



PAIN AND WELLNESS CENTER

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December 19, 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

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).

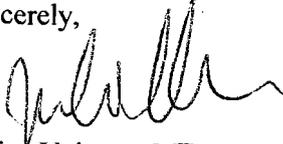
I believe that discography should be a separately payable service in the ASC as it is not treated as a surgical procedure eligible for separate payment under the payment system. The patient will be the ultimate beneficiary of these changes. This payment policy fails to recognize inequality between multiple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

The second issue relates to the update to the conversion factor while ASCs are facing losses, hospitals will still have an upper hand with a better update factor. This should be changed where both update factors are the same.

Mr. Kerry Weems
Administrator
Centers for Medicare and Medicaid Services
December 19, 2007
Page 2

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

Sincerely,



Julien Vaisman MD
Instructor of Physical Medicine and Rehabilitation
Harvard Medical School
Boston, MA



The FINANCE DIVISION

December 20, 2007

Department of Health and Human Services
Attn: CMS-1392-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Final Rule for Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates

I am writing you for clarification on the use of physician evaluation and management (E&M) codes for hospital facility billing. The final rule has conflicting information that I hope you can clarify for us.

The final rule states: "the [hospital] guidelines should not be based on physician resources." Yet in the comment response section related to this topic it states: "this does not preclude a hospital from using or adapting the physician guidelines if the hospital believes that such guidelines adequately describe hospital resources." Does this mean if a hospital is satisfied that the physician E&M code accurately represents the use of hospital resources that the hospital may use the physician CPT code as the basis for the hospital bill ?

Your clarification on this issue will be greatly appreciated.

Sincerely,

Kevin C. Pillow
Revenue Cycle Director



**FAMILY
E Y E
GROUP**

December 17, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1392-FC
Mail Stop C4-26-05
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Baltimore, MD 21244-1850

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& Strabismus
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Reconstructive & Cosmetic

Donna Leonardo, DO
Glaucoma & Cataracts

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Eric L. Singman, MD, PhD
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To Whom It May Concern:

This letter regards my comments concerning ASC payment level for CP Code 68816.

Currently, we have been using the code 68815 to report the balloon procedure. We have been using 68811 for simple probing procedures. As of 2008, a new code 68816 has been created. The payment for this code in the hospital outpatient setting is \$1,193.00. Unfortunately, CMS apparently calculated the ASC payment for this code based on performance of the code in an office setting. In my experience using the balloon for greater than ten years, I have only attempted to perform the balloon in the office setting once and failed. This was performed on an adult. The vast majority of these patients are children and require general anesthesia. Even adults who I perform this procedure on require general anesthesia for comfort reasons. Essentially, none of these procedures are performed in the office. I use the balloon procedure after a simple probing has failed. Generally, I would prefer to perform these procedures in an ambulatory surgery center. However, with the new payment proposed, which I understand will be \$434.00, the surgery centers will be very unlikely to allow these procedures to be performed there.

In light of this, I would be forced to perform all of these procedures at the outpatient department in the hospital, which would significantly increase the cost for this procedure.

I feel it is crazy that this procedure 68816 is valued significantly less than the procedure 68811, which is a simple probing. The differences between the two procedures are significant. The simple probing is part of the 68816 balloon procedure, but following that a balloon probe must be placed through the canaliculus system and localized in the nose. It then must be inflated with an inflation device in this location and verified in the nose either by direct visualization or endoscopically. Following this, it is left inflated for 90 seconds, deflated, pulled back and reinflated for one minute, deflated, pulled back and reinflated for another minute prior to being pulled out. This procedure takes significant longer than a simple probing, which is compensated higher under the current proposal.

I would ask that the payment for the code be changed to reflect the fact that it is an operating room procedure versus an office-based procedure and that it be increased so that ambulatory surgery centers can afford to pay for the cost of the device.

If you have any further questions, I would be most happy to talk to someone.

Sincerely,

David I. Silbert, M.D., F.A.A.P.

DIS/cmw



**Associated Ophthalmologists
of Kansas City, PC**

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December 10, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1392-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Category 1 CPT code 68816

Dear Sirs,

I believe you have made an egregious oversight with respect to your proposed interim payment for the ASC setting application of balloon catheter dilation of the lacrimal outflow tract. A payment of \$433.69 just barely covers the cost of the balloon, which is currently \$306, and the cost of the drapes. This would almost certainly ensure that all such cases would be performed in a hospital outpatient setting, which would obviously be more expensive. If your purpose in setting the reimbursement for the procedure this low is to ensure all of the procedures are performed in the more expensive hospital outpatient setting, then I think that you will be successful in such.

