly, physician direct supervision is not needed to administer physical therapy services. In fact, given by prescriptions that I see on a daily basis, many physicians have poor understanding of what outpatient orthopedic physical therapy entails.

In closing, I thank you for your consideration regarding this matter. To me, there should be no question as to how this should be handled. I recognize my bias, however it is hard to oversee the outright abuse that is fostered as a result of POPTS. The presence of POPTS creates a conflict of interest for all parties, especially the patient and payer.

Submitter : **Dr. CHARLES BAMBERGER** **Date: 08/24/2007**

Organization : **UROLOGICAL SURGERY CENTER**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

UNDER THESE CHANGES I WILL BE UNABLE TO PROVIDE SERVICES TO MEDICARE PATIENTS.
SINCERERALY,

CHARLES BAMBERGER, MD
MEDICAL DIRECTOR
UROLOGICAL SURGERY CENTER OF FT. WORTH,TX
418 S. HENDERSON
FT WORTH, TX 76104

Submitter : Dr. James KNIGHT **Date:** 08/24/2007

Organization : Heritage Chiropractic

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

CMS 1385P is a politically motivated bill which will cost Medicare more money than does the current status of Chiropractic referral for X-rays. Chiropractic doctors are specialists in spinal care and should really be remuncrated directly for all diagnostic services. It has only been meretricious politics which has denied our profession such access. This bill is bogus and any person who supports it is either ignorant or is driven by his personal agenda.

Submitter : **Ms. Linda Cunningham-Daniel** **Date: 08/24/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

As a practicing CRNA, and a member of the AANA, I am writing to support the CMS proposal to boost the value of anesthesia by 32%. Under CMS' proposed rule Medicare would increase the anesthesia conversion factor by 15% in 2008 compared with the current levels. If adopted, CMS' proposal would help to ensure that CRNA's as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

Due to the large number of practicing CRNA's providing anesthesia services in the U.S. annually in every setting but predominantly in rural and medically underserved areas, the increase in Medicare payment is crucial. Studies have shown that Medicare Part B only reimburses anesthesia services at approxiamately 40% of private market rates. The proposed increase would help to even out the scales and bring currently undervalued anesthesia payments up to a level where they need to be.

In summary, I support the agency's acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Linda Cunningham-Daniel CRNA, MSN
924 Garrison Ridge Blvd
Knoxville, TN 37922

Submitter : **Mr. Victro Otroszko** **Date: 08/24/2007**

Organization : **Mr. Victro Otroszko**

Category : **Other Health Care Professional**

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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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. Clifford Daub **Date:** 08/24/2007

Organization : Dr. Clifford Daub

Category : Physician

Issue Areas/Comments

Technical Corrections

Technical Corrections

It is important for proper and effective management and treatment of patients that chiropractors retain the right to refer patients for radiologic testing.

Submitter : Dr. DENNIS CIRONE **Date:** 08/24/2007

Organization : Dr. DENNIS CIRONE

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

WHEN DO YOU STOP HARASSING THE CHIROPRACTIC PROFESSION....IF THE PUBLIC ARE GETTING CARE AND ARE BEING HELPED (WHETHER OR NOT IF U THINK CHIROPRACTIC IS PART OF THE HEALTH PROFESSION)WHY STOP IT????? WE HAVE BEEN IN EXISTENCE SINCE 1895 AND STILL TAKING CARE OF PEOPLE WITH ALL TYPES OF ILLNESSES, AND THEY ARE GETTING BETTER. WHY DO U KEEP TRYING TO INTERFERE WITH PEOPLE FROM RECEIVING NATURAL HEALTH VS CHEMICAL(IF CHEMICAL WAS DOING SUCH A GREAT JOB UR HOSPITALS WOULD BE EMPTY N UR GRAVEYARDS WOULD BE AS WELL.PATIENTS COME TO US IN DOUBT N GET BETTER W/O THE FAITH THEY HAVE IN MDS. I AM IN OPPOSITION TO U TAKING AWAY ANYTHING THAT HELPS PATIENTS RECEIVE CHIROPRACTIC CARE WHETHER FINANCIAL OR INSURANCE. LET THE PEOPLE HAVE THE CHOICE TO GO WHERE THEY FEEL THEY R GETTING BETTER,W/O ANY RESTRICTIONS ON UR PART.
IF WE REMAIN A ENTITY(HEALTH PROFESSION)THAT THE PEOPLE WANT.....LEAVE US BE AND SUPPORT US THE WAY U SHOULD.

