

**Submitter :** Dr. Colin Shafer  
**Organization :** Pioneer Valley Cardiology  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

**Coding-- Additional Codes From 5-Year Review**

This letter is in regards to the potential bundling of color Doppler into the other echo based codes:

In our practice we do not perform color Doppler on all echo studies. It takes my sonographers a substantial amount of time to perform adequate Doppler when appropriate. This is the most challenging and difficult portion of the echocardiogram to perform well and to interpret. It borders on ridiculous for this fee to be removed and 'lost'. Frankly, the cost of performing echos for our patients has increased over time as we have had to buy new equipment (machines, digital storage and reading platforms as VCRs become obsolete) costing hundreds of thousands of dollars. Further decreases in reimbursement for this procedure is absolutely unacceptable.

The federal register citation for this issue is 72 Federal Register 38122 (July 12, 2007).

**Submitter :** Dr. Steven Fein  
**Organization :** Albany Medical College  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding--Reduction In TC For  
Imaging Services**

**Coding--Reduction In TC For Imaging Services**

Mark McClellan, MD, PhD  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
P.O. Box 8017  
Baltimore, MD 21244-8018  
Re: CMS 1512-PN; PRACTICE EXPENSE

Dear Dr. McClellan:

I am a practising cardiologist and the Director of the Non Invasive Diagnostic Center at Albany Medical Center in Albany NY, and I am delighted to have the opportunity to comment on the Proposed Notice published by CMS in the Federal Register of June 29, 2006, which sets forth proposed changes to the relative value units used to establish payment for services to Medicare patients under the Physician Fee Schedule.

I am extremely concerned about the possible impact of these changes on Medicare payment for cardiac ultrasound and other cardiac imaging services performed in the office setting. While the Proposed Notice would result in increases in Medicare payment for some of the services that we provide most notably evaluation and management services we are concerned that, by the end of the transition period, the Proposed Notice would result in payment reductions in the range of 25% for the most common combination of echocardiography procedures (transthoracic echocardiogram with spectral and color flow Doppler (CPT codes 93325, 93320 and 93325). Echocardiography is a crucial tool in the diagnosis of a broad range of cardiac disease, including congestive heart failure, congenital heart disease, valve disorders, and coronary artery disease. The performance of echocardiography requires the acquisition and maintenance of costly medical equipment and the retention of highly trained cardiac sonographers who are in increasingly short supply. We are concerned that payment reductions of the magnitude outlined in the Proposed Notice may have an adverse impact on the overall quality of the echocardiography services provided to our patients at the very time that the federal government is seeking to improve quality through pay for performance and similar quality-related initiatives.

While I am not in a position to provide a complete technical analysis of the Proposed Notice, I understand that the American Society of Echocardiography (ASE) is conducting such an analysis and will be submitting comprehensive comments. I support those comments, and strongly urge you to consider making the changes suggested by ASE in the Final Rule.

Thank you for your attention to this most important matter.

Sincerely yours,  
Steven A. Fein, MD

**Submitter :** Dr. Peter Kolbeck

**Date:** 08/07/2007

**Organization :** Path Logic

**Category :** Physician

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

August 7, 2007

As a board-certified practicing pathologist, director of the California Society of Pathologists, and member of the College of American Pathologists, I appreciate the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services.

I practice in Sacramento, CA as part of 7-member pathology group that operates an independent pathology laboratory that performs testing for physicians, hospitals and surgical centers throughout California. I am aware of arrangements in California that give physician groups a share of the revenues from the pathology services ordered and performed for the group's patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

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

Sincerely,

Petr C. Kolbeck, M.D.  
President, Path Logic  
3637 Mission Ave., Bld A, #5  
Carmichael, CA 95608

**Submitter :** Dr. Judy Mangion  
**Organization :** Brigham and Women's Hospital  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

Coding-- Additional Codes From 5-Year Review

I am disappointed to learn that CMS has proposed 'bundling' color flow Doppler into all the other echocardiography base codes, without providing any additional payment for those base codes, based on the argument that color flow Doppler has become 'intrinsic to the performance' of all echocardiography procedures. I am very concerned that if the 'bundling' takes effect, that physicians will have no incentive to perform high quality color Doppler studies, which are critical for determining which patients require surgery on their valves, versus which can be managed medically. High quality color Doppler is extremely valuable for providing quantitative, evidence based, information to help with surgical decision making. Used appropriately, this technique can be technically demanding, and can add at least 10 minutes to the study. I am concerned if color Doppler gets bundled with the other procedures, not only are physicians going to be forced to make decisions with inadequate information, but that this will result in other more invasive tests such as cardiac catheterization to be utilized, in order to obtain the appropriate information....color Doppler is extremely cost effective for the added value it provides...please to not take a cost-effective test, and make it unusable due to lack of appropriate reimbursement.