Looking at the proposed physician reimbursement rate for balloon catheter dilation at \$193, I believe you do not understand what is involved in performing the procedure. The surgery is typically performed when a more straightforward procedure, such as nasal lacrimal duct probing, is unsuccessful. I cannot see how a more complicated procedure such as this would reimburse less than a nasal lacrimal duct probing. I believe the procedure is more akin to an endoscopic dacryocystorhinostomy than it is to a nasal lacrimal duct probing. Once again, if your purpose here is to shift people from utilizing a balloon catheter dilation to doing a more invasive and costly procedure such as a dacryocystorhinostomy, I believe you will be successful.

In short, I believe that the proposed reimbursements that you have for both physician and the ASC setting of the procedure will ensure that very few of the procedures will be performed, and those that are accomplished will be done in the more expensive hospital setting. I would also anticipate that more dacryocystorhinostomies would be performed rather than balloon catheter dilations because of the dismal and unfair physician reimbursement you are currently proposing.

I would be happy to discuss any of the aforementioned details with you should you believe it to be useful. I also do sincerely appreciate your taking the time to read this letter.

Sincerely,

William L. White, M.D.
WLW/alnh

Steven R. Byars, M.D. Cataract Evaluation and Surgery Diseases and Surgery of the Eye	Charles M. Lederer, M.D. Glaucoma Consultation Cataract Evaluation and Surgery	William L. White, M.D. Oculofacial Plastic Surgery	Patricia L. Murray, O.D. Comprehensive Eye Examinations Ocular Disease Diagnosis and Management Low Vision and Contact Lenses
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December 28, 2007

Mr. Kerry Weems, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1392-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: 42 CFR Parts 410, 411, 412, et al. Medicare and Medicaid Programs;
Interim and Final Rule. ASC payment for 68816, Probing of nasolacrimal duct,
with or without irrigation; with transluminal balloon catheter dilation.

Dear Acting Administrator Weems:

The American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) is writing to share our comments regarding the proposed ASC payment for CPT 68816 as listed in the above-referenced document. The American Society of Ophthalmic Plastic and Reconstructive Surgery is the largest organization of oculofacial plastic surgeons, with more than 500 members. Our members have completed broad-based training in ophthalmology followed by subspecialty training in oculofacial plastic surgery. ASOPRS members specialize in aesthetic, plastic, and reconstructive surgery of the face, orbits, eyelids and lacrimal system. With this unique combination of skills, ASOPRS members perform facial plastic surgery, eyelid surgery, orbital surgery, and lacrimal surgery.

The ASC payment rate of \$433.69 for CPT 68816 is based upon the inclusion of 68816 on a list of "New CY 2008 ASC covered surgical procedures assigned temporary office-based payment indicators on an interim final basis." ASOPRS does not believe 68816 should appear on this list. ASOPRS believes that probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation, is only infrequently performed in the office setting, and is not aware of any evidence that this procedure is performed more often in the office setting than in an ASC or a hospital. Since the procedure is not principally performed in the office, it should be eligible for payment based on the appropriate percentage of the OPPS rate of \$1193.03. ASOPRS respectfully requests that this change be made prior to implementation.

Thank you for the opportunity to comment.

Sincerely,

James Karesh, MD, FACS
President



SEVEN HILLS
Surgery Center L.L.C.

December 18, 2007

Center for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1392-FC
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1840

Re: Proposed ASC payment for new CPT 68816 -- balloon dilation of the nasolacrimal duct

To Whom It May Concern:

Our office has received information on the proposed ASC payment on new CPT code 68816 for balloon dilation of the nasolacrimal duct. Medicare is proposing a payment of \$433.69 for this procedure, which is based upon an office setting.

Because it is crucial that general anesthesia be used, this procedure simply cannot be performed in the office. The potential for complications is much higher if general anesthesia is not used. Also, an ASC setting will provide the patient with more effective pre and post-op monitoring. The fee proposed does not even cover the cost of the lacrimal balloon catheter, let alone the OR time, staff and supplies. We will not be able to economically treat these patients in the ASC setting, therefore resulting in more patients being referred to a hospital. This will result in Medicare paying a much higher rate to the hospital.

The alternative procedure would be Dacryocystorhinostomy; however, our patients will have more of a chance for complications after surgery. This is not the preferred procedure. Please reconsider the proposed payment for ASCs as \$433.69 is absolutely not sufficient.