Submitter : Mrs. Kathleen Kelliher-Miller **Date:** 08/24/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

CRNA's provide the Majority of anesthetics to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability services depends in part on fair Medicare payment for them. I support the agency's acknowledgement that anesthesia payments have been undervalued, and it's proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment. Thank you Kathleen K Miller CRNA

Submitter : **Dr. Donald Frank** **Date: 08/24/2007**

Organization : **Dr. Donald Frank**

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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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: 08/24/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Regarding Federal Register/Vol.72,No.133,page 38181/3. In-Office Ancillary Services:
In general, the definition of this exception should not be limited in any ways, in order to allow the physicans to continue to provide good patient care. The scopes of practices have broadened over the years now such that the utilization of imaging services such as ultrasound and pathology services such as biopsy and cytology reading are intimately associated with the provision of good medical care.

Comments regarding "services that are not needed at the time of the office visit in order to assist the physician in his or her diagnosis or plan of treatment, or complex laboratory services":
Some of the newer and in fact more complex laboratory services are not readily available from third party laboratories or the quality from third party laboratories may be in question. It is vital for the physicians to be able to perform such laboratory services to ensure the availability and the quality of such services. For example, the FISH test for urine, is in fact not available in our local area, which is a service area of more than 1 million population in the Los Angeles County. None of the local hospital-associated laboratory provides the service. The only laboratories providing the services are out of area and this lack of in-area testing may compromise the availability of the testing, or result in the delay of diagnosis of cancer. The provision of such complex laboratory services in the physicians office in fact allow for better quality assurance as it allows for oversight by physicians whose patients interests are at stake.

The proposed changes to the reassignment and purchase diagnostic test rules will make it difficult, if not impossible for physicians to provide services that are provided by part-time employees or independent contractors. For example, for the past 15 years, my office has provided ultrasound imaging services. I have had an independent contracted ultrasound technician who have worked with me in refining the techniques as to provide expertise not available else where, such as specialized views of the female urethra without the need for painful catheterization imaging studies. Similar type of employees will also be providing services for in-office pathology services.

The sweeping changes proposed go far beyond what is necessary to prevent fraud and abuse. If enacted, these changes will negatively impact the quality of patient care.

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

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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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,

Brian T. O'Mahoney, D.O.

Submitter : **Dr. Jeff Latham** **Date: 08/24/2007**

Organization : **Dr. Jeff Latham**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I hope you support and implement the proposed fee increase for Anesthesia. It is tragic that we have accepted such a low rate for this long! (My plumber makes more per hour than you currently pay me for my services!) Taking care of the sickest patients (medicare age group) warrants payment consistant with risk! Thank you, Jeff B. Latham, M.D.

Submitter : **Dr. Albert Pawlusiewicz** **Date: 08/24/2007**

Organization : **Dr. Albert Pawlusiewicz**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Albert Pawlusiewicz, DC

Submitter : **Dr. Bhalchandra Parulkar** **Date: 08/24/2007**

Organization : **Tricounty Urology**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

This action will impede good local access to patient care.

It will limit the options of treatment available to the senior population.

Instead of saving costs, it will drive up costs because the procedures will now be increasingly hospital based.

It will stifle entreprenеurship and business.

CMS-1385-P-7774-Attach-1.TXT

#7774

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385- P
P.O. Box 8018
Baltimore, MD 21244- 8018.

Dear Mr. Kuhn:

I am a urologist who practices in a multispecialty Suburban medical group setting. We work out of a small community hospital. We have a large medicare population which is solely dependant on our practice and the hospital for their care.

I am writing to comment on the proposed changes to the physician fee schedule rules that were published on July 12, 2007 that concern the Stark self-referral rule and the reassignment and purchased diagnostic test rules.

The changes proposed in these rules will have a serious impact on the way my group practice medicine and will not lead to the best medical practices. With respect to the in-office ancillary services exception, the definition should not be limited in any way. It is important for patient care for urologists to have the ability to provide pathology services in their own offices. The proposed changes to the reassignment and purchased diagnostic test rules will make it difficult, if not impossible for me to provide quality and access to my patients.

The proposed "under arrangement" rule, will prohibit the provision of cryotherapy, laser procedures OTHER THAN LITHOTRIPSY that are provided to a hospital through a joint venture with the local statewide urologists. These equipment are expensive and due to the changing technology, they are a heavy investment for the hospital and as such hospitals are not interested in investing in a technology which potentially can lock their investment for a long time. Modern mobile technology is therefore made available for medicare patients through joint venture practices.

