

Submitter : Ms. Melissa Hull
Organization : Harris Methodist-Fort Worth Hospital
Category : Pharmacist

Date: 12/06/2007

Issue Areas/Comments

HCPCS codes

HCPCS codes

J0220 appears to be misspelled. I cannot find the drug 'aglucoSIDase alfa inj.' I believe it should be 'alglucosidase alpha,' in which case it replaces C9234. J0348 is also misspelled in the 2008 release, should be 'anidulafungin.' Older codes: J2910 is apparently an obsolete product since 4/06. Q3025=Avonex brand, supplied as 30mcg; dosing increment should be 10mcg for Q3025 and keep 11mcg for Q3026=Rebif, supplied as 22mcg syringe. J1835 has been D/C'd by manufacturer, last batches expire 2/08 per their letter.

General comment: PLEASE consider using drug name as first part of HCPCS desc, which makes it easier to alphabetize these on a spreadsheet, vs. using 'INJ' as the first part of some of the descriptions.

Submitter : Dr. Chris Haggerty
Organization : Piedmont Eye Associates
Category : Physician

Date: 12/12/2007

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern:

Regarding: payment for CPT code 68816

My name is Chris Haggerty and I am a dual oculoplastic fellowship trained ophthalmologist. I would like to make a few comments on the proposed payment schedule for CPT code 68816 (balloon catheter dilation of the nasolacrimal duct with placement of a Crawford tube).

First of all this procedure requires general anesthesia, so I don't think performing this procedure in an office setting makes any sense.

Secondly this procedure takes much more time, and is more technically challenging than performing a simple probing with placement of a Crawford tube (CPT code 68815). This procedure (68816) requires placing a balloon which has a larger diameter and is harder to pass and sometimes can be quite a struggle in some cases although other cases go very smoothly. It also requires several cycles of inflating and deflating a balloon. The advantage of this procedure is that it has a higher success rate in curing patients of their epiphora. I would think that a procedure that is more challenging and takes longer would receive a higher reimbursement.

Thirdly, although this procedure can be performed in an ASC, or hospital OR setting, the overall speed and efficiency in ASC settings are generally much greater than in a regular hospital OR. Currently I am prohibited from performing these procedures in the ASC secondary to the reimbursement. The balloon alone costs \$306, and your proposed payment in the ASC setting is only \$434. If you raise the reimbursement for the ASC significantly then these procedures can be performed just as well, but in a much more efficient and cheaper manner than if they were performed in a hospital.

I hope these comments are useful to you. Please feel free to contact me. Thanks so much for your time in reading my E-mail and reviewing your proposed reimbursement schedule. Sincerely, Chris Haggerty (chrishaggerty@hotmail.com, W: (864) 583-5312)

Submitter :**Date: 12/14/2007****Organization :****Category : Other Health Care Professional****Issue Areas/Comments****GENERAL****GENERAL**

In regards to the latest revisions to the payment structure for 2008, I feel it would be a great defeat for the field of radiation therapy to not promote IGRT and other localization techniques used in radiotherapy. I am a physicist in Tennessee, and we are currently utilizing the Varian Trilogy system for localization in radiosurgery techniques. We feel that this technique definitely requires imaging for localization for every patient every time, since this procedure is giving doses high enough to fatally harm patients. In addition, many of the abdominal sites we treat are moving toward IGRT because of the change in volume of the tumor sites during the course of treatment. If these procedures are not endorsed, there will be no hope for adaptive radiotherapy, which has the potential to be extremely effective in treating tumors and lessening morbidity of treatment. As it is true that not every patient requires these procedures due to the advanced stages of their diseases, many that are curable would definitely benefit from all guidance procedures because doses can be increased to the tumor volume, which is proven to provide more effective treatments. Please take these comments in consideration before the beginning of the new year. Thank you for your time,

Jonathan

HCPCS codes

HCPCS codes

77014, 77417, 77421

Submitter : Mrs. Teresa Singh

Date: 12/16/2007

Organization : Mrs. Teresa Singh

Category : Individual

Issue Areas/Comments

HCPCS codes

HCPCS codes

I am writing to urge Congress to continue Medicare funding for Diagnostic Radiopharmaceuticals: RIT. These treatments, Bexxar, and Zevalin, are lifesavers for persons with certain Non-Hodgkin's Lymphoma. Please allow us to have access to these life-saving treatments! There is no other option with minimal side-effects.