Thank you,

Lesley G. Lewis
Director of Billing and Insurance
Seven Hills Surgery Center



LIONS EYE INSTITUTE

of Albany

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18 December, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1392-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

It has recently come to my attention that a new CPT code has been created for balloon catheter dilation of the nasolacrimal duct for nasolacrimal duct obstruction. This code was created with the assumption that the procedure can be done in any setting without general anesthesia, does not take more time than a simple probing, and is therapeutically equivalent to a probing.

As I am a pediatric ophthalmologist, all of my patients with nasolacrimal duct obstruction are children, generally between 12 and 30 months of age. No anesthesia other than a full general anesthesia in an operating room would be appropriate. There is no ASC in our area where children can receive anesthesia for such surgery. Although I would prefer to work in an ASC, I simply must operate these children in a hospital outpatient setting.

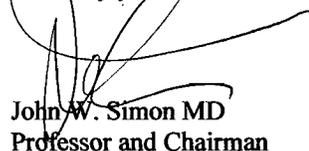
The time required for balloon catheter dilation is decidedly longer than that required for a simple probing. Although both are relatively short procedures, each duct requires more than 5 minutes longer for the balloon procedure (average 10-15 minutes longer, or 50% longer, than a simple probing).

Finally, it is important to emphasize that balloon catheter dilation is used for children who have already failed probings or who are old enough that probings would be unlikely to succeed.

I understand that the physician payment for 68816 is to be decreased from \$205 (for 68815) to only \$193. In my judgment, this is an unreasonable and unjust decrease from a reimbursement that is already too low.

I appreciate your consideration in this matter.

Sincerely yours,


John W. Simon MD
Professor and Chairman

Lions Eye Institute
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Albany Medical College
Department of Ophthalmology



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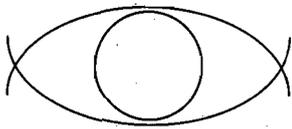
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December 14, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1392-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CPT Code 68815 and 68816

Dear Sir/Madam:

I am a pediatric ophthalmologist in full time academic practice and regularly treat children with lacrimal disorders. The proposed fee schedule associated with the above two codes is totally inadequate for the complexity and work they require. The reasons for this are:

- All procedures in children are performed under general anesthesia.
- Virtually all procedures relate to previously failed nasolacrimal duct probing (68811).
- The insertion of balloons or stents can be technically difficult. In particular, lacrimal intubation is frequently challenging in small children.
- While these procedures tend to be highly effective, facility fee reimbursement also needs to be adequate to properly cover costs. A proposed ASC payment of \$434 is woefully inadequate. I have been in pediatric ophthalmology practice for 30 years and have performed both procedures for as long as they have been in existence. It is my professional opinion that when compared with NLD probing (68811), balloon dilation should be assigned at least *double* and lacrimal intubation *triple* the RVUs assigned the basic general anesthesia probing procedure.

Sincerely,

Richard A. Saunders, MD
Miles Professor of Ophthalmology
Professor of Pediatrics

RAS/mg



Eye Associates of Tallahassee, PA

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Tony A. Weaver, M.D.
Kenneth P. Kato, M.D.
Jerry G. Ford, M.D.

Diplomates, American Board
of Ophthalmology

Fellows, American Academy
of Ophthalmology

Micah D. Brienens, O.D.
Board Certified Optometrist

Shelley W. Bertels, CPA
Administrator

December 7, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1392-FC
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Center for Medicare and Medicaid Services:

I am writing specifically regarding the new category 1 CPT code 68816 which is a balloon dilation of the nasolacrimal duct. The proposed fee for this is \$433. This is based apparently on an office setting. This procedure is done 100 percent of the time in a surgical setting. The standard of care, to repeat, is for this procedure to be done in a surgical setting and not in an office. It would be inappropriate for this procedure to be done in the office due to pain and significant complications of slipping this balloon into the nasolacrimal duct, which is through the bone of the nasal canal which would cause considerable pain. This would be something you would not want done to any member of your family unless they were under general anesthesia. This proposed payment does not cover the increased work associated with this procedure and the increased time associated with the procedure.

Another problem with this proposed pricing is the expense of the balloon catheter. The balloon catheter itself costs \$306. Again, with a payment of only \$433, you get the idea that this does not make economic sense for this procedure.