The prohibition of per click payments for space and equipment rentals will prohibit technology and options of care for patients. The sweeping changes to the Stark regulations and the reassignment and purchased diagnostic test rules go far beyond what is necessary to protect the Medicare program from fraud and abuse. The rules should be revised to only prohibit those specific arrangements that are not beneficial to patient care.

The proposed rules may actually make it more expensive since all the local cost cutting measures will be removed and instead the procedures which are inevitably needed for good patient care will have to be done either in few large hospitals that can afford to buy the equipment or increase costs by stifling competition.

Thank you for your consideration,

B.G. Parulkar, MD,
Tricounty Urology

115 Water St., Suite 104, Milford, MA 01757.

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

Organization : Dr. John McLaughlin

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

I strongly object to the proposed change in the provision providing for the ordering of radiographs from facilities without going through the patient's PCP. This results in additional costs and delays.

Submitter : **Mrs. Vivian Elegonye** **Date: 08/24/2007**

Organization : **Mrs. Vivian Elegonye**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

__Vivian____Elegonye, RRNA_____
Name & Credential
__5001 wordsworth dr___
___Garland, TX 75043

Submitter : **Dr. Mark McLeane** **Date: 08/24/2007**

Organization : **Dr. Mark McLeane**

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 : **Mr. Scott Scarnechia** **Date: 08/24/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,

__Scott Scarnechia_____
Name & Credential
___1201 Wesleyan St_____
Address
_____fort Worth, TX 76105_____

Submitter : Mr. Joseph Garolis **Date:** 08/24/2007

Organization : Mr. Joseph Garolis

Category : Individual

Issue Areas/Comments

Technical Corrections

Technical Corrections

It has been brought to my attention that proposal CMS-1385-P in part will not allow payment to a non-treating radiologist for x-rays taken for chiropractic purposes.
IMO this is unfair to four classes of people.
It is unfair to:
1. the tax payers
2. those who utilize chiropractic treatment
3. chiropractors
4. radiologists
Multiple studies have shown that increased utilization of chiropractic reduces overall health care costs. Enforcement of this proposal will introduce a disencentive to the utilization of chiropractic services. This will drive up health care costs to the Medicare system, thus forcing additional cuts of services in the future. This will be a great injustice to the tax payers, today, and to the future Medicare recipients.

2. Those who utilize chiropractic care will be unfairly adversly affected. Many states currently require "well care coverage" with no deductible and no co-pay. Often included is mandated coverage for bone densitometry. The frequency of the coverage inercases with age, and for good reason, older people have a greater propensity to bone density loss. Medicare recipients who want to undergo chiropractic care have a greater need for x-rays (because they are generally older) than the rest of the population. If Medicare will not pay for the films, regardless of who provides the service, the patient will have to pay for them out of pocket, take a greater risk (if the doctor will treat without films), or choose not to avail himself of the services of a chiropractic physician.

3. It is unfair to the chiropractor. A chiropractor should be able to take films, and get paid for them. He should be able to refer out to a radiologist for films, who should get paid for them. Medicare already gets a great discounted fee from all providers. The services should be continued to be paid for at the discounted fee. This is unfair to the chirorpactic profession at large. It reduces a chiropractor to the status to that of a second class citizen/doctor. Chiropractors are small business owners, forbidden to unionize and are in competition with the government and multibillion dollar corporations (insurance companies) for the same health-care dollar. They should be permitted to compete against MDs, and Physical therapists on an even basis. This is an economic disadvantage perpetrated on the chiropractic profession by CMS that hinders the American Spirit of fair competition.

4. This is unfair to the radiologists. At a time when malpractice premiums are at an all time high, it is inconceivable that radiologists should be denied payment for services by one of the largest payors in the nation, (even at its greatly discounted rate).

MEdicare services are cost neutral. Therefore by paying for the xray services rendered for the benefit of chiropractic patients, there will be no additional cost to the program. In the following years the rate of reimbursement will be reduced to offset any additional coverages.

I implore you to reconsider your proposal, and to innitiate payments for X-rays taken of patients under chiropractic care.

