

Submitter : Dr. Maher Fattouh
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

GENERAL

GENERAL

Attachement

CMS-1392-FC-267-Attach-1.DOC

#267

January 11, 2008

Mr. Kerry Weems
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: MS-1392-FC
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: MS-1392-FC

Dear Mr. Weems:

As a concerned interventional pain management physician I would like to comment on multiple disparities which exist between ASC setting and HOPD setting. These disparities and the CMS's new proposals and classifications will hinder patient access.

I am concerned about status indicator for CPT Codes 72285 and 72295 and non-payable issue which is related to discography. CMS pays separately for radiology portion of discography when it is performed independently in the HOPD setting, however it does not pay separately for the very same service when it is performed independently in the ASC setting. It was our understanding that in spite of significant cuts for interventional pain management the whole purpose was to apply the standards uniformly but it does not seem so. Discography procedures have two components: an injection portion that is reported by either CPT Code 62290 (Injection procedure for discography, in lumbar spine) or CPT Code 62291 (Injection procedure for discography in cervical or thoracic spine), and a radiology portion that is reported by either CPT Code 72285 (discography interpretation and supervision in cervical spine) or CPT Code 72295 (discography interpretation and supervision in lumbar spine).

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Thank you for the opportunity to comment on the Final Rule.

Sincerely,

Dr Maher Fattouh
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Maxim Gorelik
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

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Administrator
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Department of Health and Human Services
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Hubert H. Humphrey Building, Room 445-G
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Sincerely,

Dr Maxim Gorelik
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Donald Harvey
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

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Sincerely,

Dr Donald Harvey
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Douglas Keehn
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

GENERAL

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Attachement

#270

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

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

Submitter : Dr. Thomas Lass
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

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#271

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Sincerely,

Dr Thomas Lass
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Jerome Lerner
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

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CMS-1392-FC-272-Attach-1.DOC

#272

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Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
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Sincerely,

Dr Jerome Lerner
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Itzhak Matusiak
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

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Sincerely,

Dr Itzhak Matusiak
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Dermot More O Ferrall
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

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Sincerely,

Dr Dermot More O Ferrall
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Hany Nosir
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-1392-FC-275-Attach-1.DOC

#275

January 11, 2008

Mr. Kerry Weems
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: MS-1392-FC
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

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Sincerely,

Dr Hany Nosir
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Navtej Purewal
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

GENERAL

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Attachment

#276

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

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Please direct your questions or comments to 1.800.743.3951.

Submitter : Dr. Buhpinder Saini
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

GENERAL

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Attachment

CMS-1392-FC-277-Attach-1.DOC

#277

January 11, 2008

Mr. Kerry Weems
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: MS-1392-FC
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

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Dr Buhpinder Saini
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Thomas Stauss
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

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Attachment

#278

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

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Dr Harry Tagalakis
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Kostandinos Tsoulfas
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

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Sincerely,

Dr Kostandinos Tsoulfas
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Denise Chang
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

GENERAL

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Attachment

CMS-1392-FC-281-Attach-1.DOC

#281

January 11, 2008

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I am concerned about status indicator for CPT Codes 72285 and 72295 and non-payable issue which is related to discography. CMS pays separately for radiology portion of discography when it is performed independently in the HOPD setting, however it does not pay separately for the very same service when it is performed independently in the ASC setting. It was our understanding that in spite of significant cuts for interventional pain management the whole purpose was to apply the standards uniformly but it does not seem so. Discography procedures have two components: an injection portion that is reported by either CPT Code 62290 (Injection procedure for discography, in lumbar spine) or CPT Code 62291 (Injection procedure for discography in cervical or thoracic spine), and a radiology portion that is reported by either CPT Code 72285 (discography interpretation and supervision in cervical spine) or CPT Code 72295 (discography interpretation and supervision in lumbar spine).

I believe that discography should be a separately payable service in the ASC as it is not treated as a surgical procedure eligible for separate payment under the payment system. This payment policy fails to recognize inequality between multiple settings and importance of these being done in an ASC setting.