To reiterate, this is a wonderful procedure that has significant advantages for the patient with decreased morbidity. An analogy would be like a cardiologist doing a balloon angioplasty versus a coronary artery bypass. While there is significantly less morbidity, there are significant costs with this procedure and significant time involved for the procedure to be done correctly and with the proper standard of care.

To reiterate, I am asking you to please consider increasing the reimbursement to allow for this wonderful procedure to be offered to our patients.

Sincerely,

Tony A. Weaver, M.D.
TAW/lm



**Children's Hospital
of Michigan**

DETROIT MEDICAL CENTER / WAYNE STATE UNIVERSITY

Department of Ophthalmology

3901 Beaubien
Detroit, MI 48201-2196
313-745-5777 Phone

December 28, 2007

Center for Medicaid and Medicare Services
Department of Health and Human Services
ATTN: CMS-1392-FC, Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

To Whom It May Concern:

This is in response to the proposed revision for the CPT code 68816 for balloon dilation of the lacrimal system. I am a Pediatric Ophthalmologist who care for many children with dacryostenosis. If they have failed conventional probing, we will use balloon dilation of the lacrimal system to treat the persistent dacryostenosis. The technique involves the placement of the lacrimal catheter into the nasal lacrimal system down into the nose. You enter through the puncta on the lower lid or upper lid of the eye. There is significant sensitivity to the mucosa in the lacrimal system as well in the nose. You could appreciate this if you ever placed a cotton tip well up into your nose. The balloon is inflated for a minute and a half deflated and re-inflated for 30 seconds. This process is then repeated with the Lacricath pull back to the upper part of the lacrimal system. Therefore, the Lacricath is in the nose and lacrimal system for up to 3 to 4 minutes.

As you can imagine in young children as well as in adults, this would be a very uncomfortable process. It would be impossible to leave the balloon catheter in the lacrimal system in a child for 4 minutes let alone placing it for 30 seconds.

100% of my patients with dacryostenosis that are treated with balloon dilation are children. It is totally inappropriate to perform this procedure in the office setting without general anesthesia. In fact, many adults would suffer through this in an office setting.

Thank you for your attention to this. If you have any questions, please do not hesitate to contact me.

Sincerely,

John D. Roarty, M.D.

JDR/tm

cc: Sue Reynolds, M.S.
Ophthalmology Sales & Marketing Manager
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December 12, 2007

Centers for Medicare and Medicaid Services
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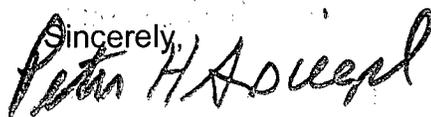
Re: ASC Setting for New CPT Code 68816

To Whom It May Concern:

This letter is intended to provide guidance for payment for the code 68816. This calculation should be made based upon an ASC setting for the procedure. One hundred percent of my use of this procedure is done in the ASC. Balloon dilation is a treatment of choice when probing does not succeed. This procedure requires general anesthesia to perform. Thus, the ASC is the preferred and usual setting for performing this procedure. The Lacricath procedure takes significantly more time than a simple probing. The device is more expensive than reusable probes. However, because the success is higher, a lower percentage of repeat procedures would be expected. Also, we desire to provide these services in an ASC rather than the more costly hospital outpatient setting.

Thank you for considering the above in your analysis of the review of the payment for this code.

Sincerely,



Peter H. Spiegel, M.D.

PHS/baa

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December 26, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CM-1392-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: Billing Critical Care Services under OPSS.

Dear Sir or Madam:

On behalf of our 42 hospitals in Arizona, California and Nevada, Catholic Healthcare West (CHW) would like to respond to the topic of billing Critical Care Services, CPT code 99291 as discussed during the December 20, 2007 Open Door Forum.

During this Open Door Forum, it was communicated to all that Hospital providers must follow the CPT instructions related to CPT code 99291 and that any services included in the reporting of CPT code 99291 should not be billed separately by the hospital.

Section Notes - Critical Care Services - (99291-99292)

Critical care is not specific to a location such as an ICU or CCU. Rather it is determined by the patient's critical condition requiring this type of physician care. Therefore, routine visits to a stabilized patient in an ICU are not necessarily critical care. Services such as endotracheal intubation (31500) and the insertion and placement of a flow directed catheter (e.g., Swan-Ganz, 93503) may be reported separately. Append modifier 25 to the critical care code to indicate a separate service was performed. The following CPT codes are considered part of critical care services and should not be separately reported: the interpretation of cardiac output measurements (93561, 93562), interpretation of chest x-rays (71010, 71015, 71020), pulse oximetry (94760-94762), blood gases and other information stored in computers (e.g., blood pressures, hematologic data, ECGs (99090), gastric intubation (43752 and 91105), ventilation management (94002-94004, 94660, 94662), temporary transcutaneous pacing (92953), and vascular procedures (36000, 36410, 36415, 36540, and 36600). The physicians should separately report any procedures performed that are not listed above.