Sincerely,
Joseph Garolis

Submitter : Dr. SAMSON OTUWA **Date:** 08/24/2007

Organization : SIERRA HEALLTH 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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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 : **Joseph Mortensen** **Date: 08/24/2007**

Organization : **American Society of Anesthesiologists**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : Mrs. GRACE OTUWA **Date:** 08/24/2007

Organization : Mrs. GRACE OTUWA

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Scott Knight** **Date: 08/24/2007**

Organization : **HealthSource of Olathe**

Category : **Health Care Industry**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Sincerely,
Dr. Scott R. Knight, D.C.

Submitter : Dr. Gary Young **Date:** 08/24/2007

Organization : Member ACA, ISCA, ICA and ICAI

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

I agree with the Medicare rule to eliminate payment of x-ray by other than a chiropractic. If they are not paid for in a chiropractors office, they should not be supporting the medical profession by being paid for when taken outside our offices. I have always had my patient pay for their x-rays taken in my office without serious objection.
Sincerely,
Gary A. Young, D.C.
Anderson, IN 46013

Submitter : Dr. Michael O'Keefe **Date:** 08/24/2007

Organization : American Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

As it relates to 1385-P I would respectfully ask that CMS reconsider the proposed decision to not allow a non-treating physician to order an x-ray at the request of a chiropractor. The information provided to the chiroprctor by an x-ray allows for the efficient managment of the patient's care. The x-ray lets the doctor of chiropractic know how to treat, when to treat, when not to treat, and when additional studies or a referral are indicated. To require the patient to return to the primary care physician for the purpose of ordering x-rays, causes delays in proper administration of care and additional expense to CMS. The patient's best interest is served, which is the goal of CMS, by allowing the non-treating physician to order requested x-rays. This method of ordering medically necessary x-rays is also the most fiscally responsible as it does not require an additional cost of referral to the primary care physician. Your consideration of these comments is appreciated. I can be reached at the American Chiropractic Association if additional information is needed.
Thank you,
Michael J. O'Keefe,D.C.
American Chiropractic Association

Submitter : Dr. Dan Vick **Date:** 08/24/2007

Organization : St. Joseph's Pathology, P.C.

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Syracuse, New York as part of a 6-person private practice pathology group at a 421-bed community hospital.

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

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

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

Sincerely,

Dan J. Vick, MD

Submitter : Dr. Jason Workman **Date:** 08/24/2007

Organization : Dr. Jason Workman

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Please see the attachment for my letter of supprt for the payment increase to anesthesiologists under the proposed 2008 Physician Fee Schedule.

CMS-1385-P-7787-Attach-1.DOC

7787

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.

Jason N. Workman MD
Las Vegas, Nevada

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

Organization : michael minett

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

cms-1385-p: Do not change the ruling with regards to a non-treating physician taking xrays for use by a chiropractor. Xrays are an integral part of caring for all types of patients. It is an invaluable diagnostic tool that should be reimbursable by whom ever takes the xrays, even chiropractors. So if you want to make any changes to the rule, you should change to pay chiropractors for all the services they provide, are trained in, and in which they are vigorously tested via 4 national board exams + in some states State Board exams. So changing the rule to the proposed way would be a huge mistake and a step in the absolute wrong direction. It is time to expand coverage for chiropractic for our seniors, not create obstacles and more hoops to jump through to get the much needed care they need. Stop creating more red tape. thank you

Submitter : Dr. Loren Miller **Date:** 08/24/2007

Organization : Quality Life Health Center, INC

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Please refer to file code CMS-1385-P. I would like to stipulate to Technical Corrections .

I urge you (MEDICARE) to abolish the recommendation that would affirm the proposed change in the law which would specifically eliminate Medicare reimbursement in connection with the referral of a patient by a doctor of chiropractic to a radiologist or other non-treating physician for X-rays; however, doctors of chiropractic will still be able to refer patients back to any treating physician, such as a primary care provider, for needed X-rays.

X-rays, when needed, are integral to the overall chiropractic treatment plan of Medicare patients, and unfortunately in the end, it is the beneficiary who will be negatively affected by this proposed change in coverage. The current X-ray Medicare protocol has served patients well, and there is no clinical reason for this proposed change,

While subluxation need not always be detected by X-ray, it is very often the case that a patient requires an X-ray to rule out any contraindications to chiropractic care or to determine appropriate treatment options. X-rays may also be required to help determine the need for further diagnostic testing, such as an MRI, or for a referral to an appropriate health care specialist.