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In addition, CMS should delay implementing the payment cap for office-based procedures. The present formula appears to be arbitrary.

To avoid exponential increases in procedures performed in all settings specifically in-office settings, CMS should establish that these procedures should be performed by only well-trained qualified physicians and in accredited office settings, thus creating an accreditation standard for offices to perform interventional procedures. This philosophy may be applied to other settings to simply reduce the overuse.

Thank you for the opportunity to comment on the Final Rule.

Sincerely,

Dr Denise Chang
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Satvinder Dhesi
Organization : Advanced Pain Management
Category : Ambulatory Surgical Center

Date: 01/11/2008

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-1392-FC-282-Attach-1.DOC

#282

January 11, 2008

Mr. Kerry Weems
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: MS-1392-FC
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: MS-1392-FC

Dear Mr. Weems:

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Thank you for the opportunity to comment on the Final Rule.

Sincerely,

Dr Satvinder Deshi
4131 W Loomis Road
Suite 300
Greenfield, WI 53221

Submitter : Dr. Antoinette Gomes
Organization : UCLA Medical Center
Category : Physician

Date: 01/11/2008

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1392-FC-283-Attach-1.DOC

CMS-1392-FC-283-Attach-2.TXT

#283

January 12, 2008

Steve E. Phurrough, M.D.,
M.P.A. Director, Coverage and Analysis Group
Office of Clinical Standards and Quality Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C1-09-06 Baltimore, MD 21244-1850

Re: Proposed National Coverage Determination for Coronary CT Angiography (CAG-00385N)

Dear Dr. Phurrough:

I would like to take the opportunity to comment on CMS' proposed national coverage determination (NCD) for coronary computed tomography angiography (CCTA). I understand the need to control rising health care costs and understand that CMS has a responsibility to ensure that covered services are "reasonable and necessary" for the Medicare population. However, I respectfully disagree with CMS' conclusions in this proposed coverage determination and believe that if implemented, the policy would have a negative impact on Medicare beneficiaries by limiting needed access to this technology for clinically appropriate indications.

I strongly urge CMS to maintain the current coverage status for CCTA and urge CMS to continue to allow local Medicare carriers to determine coverage through the Local Coverage Determination (LCD) process. The LCDs now in place for all 50 states and the District of Columbia permit access to this important diagnostic tool for many Medicare beneficiaries undergoing evaluation for coronary artery disease (CAD). The analysis presented in the proposed decision memo simply does not support establishment of what will effectively be, in practice, a national non-coverage policy for the vast majority of Medicare patients.

The proposed NCD does not fully consider all of the available evidence. Although there is early literature regarding the use of 4-, 8-, and 16 row scanners for performing CCTA, those practitioners with experience recognize that to perform these studies on less than 64 row scanners is not helpful and is not good use of resources. The standard of practice in 2007 is to perform CCTA with MDCT scanners of 64-slices, and I encourage CMS to consider the large numbers of 64-slice CCTA studies omitted from the proposed NCD in lieu of other studies involving outmoded 4-, 8-, and 16-slice MDCT scanners. While 8 manuscripts employing 40 or greater slice CT scanners were evaluated, 25 full manuscripts using this contemporary level of CT scanner were not considered.

Approximately one half of the available evidence with 64 slice CT scanners has not been considered in the draft proposal.

There are many patients in whom CCTA use on the appropriate scanner can result in the acquisition of information in a non-invasive, less costly way with lower risk.

If CMS does choose, however, to establish a national coverage policy, I recommend as have several of the major Societies national coverage without requiring evidence development for at least the following indications:

Symptomatic patients with chronic stable angina or anginal equivalent and an intermediate pre-test probability of CAD;

Symptomatic patients with possible acute coronary syndrome (ACS), a low risk of short term death and an intermediate probability of CAD;

Assessment for presence and course of coronary artery anomalies;

Coronary artery evaluation in individuals in whom prior clinical non-invasive coronary artery test data (e.g., ECG or imaging results) are equivocal or discordant;

Assessment of bypass graft location (e.g., internal mammary artery) prior to surgical intervention in patients undergoing repeat sternotomy; and

Coronary artery evaluation in patients undergoing non-cardiac surgery.