Submitter : Dr. Ashima Kumar
Organization : SUNY Downstate Medical Center
Category : Physician

Date: 12/16/2007

Issue Areas/Comments

GENERAL

GENERAL

The proposed interim payment in the ASC setting for the new CPT code 68816 is \$433.69. The payment for 68816 in the hospital outpatient setting is \$1,193.03. CMS calculated the ASC payment for 68816 based on an office setting. However, the majority of procedures are performed under general anesthesia in a hospital setting or ASC and NOT in the office.

I am a pediatric ophthalmologist practicing in an academic setting. 100% of my 68816 procedures are performed in the Hospital Outpatient setting. 100% of my probing procedures including those needing balloon dilation are performed on children, all of who require general anesthesia as there is increased risk of damage to the lacrimal system, the eye and overall stress to the child if performed in the office setting without anesthesia. Balloon dilation is the treatment of choice when primary probing does not succeed or as the primary procedure if performed over the age of one.

Performing the LaciCath procedures take at least 6-10 minutes longer per eye than the standard probing procedure. First, the standard probing is passed through the lacrimal system. Then, the LaciCath is passed. The balloon is inflated to 8 atmospheres at the 15mm mark for 90 seconds, released, then re-inflated to 8 atmospheres for 60 seconds, released; the LaciCath is then retracted to the 10mm mark and the balloon is inflated to 8 atmospheres for 90 seconds, released and re-inflated for 60 seconds, then removed. So, once the LaciCath is in place, the balloon is inflated for exactly 5 minutes plus the interim time to release the balloon and reposition the LaciCath; whereas a simple probing may take just a minute or less per eye.

The proposed lower ASC payment serves as a financial deterrent forcing us (ophthalmologists) to treat patients in the more costly hospital outpatient setting rather than in the more cost efficient ASC. The cost of the balloon catheter alone is \$306 relative to the payment of \$434 which CMS is proposing for 68816 in the ASC setting. This does not allow me or the ASC to economically treat patients in an ambulatory setting. Please feel free to contact me if you would like to speak with me directly: (cell) 202-494-8423.

Submitter : Dr. Brent Moody
Organization : Dr. Brent Moody
Category : Physician

Date: 12/18/2007

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS 1385-FC: 2008 Medicare Fee Schedule
Coding Multiple Procedure Payment Reduction for Mohs Surgery

Dear Acting Administrator Weems:

As a Mohs surgeon I am deeply concerned about the proposed rule to remove Mohs surgery from the Multiple Procedure Reduction Rule (MPRR) exemption list. This proposal represents a dramatic reversal of sixteen years of the Centers for Medicare and Medicaid Services (CMS) own determination that the Mohs codes are and should be exempt from the MPRR. I believe this proposal will negatively impact Medicare beneficiaries access to timely and quality care. In addition, application of this proposal will not likely generate significant cost savings and may paradoxically increase costs of providing care to these patients.

I have three main areas of concern with applying a 50% reduction to Mohs Micrographic Surgery.

1. In instances where the primary Mohs code (17311 or 17313) is reduced, the associated add on codes (17312 or 17314) will be more highly valued than the primary codes. As the value of the add on codes has already been determined to reflect the fact that less work is involved in the add on code, it appears inconsistent to value the primary code below the add on code. In no other family of codes in the integumentary system does this phenomenon exist, this making the reduction of the Mohs codes a true anomaly.
2. The application of a 50 % reduction is not appropriate given the amount of intraservice work in the Mohs codes. In my practice, at least 80% of the total work is repeated when a second Mohs procedure is performed. Therefore, reducing the value of this code by 50% would significantly undervalue the code when utilized a second time.
3. The application of a 50% reduction to either the Mohs surgery code or an associated reconstruction code will drive the value of the code below the cost of providing the service, thus limiting my ability to effectively care for Medicare patients.

In light of the concerns raised above, I am requesting that CMS reconsider their plan to remove Mohs surgery from the MPRR exemption list permanently or delay implementation until a refinement in the reduction can be established that will alleviate the inconsistencies that a 50% reduction will generate.