Signed,

Loren C. Miller DC FACO PS
Spokane, WA 99205
509-327-3393

GENERAL

GENERAL

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Submitter : **Dr. Mark Bronson** **Date: 08/25/2007**

Organization : **Dr. Mark Bronson**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

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

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

Sincerely,
Mark R. Bronson, D.C.
Board Certified Chiropractic Orthopedist

Submitter : **Dr. Paul Aaronson** **Date: 08/25/2007**

Organization : **Dr. Paul Aaronson**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Herb Kuhn
Acting Deputey Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1385-P
PO Box 8018
Baltimore, MD 21244-8018

August 24, 2007

Dear Mr. Kuhn:

I am a urologist who practices in Forest Hills, New York. Currently, I am in a two person full-time clinical practice. However, because of the increasing costs associated with running a practice and the decreasing rate of reimbursements, we are in the proeess of forming a large group practice with other urologists here in Queens. Our hope is that a larger group will foster greater efficiency, permit economy of scale benefits to be realized and provide patients with improved quality of care by integrating additional services into the practice. As such, I am quite concerned about the impact of the proposed changes to the physician fee schedule rules published July 12, 2007 that pertain to the Stark self-referral rule and the reassignment and purchased diagnostic test rules.

Regarding the in-office ancillary services exception, the definition should not be limited in any way. Patients absolutely benefit when urologists provide in-office pathology and radiology services by ensuring quality and expediency. Similarly, allowing urologists to establish formal business relationships with radiation oncologists clearly enhances patient care by creating a more coordinated and cohesive approach to the often complex, inconvenient and stressful experience of undergoing radiation therapy for cancer.

The proposed changes to the Stark regulations and the reassignment and purchased diagnostic test rules are drastic and do not serve the best interest of patients. They will make our health care system even more fragmented,redundant and inefficient by discouraging and prohibiting urologists from delivering services in a direct, highly accountable manner.

Sincerely,

Paul Aaronson, MD

Submitter : Dr. Norman Lepor **Date:** 08/25/2007

Organization : Westside Medical Associates of Los Angeles

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

As a cardiologist, I have found Microvolt-T-Wave-Alternans to be very important for risk stratification of patients who are at risk for sudden cardiac death. I am certainly grateful for the recent CMS decision to reimburse for this examination. However, the assumption is that MTWA equipment is used 50% of the time is just not true, even in a mature cardiology practice such as mine. During the course of a typical week, we perform this exam 3-4 times. With each examination taking about 30 minutes, total utilization time is about 2 hours of a 40 hour week, constituting a 5% utilization. This assumption as many of you know is inaccurate and could result in an inappropriately low payment. Although MTWA can be used several times each week under the busiest of circumstances, use of the equipment is significantly less than 50% of the time.

Thank you very much for your consideration.

Norman E. Lepor MD

Submitter : **Dr. Celso Antiporda** **Date: 08/25/2007**

Organization : **Dr. Celso Antiporda**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the proposal to increase anesthesia payments under the 2008 Physician Fee schedule. Anesthesia work has long been undervalued compared to other physician services despite the
fact that members of our profession have succeeded in tremendously
improving the safety of surgical and other procedures through our intervention. The current payment schedule does not come close to
adequately compensating for the huge investment made to achieve such progress in safety and efficacy. The risk exists that with continuing disparity in the way our profession is paid, patient access for our services may be reduced when it becomes economically burdensome for the provider. Hopefully the proposed rule will correct this situation.

Respectfully,
Celso Antiporda, MD

Submitter : **Mr. Randall Davis** **Date: 08/25/2007**

Organization : **University of Kansas Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Randall D. Davis SRNA
5004 Hilltop Drive
Shawnee,Ks 66226

Submitter : Dr. Rosemary Calio **Date:** 08/25/2007

Organization : Dr. Rosemary Calio

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

The movement to eliminate chiropractic referral of a medicare patient to a radiologist is certainly not cost effective or patient centered. When the Chiropractic physician determines that x-rays are necessary, particularly for the types of procedures we used in practice, the need for a patient to have to consult their family doctor as opposed to going directly to a radiologist, would result in unnecessary delays and potentially alter patient care. I fail to see why any representative of the people would support this change, particularly when it can hamstring the chiropractic-patient relationship and the patients well-being. This is a time when many conditions present that would require comanagement or referral out to a specialist, i.e., bone pathology or spontaneous compression fractures. In view of the types of patients under this coverage, the action to remove a chiropractors right to refer for x-ray is not
reasonable or responsible. I strongly urge you to reconsider this
action. Thank you.