If possible, CMS should consider setting limits on what type of systems CCTA will be covered.

It is critically important that CMS modify its major premise used in forming the basis of the proposed NCD—the notion that CCTA must improve health outcomes. No diagnostic test improves health outcomes by itself; only the resulting therapeutic interventions may do so. This is true for the simple reason that even in situations where a correct diagnosis is made, any number of variables affecting treatment (e.g. comorbidities)—including the course of treatment itself (i.e. appropriateness, timeliness, patient cooperation, etc.)—may lead to poor health outcomes irrespective of whether the diagnosis was correctly issued due to CTA or other modalities.

I strongly urge you to reconsider your position on this issue. It is appropriate to try to control costs, but you cannot turn back the clock. CCTA performed on appropriate scanners is here to stay and is appropriate for certain indications. The non-invasive imaging of the coronary arteries will continue, as it should. Those who can afford to pay out of pocket for it will get it. Your actions are only temporizing, and the general less affluent Medicare population will be very unhappy with your decision.

Sincerely yours,

Antoinette S. Gomes, M.D.
Professor of Radiology and Medicine
UCLA School of Medicine

Submitter : Dr. Lora Brown
Organization : Dr. Lora Brown
Category : Physician

Date: 01/13/2008

Issue Areas/Comments

GENERAL

GENERAL

December 18, 2007

Mr. Kerry Weems
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: MS-1392-FC
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: MS-1392-FC

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Thank you for the opportunity to comment on the Final Rule.

Sincerely,
Lora Brown, MD

CMS-1392-FC-285 Medicare

Submitter : Dr. Sukdeb Datta

Date & Time: 01/16/2008

Organization : Vanderbilt University

Category : Physician

Issue Areas/Comments

GENERAL

see attachment

285~

December 18, 2007

Mr. Kerry Weems
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: MS-1392-FC
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: MS-1392-FC

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Thank you for the opportunity to comment on the Final Rule.

Sincerely,

Sukdeb Datta, MD, DABPM, FIPP

Director
Vanderbilt University
Interventional Pain Program
Associate Professor
Dept. of Anesthesiology
Vanderbilt University Medical Center
2501 TVC
1301 Medical Center Drive
Nashville TN 37232-5795

Phone: (615)-322-4311
Fax: (615)-322-9089

CMS-1392-FC-286 Medicare

Submitter : Wanda Wilson, CRNA,PhD,MSN Date & Time: 01/16/2008

Organization : American Assoc. of Nurse Anesthetists

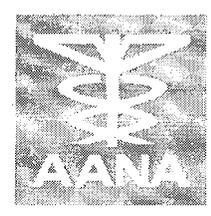
Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

See Attachment.

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January 28, 2008

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Bldg
200 Independence Ave., SW
Washington, DC 20201

ATTN: CMS-1392-FC

Re: Comments on Interim and final rule with comment period - Medicare Program: Proposed Changes for Hospital Outpatient Prospective Payment System and CY2008 Payment Rates; (72 Fed. Reg. 66580, November 27, 2007).

I. HOSPITAL Conditions of Participation (CoP)

Dear Sir/Madam:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the interim and final rule with comment period - Medicare Program; Proposed Changes for Hospital Outpatient Prospective Payment System and CY2008 Payment Rates; (72 Fed. Reg. 66580, November 27, 2007). The AANA is submitting comments in the area of Hospital CoPs.

The AANA is the professional association for more than 36,000 Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice nurses who administer about 27 million anesthetics given to patients each year in the United States, according to the 2005 AANA Member Survey. Nurse anesthetists have provided anesthesia in the U.S. for over 125 years, and high quality, cost effective CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1986, have billed Medicare directly for 100 percent of the physician fee schedule amount for their services.