Respectfully,

Brent R. Moody, MD, FACP, FAAD

Submitter : Dr. Robert Gold
Organization : Eye Physicians of Central Florida
Category : Physician

Date: 12/19/2007

Issue Areas/Comments

GENERAL

GENERAL

As pediatric ophthalmologists, we are fortunate to be able to offer our patients/families with nasolacrimal (tear) duct obstructions several excellent procedures to permanently open the blockage. I personally am glad that the new code, 68816, specific for balloon dilation of the nasolacrimal duct, has been approved and will be instituted beginning in January of 2008. This procedure is my procedure of choice in almost all probings after the age of 2 as an initial procedure and as well if an initial probing procedure has failed. The use of the balloon dilator has allowed me to have successful results without the potential complications of silicone intubation into the tear duct. The most common complication of intubation is dislodging of the tube, which in a study that I presented as a poster at a recent AAPOS (American Association of Pediatric Ophthalmology and Strabismus) meeting was 19.7%. Other complications included canalicular cheesewiring, corneal abrasion, difficulty with tube placement, post operative monitoring and a 20% rate of needing a second anesthesia for tube removal. There were no complications with the balloon dilation procedure in my study.

In general, the balloon dilation procedure is more complex and time consuming than the silicone intubation, and thus I strongly feel that the physician reimbursement should be allocated accordingly. The physician should be paid more than the reimbursement for silicone intubation and that is not reflected in the 2008 schedule. In addition, this procedure should be performed for the most part in ASCs, but the cost of the goods do not even make up for the ASC costs and thus we currently have to take these patients to hospitals for their surgery instead of the more cost effective ASCs.

Sincerely,
Robert S. Gold, M.D.
Pediatric Ophthalmology
Eye Physicians of Central Florida
Orlando, FL
407-767-6411
RSGEye@aol.com

Submitter : Dr. Timothy Lubenow
Organization : Rush University Medical Center
Category : Physician

Date: 12/20/2007

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

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 CMSs 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 Cod 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.

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.

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,

Timothy R. Lubenow MD
Rush University Medical Center
Chicago, IL 60612 Phone number 312.942.6504

Submitter :

Date: 12/20/2007

Organization :

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Comments to CMS Regarding the Final Rule on Patient Signatures by December 31st Deadline.

The implementation of this new rule presents a great burden on suppliers and providers alike, for no real time has been afforded to properly train our staff which has created much confusion and it appears that the Medicare contractors are also confused as to how the regulations should be applied. I am confused as to why this rule is even necessary and I believed the current regulation regarding the signature requirement is more than sufficient.

I ask that you consider repealing this final rule and or afford more time so this rule can be properly implemented and additional training can be conducted.

Submitter : Mrs. Heather Keenan
Organization : MAPS Medical Pain Clinic
Category : Health Care Professional or Association

Date: 12/21/2007

Issue Areas/Comments

HCPCS codes

HCPCS codes

CMS-1392-FC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
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 : Ms. Georgann Gillund
Organization : MAPS Medical Pain Clinic
Category : Health Care Professional or Association

Date: 12/21/2007

Issue Areas/Comments

HCPCS codes

HCPCS codes

CMS-1392-FC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
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Please direct your questions or comments to 1 800 743-3951.

Submitter : Ms. Megan Menning
Organization : MAPS Medical Pain Clinic
Category : Health Care Professional or Association

Date: 12/21/2007

Issue Areas/Comments

GENERAL

GENERAL

December 21, 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 staff member of an 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.

HCPCS codes

HCPCS codes

CMS-1392-FC

Submitter : John Mostek

Date: 12/26/2007

Organization : John Mostek

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a patient who relies on interventional pain management physicians for my care. I am writing to you because of my grave concern for the future of patient access to this type of care. Based on my knowledge of the planned reduction in reimbursement, it is my firmly held belief that, unless Congress takes action soon, seniors will lose access to interventional pain management. If past actions are any guide, it is certain that Medicaid and third party payors will follow Medicare, cutting their reimbursement for these valuable services as well.

As a concerned patient, I write urging you to take steps to stop the pending physician reimbursement cuts and the devastating ASC cuts for interventional pain management procedures. I am extremely disappointed that Congress does not appear to be willing to take action prior to the holiday recess. This inaction could very well cause seniors to lose access to interventional pain management.