Sincerely,

Judy R. Mangion, MD

**Submitter :** Dr. Walter Mashman  
**Organization :** Fuqua Heart Center of Atlanta  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in Atlanta, Georgia, I am writing to object to CMS's proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS's proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler's role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

Walter Mashman, M.D., F.A.C.C.  
The Fuqua Heart Center of Atlanta  
Atlanta, Georgia 30309

**Submitter :** Dr. Clint Gosse  
**Organization :** Gosse Chiropractic LLC  
**Category :** Chiropractor

**Date:** 08/07/2007

**Issue Areas/Comments**

**Chiropractic Services  
Demonstration**

**Chiropractic Services Demonstration**

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

Re: TECHNICAL CORRECTIONS

The proposed rule change that discontinues the ability of a chiropractor to order an X-ray for a patient through another non-treating provider is extremely detrimental to the beneficiaries of Medicare Part B. Currently it is difficult at best, and impossible at worst for chiropractors to refer Medicare patients to medical physicians for second opinions and management of conditions that lie outside the chiropractor's scope of practice. With the complexity of a patient's medical care increasing with age, and the increasing amount of technological advancement in medicine, it is of highest importance to allow all physicians to have a full arsenal of interventions and diagnostic tools when considering a Medicare Beneficiary's care.

Specifically, chiropractors are defined by statute as primary care providers. Limiting our ability to be reimbursed for services such as examination, x-ray, and therapeutics ties our hands behind our back on the quality and amount of evidence-based health care available to the patients we see. There is already a large disparity between the payment of services to chiropractors versus the payment of comparable services to other healthcare providers, but to a limit chiropractor's ability to even refer a patient to another healthcare provider further narrows our ability to treat and serve the public. Not only that, but it nurtures an atmosphere of isolation among chiropractic providers which will undoubtedly lead to further alienation of our services to the medical community. As a provider I have seen first-hand the effects of the limitations Medicare already places on the care of chiropractic patients, and would implore that the Department of Health and Human Services reconsider their position on the technical corrections made in CMS-1385-P to disallow the payment for x-ray examinations to non-treating physicians when taken at the request of a referring chiropractic physician.

Sincerely,

Clint J. Gosse, D.C.  
702C East Willow Drive  
Spencer, WI 54479  
gossechiropractic@gmail.com  
(715) 659-4411

**Submitter :** Dr. Peter Mercurio  
**Organization :** Westchester Health Associates  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding--Reduction In TC For  
Imaging Services**

Coding--Reduction In TC For Imaging Services

please note

that color flow doppler is not always performed with an echo procedure and when it is , it requires additional time from the sonographer to perform the additional study as well as additional time on the part of the interpreting physician to interpret the study Please do not bundle these studies Thanks Peter Mercurio

**Submitter :** Dr. Daniel Niendorff  
**Organization :** Medical Resources NW PC  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

**Coding-- Additional Codes From 5-Year Review**

I became aware that CMS is considering bundling the color flow evaluation in with other echocardiography codes. I am very concerned by this. Removing additional payment for color flow doppler would ignore the additional time that is required of both the sonographer and the physician to obtain and interpret the additional color flow data. This is truly a time issue, and time is spent that should be compensated fairly. Additionally, there is a real cost to the equipment to perform the color flow analysis, and that cost also deserves fair compensation. I request that you carefully evaluate the cost in time and equipment involved in color flow doppler, and I think you will see that these elements merit a fair compensation.

Sincerely,

Daniel F. Niendorff, MD

**Submitter :** John Krier RDCS

**Date:** 08/07/2007

**Organization :** John Krier RDCS

**Category :** Other Technician

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

Coding-- Additional Codes From 5-Year Review

Bundling of Doppler IS appropriate. Not performing doppler would be malpractice. I am a registered echo tech. I have never performed an echo without doing doppler. Doppler is a crucial aspect of the exam. Please note that nearly half of my exam time is doing doppler iamges and measurements. Bundle the code, but continue to pay for it. Don't pay for a 2D only echo! Require doppler, and pay for it.