This direction represents an extremely difficult requirement to administer and operationalize. In addition, it is not consistent with CMS's desire to reimburse hospitals according to use of facility resources, thus this is a significant monetary loss to our hospitals although we incur costly resources. CHW would appreciate the opportunity to submit financial data to demonstrate that the national APC rate of \$436.16 does not cover the cost of providing all of the packaged services outlined above to these patients.

We respectfully request that CMS reconsider this direction communicated during the December Open Forum and allow hospitals to separately bill the ancillary services and procedures provided to these Critically Ill outpatients; or at a minimum, postpone implementation of this directive allowing hospitals time to provide additional data to CMS on the financial hardship this will cause.

Thank you in advance for your consideration of this request. If you have any questions, please contact Cathy Schloeder, Corporate CDM Department Manager at 602-307-2978; cathy.schloeder@chw.edu.

Respectfully Submitted,

Cathy Schloeder RN BSN MAOM

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Neuro-Ophthalmology

Comprehensive Ophthalmology
Cataract Surgery

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Cynthia A. Bradford, M.D.
Laynie E. Goetzinger, M.D.
David W. Jackson, M.D.
Deana S. Watts, M.D.

Cornea and External Disease

James Chodosh, M.D., M.P.H.
David W. Jackson, M.D.
Rhea L. Siatkowski, M.D.
Donald U. Stone, M.D.

Glaucoma

Steven R. Sarkisian, M.D.
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Low Vision Rehabilitation

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R. Michael Siatkowski, M.D.

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Matthew D. Bown

RMS/jw

December 10, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1392-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

I am writing with regard to the new CPT code 68816 for balloon dilatation of the nasolacrimal duct. I am concerned about the proposed fee schedule in this regard. In only very rare cases would this procedure be able to be performed in the office and almost always I do it under general anesthesia. In order to minimize costs, an ambulatory surgical center is much more efficient than a hospital outpatient setting. Thus, as currently proposed, the ASC proposed reimbursement service is a financial deterrent, pushing patients toward treatment in a more costly hospital outpatient setting.

The standard of care has now changed such that balloon dilatation is an appropriate treatment of choice when primary probing does not succeed, or in older patients who have never had primary probing. In addition, the ability to irrigate and suction fluid immediately after the surgery is another advantage of the ASC setting. It should be noted that the balloon dilatation procedure is technically more difficult to perform than the probing and irrigation, and takes a longer period of time, in part due to the time required for dilatation, and in part, due to the fact that the system must be probed and partially dilated before the Lacricath can be used.

In summary, I would recommend that you reconsider normalizing ASC reimbursement relative to the hospital, and also note that when deciding upon physician payment that the time and expertise required for successful balloon intubation and dilatation is certainly greater than simple probing and on par with that for silicone tube intubation.

Thank you for your time. Please do not hesitate to contact me if I can provide any further information.

Yours very truly,



R. Michael Siatkowski, M.D.
Professor of Ophthalmology



Ophthalmic Plastic Surgery
PLLC

Dale R. Meyer, MD, FACS
Rhonda V. Barrett, MD

December 12, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1392-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Sir or Madam:

It has recently come to my attention that a new CPT code has been proposed for balloon catheter dilation of the nasolacrimal duct for nasolacrimal duct obstruction. I understand that this code was created with the assumption that the procedure can be done in any setting without general anesthesia, that it does not take more time than a simple probing, and that it is therapeutically equivalent to a probing.

I am an ophthalmologist with specialty of oculoplastic surgery. Most of the patients in whom I perform this procedure have failed other measures. Most of my patients with nasolacrimal duct obstruction are children, but adults as well are treated. Patients generally require a full general anesthesia or sedation (MAC) in an operating room. I believe my practice is reflective of most other oculoplastic specialists. Although I would generally prefer to work in an ASC, most of the children receive treatment in a hospital outpatient setting.

The time required for balloon catheter dilation is decidedly longer than that required for a simple probing. Although both are relatively short procedures, each duct requires 5 minutes longer for the balloon procedure. In our operating rooms, probings require about 30 minutes for one eye and balloon catheter dilations 35 or 40 minutes for total OR time scheduling.