I understand that the physician payment fix should be for at least two years with a change in the law rather than yearly fix which will accumulate the cuts in the third year to 20% at one time. I also support modest cuts for Medicare Advantage Plan; however, we do not support complete elimination of Medicare Advantage Plans. This is especially true in Illinois as malpractice costs are rising for interventional pain management physicians. Based on these statistics it is obvious that physicians will have an extremely difficult time continuing to practice and offer the care that they are currently.

A second issue of concern relates to ambulatory surgery center payment cuts for interventional pain management procedures. This is one of the most effective locations for these procedures to be performed, along with physician offices. Since the Government has decided to reduce payments to offices and ASCs, we will be forced to return to the hospital setting. This is, without a doubt, a less effective, more inefficient, and more expensive setting. It appears to be criminal to punish both of the most effective interventional pain management settings, namely the offices, and ASCs, with draconian cuts. If this is allowed to stand, it will significantly affect our access to these valuable services which have significantly improved our quality of life.

Although we appreciate the bills introduced by Honorable Mike Crapo (R-ID) in the Senate and Honorable Kendrick Meek (D-17th FI) and Wally Herger (R-2nd CA) in the House; these unfortunately will not fix the ASC issue for interventional pain management. They also would be extremely expensive and consequently, we request a temporary reprieve for interventional procedures performed in ASCs by a carve-out for 9 procedures which will cost \$8 million in the year 2008 and a total of \$34 million by 2010.

Please act immediately, as these issues are extremely important to the American public, namely your voters. I am very much interested in hearing your response and hoping for your support on these important issues.

Once again, thank you for all your help.

Submitter : Ms. Kimberly Finchium
 Organization : Ms. Kimberly Finchium
 Category : Individual

Date: 12/26/2007

Issue Areas/Comments

GENERAL

GENERAL

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 For more information visit www.asipp.org

Print Name: _____

Signature: _____

Email address: _____

Submitter : Ms. Angela Sherman
Organization : Ms. Angela Sherman
Category : Individual

Date: 12/26/2007

Issue Areas/Comments

GENERAL

GENERAL

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For more information visit www.asipp.org

Print Name: _____

Signature: _____ Date: _____

Email address: _____

Submitter : Mr. Michael Kimmer

Date: 12/26/2007

Organization : Mr. Michael Kimmer

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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For more information visit www.asipp.org

Print Name: _____

Signature: _____ Date: _____

Email address: _____

Submitter : Ms. Joan Bernicky
 Organization : Ms. Joan Bernicky
 Category : Individual

Date: 12/26/2007

Issue Areas/Comments

GENERAL

GENERAL

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 For more information visit www.asipp.org

Print Name: _____

Signature: _____

Email address: _____

Submitter : Ms. Nancy McIntyre

Date: 12/26/2007

Organization : Ms. Nancy McIntyre

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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Once again, thank you for all your help.
For more information visit www.asipp.org

Print Name: _____

Signature: _____

Email address: _____

CMS-1392-FC

Because the referenced comment number does not pertain to the subject matter for CMS-1392-FC, it is not included in the electronic public comments for this regulatory document.

Submitter : Mr. Thomas Horney

Date: 12/26/2007

Organization : Mr. Thomas Horney

Category : Individual

Issue Areas/Comments

GENERAL

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Print Name: _____

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Submitter : Mrs. Kristine Lobotzke
Organization : Mrs. Kristine Lobotzke
Category : Nurse

Date: 12/26/2007

Issue Areas/Comments

GENERAL

GENERAL

December 26, 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 nurse I would like to comment on multiple disparities which exist between ASC setting and HOPD setting. These disparities and the CMSs 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 Cod 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.

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.

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

Sincerely,
Kristine Lobotzke RN
414-325-3701
Greenfield WI 53221

Submitter : Mr. Doug Krikava

Date: 12/26/2007

Organization : Mr. Doug Krikava

Category : Individual

Issue Areas/Comments

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Submitter : Ms. Patricia Behan

Date: 12/26/2007

Organization : Ms. Patricia Behan

Category : Individual

Issue Areas/Comments

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