**Submitter :** Dr. T Pratap

**Date:** 08/07/2007

**Organization :** Dr. T Pratap

**Category :** Physician

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

Coding-- Additional Codes From 5-Year Review

We do not perform color doppler studies on all our echo studies. Color doppler entails significant physician and sonographer time. It takes as much time to perform color doppler as it takes to perform the rest of the study!!

**Submitter :** Dr. Michael Mitchell  
**Organization :** Dr. Michael Mitchell  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

**Physician Self-Referral Provisions**

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Worcester, Massachusetts as part of reference laboratory within a hospital Department of Pathology. We are the primary provider for the residents of Central Massachusetts.

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

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

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

Yours truly,

Michael Mitchell, M.D.  
Director, Microbiology and Genetics Services

**Submitter :** Dr. Elizabeth Klodas  
**Organization :** Cardiovascular Imaging Consultants  
**Category :** Individual

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I am appalled that CMS would consider 'bundling' Doppler codes together with the 2D component of an echocardiographic evaluation WITHOUT additional compensation for the echo code. Doppler imaging (whether color, pulsed, or continuous wave) requires specialized skills on the part of the sonographer and interpreting physician, significant additional time for performance and interpretation of the study, and more sophisticated equipment. Indeed, equipment purchase decisions often come down to Doppler signal quality. Incomplete, or poorly performed Doppler evaluations can MARKEDLY impact the quality of the interpretation and could lead to inappropriate therapeutic decisions with potentially dire consequences. This is not a matter of turning a button on and off. This interrogation requires immense skill on the parts of both the performing and interpreting individuals, and often accounts for over half of all the image data. Finally, not ALL echocardiographic studies are performed with these add-on codes. Limited studies for follow-up of LV systolic function do not require the addition of Doppler imaging. If CMS INSISTS on 'bundling' these codes together, then reimbursement for the bundled code MUST be appropriately (and significantly) increased to reflect the significant added work, experience, time, and practice cost associated with the included bundled services.

**Submitter :** Dr. Jay Lisker  
**Organization :** The Cardiology Group  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

**Coding-- Additional Codes From 5-Year Review**

Color flow Doppler is, indeed an integral portion of many echocardiographic examinations. By "bundling" this into other codes and indirectly detracting from the total reimbursement of a complete echocardiographic examination you are not taking into account the cost of expertise and technical requirements that allow for this tool to be our best, non-invasive test for the sickest population of heart disease.

**Submitter :** Dr. Martin O'Laughlin  
**Organization :** Dr. Martin O'Laughlin  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

**Coding-- Additional Codes From 5-Year Review**

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Mr. Herb Kuhn, Center for Medicare and Medicaid Services

Dear Sir:

I am a Pediatric Cardiologist in Kansas City, Missouri who provides echocardiography services to Medicaid and occasionally Medicare patients and others in the greater Kansas City area. I have been a Pediatric Cardiologist for 20 years, at Baylor College of Medicine, Duke University Medical Center, and now in Kansas City. I am writing to urge you to reject the proposal to 'bundle' Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography 'base' services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become 'intrinsic to the performance' of all echocardiography procedures. It is fair to assume that private insurers and Medicaid would follow suit.

I understand that the recommendation from the CPT editorial panel is that 93325 be bundled with 93307 and not with the other echocardiography codes listed in the File Code CMS-1385-P. Importantly, the use of color Doppler in pediatric cardiology is substantially different from that in adult cardiology, and some of the risk higher (consider merely the much longer statute of limitations for negligence and other suits).

This 'bundling' would be like a government agency's deciding that its beneficiaries could not be asked to pay any extra to a car dealer for 4 wheel drive versus front wheel drive because a drive train is 'intrinsic' to the construction of an automobile. It conjures up a government's deciding not to pay attorneys with whom it works costs of photocopying because copies are 'intrinsic' to the practice of law. It is somewhat analogous to a governing body's eliminating reimbursement for grapefruit at a grocery store because vitamin C is intrinsic to a healthy diet. With private payor reimbursement tied inextricably to that of CMS, any CMS cuts have a bigger impact on my practice than just their Medicaid effects.

I am worried about the reductions themselves in physician reimbursement for services. This proposal would be unduly burdensome to pediatric cardiologists.