Finally, it is again important to emphasize that balloon catheter dilation is used for children who have already failed probings or children who are older in whom probings would be less likely to succeed. In children the alternative for balloon catheter dilation, is most typically silicone intubation. Complications associated with tubes in addition to additional time required to insert and remove them should be considered in the overall evaluation of the utility of balloon catheter dilation.

I understand that the physician payment for 68816 is to be decreased from \$205 (for 68815) to only \$193. In my judgment, this is an unreasonable and unjust decrease from a reimbursement that is already too low for both procedures. I might also add that the reimbursement for the ASC and hospital portions should be adequate to make it economically feasible to perform these procedures.

I appreciate your consideration in this matter.

Dale R. Meyer, MD, FACS
Professor of Ophthalmology

PEDIATRIC OPHTHALMOLOGY OF ERIE

Nicholas A. Sala, D.O.

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December 12, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1392-FC
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7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CPT 68816

To Whom It May Concern:

I will attempt to make this letter brief. I am a pediatric ophthalmologist in Erie, Pennsylvania that does 95% pediatric ophthalmology and 5% adult strabismus and adult nasolacrimal disorders. I have been using the LacriCATH since its inception. I find this to be a much easier and a much better option for recalcitrant dacryostenosis that has failed standard probes and in patients that present requiring a primary procedure as they are older. Prior to the LacriCATH, I had done silicon intubation for years. Silicon intubation is also a very nice and successful procedure, however with it comes the difficulties in dealing with a retained material in the nasolacrimal system for up to six months and then there are times in which we are required to remove the material under general anesthesia.

As a reimbursement number is being determined for 68816, I think it is important to indicate that this procedure is done under general anesthesia in every single instance in my practice. I cannot imagine for a moment that this could be done readily and tolerated in an office setting. I would not even offer this as an option to an adult patient. I definitely feel that general anesthesia should be taken into account as a reimbursement value is being determined. The actual equipment required for this procedure is costly as well and the current reimbursement may not even be sufficient enough to cover the expenses of the surgery centers and/or hospitals.

Hopefully you will take some of these considerations into account as decisions continue to be made as to an appropriate reimbursement for this procedure. I hope this information is of benefit to you. If I can be of further assistance, please notify me.

Sincerely,



Nicholas A. Sala, D.O.



LIONS EYE INSTITUTE

of Albany

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7 December 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1392-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

To Whom It May Concern:

It has recently come to my attention that a new CPT code has been created for balloon catheter dilation of the nasolacrimal duct for nasolacrimal duct obstruction. This code was created with the assumption that the procedure can be done in any setting without general anesthesia, does not take more time than a simple probing, and is therapeutically equivalent to a probing.

As I am a pediatric ophthalmologist, all of my patients with nasolacrimal duct obstruction are children, generally between 12 and 30 months of age. No anesthesia other than a full general anesthesia would be appropriate. There is no ambulatory surgery center in our area where children can receive anesthesia for such surgery. Although I would prefer to work in an ASC, I simply must operate these children in a hospital outpatient setting.

The time required for balloon catheter dilation is decidedly longer than that required for a simple probing. According to the accepted protocol, each duct requires 5 minutes longer for the balloon procedure. In our operating rooms, probings require about 30 minutes for one eye and balloon catheter dilations 35 or 40. Finally, it is important to emphasize that balloon catheter dilation is used for children who have already failed probings or who are old enough that probings would be unlikely to succeed. It is clearly not the equivalent of a simple probing.

I understand that the physician payment for 68816 is to be decreased from \$205 (for 68815) to only \$193. In my judgment, this is an unreasonable and unjust decrease from a reimbursement that is already too low.

I appreciate your consideration in this matter.

Sincerely yours,

John W. Simon MD
Professor and Chairman

*Pediatric Ophthalmology
& Strabismus*

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Pediatric Eye Associates & Family Eye Care

34

December 9, 2007

GARY T. DENSLow, M.D., M.P.H.
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To Whom It May Concern:

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Pediatric Ophthalmologist

ALISON HANSEN, O.D.
Optometrist

AMY MCCARTHY, C.O., C.O.T.
Certified Orthoptist

MATTHEW CLAYTON, C.O.
Certified Orthoptist

I have recently learned of the new code for nasolacrimal dilation using the lacricatheterization- 68816. I am writing as a pediatric ophthalmologist with 30 years of experience in treating congenital and acquired nasolacrimal obstructions and have used the probing and irrigation as my primary procedure during this time. I do not perform intraoffice probings due to the lack of monitoring and higher risk to the patient. The ballon lacricatheterization procedure has been a real improvement in patients in which the primary probing has failed. Even though the procedure requires an increase in time and expense initially, I have found that it is easier on the patient and has less morbidity than a stenting procedure as well as requiring fewer office for followup visits. In the long run, therefore, it is less expensive and has better long term outcomes in my hands. I perform all of my surgeries in a ASC, unless medically indicated, and all should be performed under general anesthesia. I can not imagine doing a ballon lacricatheterization on a child or an adult as an inoffice procedure or without the benefits to the patient of a general anesthetic. I would be willing to attempt one, however, if someone from CMS would volunteer. We should not attempt to save money by increasing the risk and discomfort to the patient.

Cordially

Gary Denslow, M.D., M.P.H.

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Celebrating Our **10** 10th Anniversary

1 9 9 8 **ANNIVERSARY** 2 0 0 8

January 8, 2008

Mr. Kerry Weems
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1392-FC
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

Re: MS-1392-FC

Dear Mr. Weems:

The American Society of Interventional Pain Physicians (“ASIPP”) would like to thank you for the opportunity to comment on the Final Rule CMS-1392-FC, “Medicare Program: Changes to the Hospital Outpatient Prospective Payment System (“HOPPS”) and CY 2008 Payment Rates and the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates (the “Final Rule”) published in the *Federal Register* on November 27, 2007.

ASIPP is a not-for-profit professional organization comprised of nearly 4,000 interventional pain physicians and other practitioners who are dedicated to ensuring safe, appropriate and equal access to essential pain management services for patients across the country suffering with chronic and acute pain. There are approximately 7,000 physicians practicing interventional pain management in the United States. Hospital outpatient departments (“HOPD”) and ambulatory surgery centers (“ASC”), along with physician offices, are important sites of service for the delivery of interventional pain services.

ASIPP is concerned that significant payment disparities exist, and will continue to exist, for procedures performed in the ASC setting unless CMS makes certain modifications to its ASC payment methodology that will ensure that ASCs are appropriately paid for the interventional pain services that they offer to Medicare beneficiaries.

I. CMS should change the status indicator for CPT Codes 72285 and 72295 to status indicator “Q” to permit separate payment for these radiology procedures

ASIPP believes that an ASC should have the ability to receive separate reimbursement just like a HOPD when a service is performed independently.

While CMS pays separately for the radiology portion of a diskography when it is performed independently in the HOPD setting, it does not pay separately for the very same service when it is performed independently in the ASC setting. This payment decision contradicts the CMS' policy of aligning these two payment systems. We urge CMS to follow PPAC's recommendation at its December 2006 meeting that CMS apply any payment policies uniformly to both ASCs and HOPDs.

Diskography procedures have two components: an injection portion that is reported by either CPT Code 62290 (Injection procedure for discography, each level; lumbar) or CPT Code 62291 (Injection procedure for discography, each level; cervical or thoracic), and a radiology portion that is reported by either CPT Code 72285 (Discography, cervical or thoracic, radiologic supervision and interpretation) or CPT Code 72295 (Discography, lumbar, radiological supervision and interpretation). In the Proposed Rule, CMS acknowledged that the supervision and interpretation component is occasionally performed independently of a surgical procedure. CMS provides for separate payment when the radiology service is the only service reported on a claim and assigned status indicator "Q" to CPT Codes 72285 and 72295 in the Final Rule to provide for such payment.

We recommend that CMS treat the radiology portion similarly in the ASC setting. To the extent that an ASC provides the supervision and interpretation of the diskography independently, it should be paid separately just like a HOPD.

II. Diskography should be payable as a separate ASC service

ASIPP believes that diskography should be a separately payable service in the ASC. Diskography is not treated as surgical procedure eligible for separate payment under the ASC payment system. This payment policy does not reflect how diskography and other invasive radiology procedures have evolved and are important surgical techniques today.

We believe that CMS should use a more inclusive definition of "surgical" procedures. Surgical procedures are becoming increasingly less invasive due to technological advancements and open surgical techniques are being replaced or augmented by interventional radiology techniques. We recommend that CMS treat diskography as a surgical service eligible for separate ASC payment so that the ASC payment policy recognizes the use of these procedures in the operating room.