Submitter : **Dr. Richard Whitten** **Date: 08/25/2007**

Organization : **Noridian Administrative Services**

Category : **Physician**

Issue Areas/Comments

Medicare Telehealth Services

Medicare Telehealth Services

Colleagues: You note that initial consultations are logical to perform by telehealth, which makes sense. You indicate you are requesting comments on what conditions could be applied to subsequent hospital care, so that subsequent hospital care is used for telehealth services only when the service reflects a follow-up inpatient consultation. We agree with the concern and are also concerned that the universe of follow-up hospital services even following initial consultation is quite large, and currently reflects a face-to-face service. It would be much more prudent, much less a radical change, to allow a follow-up hospital service by telehealth only when it follows an initial consultation PERFORMED BY TELEHEALTH. The much larger number of services following face-to-face consultation shold not be changed to enable THESE to be performed by telehealth (which might dramatically increase utilization while decreasing the face-to-face benefits of the current service), at least until a future time when the initial, less drastic change has been authorized to allow telehealth follow-up only when the initial service was by telehealth. Thank you for considering.

Richard W. Whitten, MD, MBA, FACP Contractor Medical Director for AK, HI & WA

Submitter : Dr. Robert Schuck **Date:** 08/25/2007

Organization : Midwest Chiropractic Center, PA

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I am writing you in strong opposition to the July 12th item which would prevent doctors of chiropractic from using x-rays to determine misalignments. Though misalignments can be found without x-ray many underlying conditions that may delay the patient from getting proper care can not. In some situations, the inability to take and x-ray would limit the doctor in determining whether the underlying condition could be harmful to the patient if treated. Our training includes extensive x-ray classes and national board examinations, eliminating x-rays from our "tool box" would make us mueh less effective as portal of entry doctors to the health care system.

X-rays are an important tool for the safety of the patient and allow the doctor to do his/her job better. Please do not make patients suffer by allowing this to pass.

Please feel free to call me with any questions that you may have.

Sincerely,

Robert R. Schuck, DC

Submitter : Dr. Richard Whitten **Date:** 08/25/2007

Organization : Noridian Administrative Services

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

The proposed change to eliminate the modifier -51 exemption and apply the multiple procedure payment reduction rules to these codes is fair, appropriate, needed, and consistent with the way the codes were presented and valued. Thank you.
Richard W. Whitten, MD, MBA, FACP
Contractor Medical Director for AK, HI & WA

Submitter : **Dr. Scott Olsen** **Date: 08/25/2007**

Organization : **Anesthesiologist Consultants Incorporated**

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 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. Alexander Lim** **Date: 08/25/2007**

Organization : **Dr. Alexander Lim**

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.

Alexander J. Lim, M.D.

Submitter : Michelle Lewis **Date:** 08/25/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 25, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
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Sincerely,

Michelle Lewis CRNA
2303 RR 620 S. Ste 135 PMB 293
Austin, TX 78734

Submitter : **Dr. Byron Folwell** **Date: 08/25/2007**

Organization : **Folwell Chiropractic Clinic, Inc.**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Dear CMS Representative:

As a Chiropractic Physician, the need to have direct access and available supportive services offered by local radiologists is essential to my patients under Medicare. When employing a patients family physician, duplicate steps are taken involving additional costs and time to the Medicare receipient.

Upon the passing of this ruling, the patient will be forced to undergo two examinations, the one completed by myself and another by their family physician, prior to having x-rays completed. This makes no sense and increases time and costs to everyone involved.

Although family physicians often act as a portal of entry physician for most Medicare patients, a chiropractic physician is best suited to address musculoskeletal issues, especially those of the spine. Patients and the public at large, choose chiropractic care because of their confidence and trust in the training of their chiropractic physician. They have come to realize the benefit and results from the care they receive by their chiropractic physician. This ruling will only work to complicate that relationship and increase costs to the Medicare patient therefore, impairing future access to appropriate care.

This office has worked diligently to develop positive relations with local primary care physicians of the medical type however, not all physicians receipicate in a kind manner. Instead, patients are encouraged to utilize out dated (bed rest and heat applications) and often times failed approaches to their conditions. Costs are typically increased and outcomes are diminished when their medical practitioner becomes involved in the care process.

If Medicare is working to address outcomes associated with currently escalating costs, then avoid policies which only add to this burden of the American tax payers. Allow the current relationship between chiropractic physicians and radiologists remain intact.

Sincerely,
Byron R. Folwell, D.C.
Doctor of Chiropractic

Submitter : **Dr. Brian McGlinch** **Date: 08/25/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.