I think that a great part of the problem is that much of the debate is semantic. If one looks hard enough, almost any procedure described by a CPT code can be considered part of another code. Thus coronary angioplasty would not be paid separately from cardiac catheterization, cardiopulmonary bypass would not be considered a separate part of heart surgery, and balloon dilation of the pulmonary valve would be folded into a congenital heart catheterization although it is clearly an additional procedure. An example of a bundled code that demonstrates bundling gone wild is the payment scheme for services rendered to a newborn infant with transposition of the great arteries, in whom cardiac catheterization is bundled with balloon atrial septostomy. The septostomy adds both a critically-needed level of skill and precision and level of danger and risk to the intervention, but the catheterization and septostomy are bundled (and markedly under-reimbursed). Perhaps the test should be whether a code is reasonable to stand separately rather than whether it can fit logically into something else and thus not be reimbursed. I will tell you that, in my judgment, color Doppler is reasonable to be kept as an add-on code, because it is not 'intrinsic' or inseparable from echocardiography. It requires additional equipment capability and (especially in children and people with congenital heart disease) an important additional level of training and experience.

I urge you to reject the proposed 'bundling' of color flow Doppler into other echocardiography procedures, and to leave the code as is. Thank you very much.  
Sincerely, Martin P. O'Laughlin, M.D.

**Submitter :** Ms. Leanne Harmann  
**Organization :** Medical College of Wisconsin  
**Category :** Other Technician

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

As a cardiac sonographer who provides echocardiography services to Medicare patients and others in Milwaukee, WI, I am writing to object to CMS's proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decision-making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS's proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler's role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirms that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years. Important to the quality care of a critically ill patient is the serial monitoring of cardiac anatomy and function. In this example, color flow Doppler is not employed and in our institution this exam is billed appropriately.

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

Leanne M. Harmann, RDCS, RDMS, RVT  
Medical College of Wisconsin  
Milwaukee, WI 53226

**Submitter :** Mrs. Monica Swinford  
**Organization :** Mrs. Monica Swinford  
**Category :** Other Health Care Professional

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding--Reduction In TC For  
Imaging Services**

**Coding--Reduction In TC For Imaging Services**

It is unfortunate that you continue to try to reduce the reimbursement for echocardiography. It is the cheapest test the doctor can order and get the most information!! Now, you want to 'bundle' an important part of the exam into a single code. This is ridiculous. Color Doppler is a separate entity in the performance of an echocardiogram. Whether or not color doppler is used depends on the pathology present and symptoms of the patient. When making decisions about cutting reimbursement, please remember that you are cutting the quality of the exams... if you lump it all into one code, why should sonographers even attempt color doppler? It takes time and effort that will not be paid for!! Color Doppler was not available when ultrasound became a diagnostic imaging modality, it was invented for a reason... because it is a helpful and necessary tool for getting a comprehensive echocardiogram!!

**Submitter :** Dr. Gerard Freisinger  
**Organization :** St Anthony Community Hospital  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding--Reduction In TC For  
Imaging Services**

**Coding--Reduction In TC For Imaging Services**

Re: Bundling of color doppler into standard echo exam. An echo/doppler exam can be as complicated and time consuming as is needed for everything from ischemia to evaluation for biventricular pacing appropriateness. Newer modalities added to ultrasound include spectral and color doppler, tissue doppler with strain and strain rate imaging, tissue synchronization imaging, use of i.v. with bubble study, contrast imaging, non doppler speckle imaging, etc. All these modalities can tell the clinician about physiology explaining symptoms of shortness of breath, pain, prognosis, therapeutic intervention, etc. Equipment and training and performance all are increased in terms of time and cost. Yet, it is still cheaper than nuclear, cath and hemodynamic bedside monitoring. So much information can be gained without reverting to more expensive invasive studies. Yet the reimbursement has come down steadily the more complicated the study and the more information of value gained as well as the more quality control involved in terms of certification of providers and laboratories. There is something wrong with such a system. Please reevaluate your decision to reduce reimbursement for color flow and consider adding coding for tissue doppler, speckle doppler and the host of other modalities used in association with the "common" echo exam. For diastolic function alone, one looks at atrial volumes, E/Em ratio, E/A ratios with valsalva, color flow propagation velocity, pulmonary c wave reversal and for pulmonary pressures, rate corrected isovolumic relaxation time. And newer parameters are being studied all the time.