CRNA services include administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide assessment and evaluation for acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and are the sole anesthesia providers in almost two-thirds of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization, and pain management capabilities. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Forces. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management units and the offices of dentists, podiatrists, and all varieties of specialty surgeons.

I. HOSPITAL COPs

We appreciate CMS' efforts to update and revise the Medicare Part A Hospital Conditions of Participation (CoP) at 42 CFR §482.52(b) in this interim final rule so that this section of the CoP better reflects current anesthesia practice. We were pleased to see that CMS incorporated our comments into the CoP language in the interim final rule and appreciate the opportunity to contribute to CMS' continued work in this area. As you recall, the AANA commented on the proposed rule (72 Fed.Reg. 42628, Aug. 2, 2007) for this CoP in three areas.

First, we agreed with CMS' proposal to revise §482.52(b)(1) and (b)(3) so that these sections of the CoP apply to all surgical and other procedures provided in inpatient and outpatient settings that would require anesthesia services. We agree that it is appropriate to clarify that the completion of preanesthesia and postanesthesia evaluations applies to surgical and other procedures that require anesthesia services. We therefore agree with this change to the CoP as published in this interim final rule.

Second, we argued that CMS' proposal to requiring the anesthesia provider to complete and document the postanesthesia evaluation before the patient is transferred or discharged would create a number of unintended consequences to the detriment of patients' health and their continued access to surgical and other services requiring anesthesia. We stated that though the effects of anesthesia can last beyond the point at which a patient is transferred or discharged that

this does not mean that it is not appropriate to transfer or discharge the patient. Therefore, the CoP for §482.52(b)(3) as published in the proposed rule would have created a situation in which patients who could be safely transferred or discharged would be needlessly held for hours in the recovery area. Such prolonged time in the recovery area is not necessarily best for the patient's full recovery. Alternatively, the CoP language in the proposed rule could have caused qualified anesthesia providers to complete the postanesthesia evaluation without capturing or addressing the patient's full postanesthesia experience or anesthesia related complications.

Third, we argued that the language published in the proposed rule could also cause a decrease in patients' access to surgical and other procedures that require anesthesia. Current, safe anesthesia practice allows for the qualified anesthesia provider to move to the next anesthesia case while the prior patient is in the recovery area. Anesthesia providers are required, and in fact it is crucial for a patient's safety that an anesthesia provider remains with a patient throughout a surgery or procedure. If the anesthesia provider had to complete the postanesthesia evaluation before the first patient is transferred or discharged the anesthesia provider would have to remain with the first patient and therefore, could not simultaneously provide anesthesia services for the second patient. Subsequent surgeries or procedures could not occur without the anesthesia provider, thereby slowing the number of surgical or other cases the hospital can schedule each day. A reduced number of cases per day results in a decrease in patients' access to timely surgical and other services that require anesthesia. Additionally, many hospitals may only have one or a very limited number of anesthesia providers. CMS' proposed change could have resulted in hospitals unnecessarily having to hire an additional anesthesia provider to comply with the CoP at an increased cost to the hospital and to the patient, without yielding benefits such as increased patient safety or access to care.

According to CMS in this interim final rule, in light of AANA's and others' comments, CMS revised the CoP language it had originally proposed so that the postanesthesia evaluation must now be "completed and documented by an individual qualified to administer anesthesia ...no later than 48 hours after surgery or a procedure requiring anesthesia services." (72 FR 66580, 66934) We agree with the revision CMS made to this CoP in the interim final rule as it appropriately accounts for current safe anesthesia practice in which anesthesia providers

complete the postanesthesia evaluation by making follow-up visits or calls to patients that day or the next are able to capture and address any complications due to anesthesia that may arise after transfer or discharge. We also agree that this change as published in the interim final rule helps to ensure that patients will continue to have access to surgical and anesthesia services.

We thank CMS for its openness in considering our comments and in its decision to incorporate our comments into the interim final rule. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400.

Sincerely,

A handwritten signature in cursive script that reads "Wanda Wilson".

Wanda Wilson, CRNA, PhD, MSN
AANA President

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