III. CMS should exercise its discretion to use hospital market basket to update the ASC conversion factor

ASIPP believes that utilizing different metrics to update the ASC and HOPD payment rates will create significant payment differentials between the two sites of service, resulting in fewer options for Medicare beneficiaries. CMS' decision to update the ASC conversion factor based on the Consumer Price Index for all urban customers ("CPI-U") when HOPDs receive an update based on the hospital market basket will exacerbate existing payment disparities.

CMS should exercise its discretion to establish a more appropriate basis for updating ASC payments. Section 333(i)(2)(C)(iv) of the Social Security Act (the "Act") gives the

agency board authority to determine the update mechanism for ASC payments. The Act merely establishes the CPI-U as a default if CMS does not establish any other mechanism.

The hospital market basket is certainly a more appropriate mechanism upon which to update payment for health care services than the CPI-U. CPI-U is not an accurate measure of the cost of providing health care services. Rather, it reflects the overall inflation rate across all commercial sectors. It is widely recognized that the cost of providing health care service is rising at a much more rapid pace than the rest of the economy. The annual hospital market basket updates have exceeded the CPI-U, and it is unlikely that the spread will narrow in the near future. These market updates account for the increased cost incurred by hospital outpatient departments to provide services. An update factor based on CPI-U will fall short of the true cost of providing services in the ASC.

Furthermore, ASCs face the same inflationary pressures as hospital outpatient departments. Both facilities purchase same cutting-edge technology and equipment, buy expensive devices, and hire nursing and clinical staff to provide surgical services. In fact, the new ASC methodology is based on the assumption that the HOPPS relative weights reflect the relative cost of performing the ASC procedures. It is nonsensical to establish ASC payment rates based on HOPPS relative weights because they have similar cost and resource utilization and then use an entirely different metric to update the ASC payment rates.

ASIPP recommends that CMS exercise its discretion to establish an ASC update factor based on the hospital market basket. Payment policies, including the payment update metric, should be applied uniformly to both systems.

IV. CMS should delay implementing the payment cap for office-based procedures

ASIPP has great concern that the payment cap for office-based procedures will effectively mean that these procedures will not be performed in the ASC. We fear that CMS' decision to cap payment for office-based procedures at the physician fee schedule non-facility practice expense in attempt to prevent any migration of services will have disastrous consequences for Medicare beneficiaries. Unless ASCs are appropriately paid for the services it provides, ASCs simply will refuse to provide those services, resulting in fewer sites of service options for Medicare beneficiaries.

A physician decides to perform a procedure outside of his/her medical office because the ASC or a HOPD is the most medically appropriate site of service for the patient. A particular patient's condition may require a higher level of care than what can be provided in the physician office. That higher level of care requires additional nursing staff, an operating room, and more sophisticated equipment than what is available in a physician office. Just like a HOPD, an ASC should be appropriately paid for the costs it incurs to provide that heightened level of care.

Unfortunately, unless ASCs are adequately reimbursed for their services, financial considerations will inappropriately drive medical decision-making. Physicians will no longer be able to provide these services in the ASC setting, resulting in fewer sites of

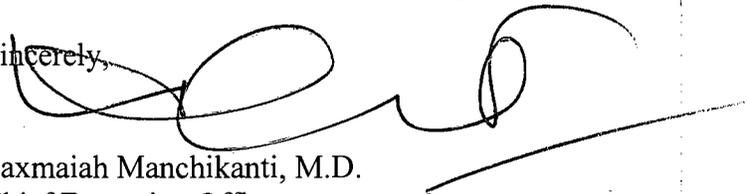
services options for Medicare beneficiaries and procedures being performed in the more expensive HOPDs.

CMS is adopting this policy because it suspects that the payment differential between the physician fee schedule rate and the ASC payment rate will inappropriately influence site of service selections. This has not been case for the office-based procedures currently performed in the ASC setting. The rate of office-based procedures performed in the ASC setting has been relatively stable over the last ten years.

ASIPP recommends that CMS refrain from adopting this payment cap until there is sufficient evidence that inappropriate migration of services is occurring. This would allow the agency, along with the physician community, to identify and evaluate the factors that are contributing to the change in utilization rates for office-based procedures and develop an appropriate policy to address the concern.

Thank you for the opportunity to comment on the Final Rule. We fear that unless CMS addresses the inequities in the ASC payment rates and policy today that there is a risk that Medicare beneficiaries will be unfairly harmed if they do not have 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.

Sincerely,


Laxmaiah Manchikanti, M.D.
Chief Executive Officer