Please reconsider your decision to bundle methods of evaluation and consider various levels of an echo exam from a simple look for a prolapse to a more complicated evaluation which might take over an hour to assess.

Yours truly, Gerard Freisinger, MD age 69 with 35 years of echo experience and Director of Noninvasive Laboratory at St Anthony Community Hospital, Warwick, NY.

**Submitter :** Dr. Joseph Graham  
**Organization :** Heart and Vascular Care, P.C.  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

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Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a Cardiovascular Surgeon who provides echocardiography services to Medicare patients and others in Heart and Vascular Care, P.C.Joplin, MO, I am writing to object to CMS's proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions, including quantitation of regurgitation area ratio for disease classification, and used in serial echoes to determine progression of disease.

CMS's proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler's role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

Joseph Graham  
Heart and Vascular Care, P.C.

**Submitter :** Dr. Dinesh Kushangi

**Date:** 08/07/2007

**Organization :** AAKC

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Dinesh Kushangi

**Submitter :** Mrs. Lisa Durand  
**Organization :** Cardiology Consultants of Central MA  
**Category :** Health Care Professional or Association

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a cardiac sonographer who provides echocardiography services to Medicare patients and others in Worcester Massachusetts, I am writing to object to CMS's proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS's proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler's role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

Lisa Durand, RDCS  
Cardiology Consultants of Central MA

**Submitter :** Dr. Joseph Golubski  
**Organization :** Great Lakes Pathologists, S.C.  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

**Physician Self-Referral Provisions**

August 7, 2007

I am submitting comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified dermatopathologist and a member of the College of American Pathologists. I practice in Sheboygan, Wisconsin as part of Great Lakes Pathologists, S.C. which is a 42-member pathologist group based in West Allis, Wisconsin.

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

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

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

Sincerely,

Joseph F. Golubski, D.O.

**Submitter :** Dr. Melton Fish  
**Organization :** Good Shepherd Medical Center  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Longview, Texas at Good Shepherd Medical Center, as part of Community Pathology Associates, with four pathologists at this hospital.

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

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

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

Sincerely,

Melton H. Fish, D.O.

**Submitter :** Dr. Eric Stevens

**Date:** 08/07/2007

**Organization :** Southern Indiana Pathologists

**Category :** Physician

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

**Physician Self-Referral Provisions**

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program, Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Bloomington, Indiana as part of a 4-member hospital-based pathology group.

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

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

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

Sincerely,

Eric C. Stevens, M.D.

**Submitter :** Mr. Tim Chambers  
**Organization :** Diagnostic Health Services  
**Category :** Other Health Care Professional

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

**Coding-- Additional Codes From 5-Year Review**

The proposal to re-bundle color flow Doppler into existing codes is based on a false premise. The expense of the technology adding this ability is significant. While color flow is a regular component of a standard exam, there are still opportunities to perform an exam without using color flow. When echo codes were unbundled years ago, the rationale was to reimburse those who had incurred the additional expense to add color flow technology to their imaging systems. Re-bundling the codes will allow non-quality providers to cut corners and still receive the same reimbursement as a provider that follows ASE and ICAEL standard protocols.

I strongly urge you to not support this proposal to bundle CPT codes relating to echocardiography.

**Submitter :** Dr. Mark E. Van Wormer  
**Organization :** Union County Medical Center  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

Coding-- Additional Codes From 5-Year Review

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a {physician} {cardiac sonographer} who provides echocardiography services to Medicare patients and others in Clayton, New Mexico I am writing to object to CMS's proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decision-making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS's proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler's role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirms that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, Tran esophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

Mark E. Van Wormer  
M.D. RVT, RDCS, ABAAM

**Submitter :** Dr.  
**Organization :** Dr.  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Color Flow Doppler should not be bundled into all echo procedure reimbursement. This takes more physician and sonographer time to complete!

**Submitter :** Dr. Mark Lovich  
**Organization :** Caritas St. Elizabeth's Medical Center  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

**Coding-- Additional Codes From 5-Year Review**

Please preserve the coding for color flow dopler. It is not a routine part of every TEE exam and requires considerable time, expertise and interpretation. To use this tool effectively, one has to be well trained and also have an intuitive feel for the physics and mathematics behind color dopler, thus preventing gross misinterpretation and misdiagnosis. We frequently use this tool to change surgical plan, which is a tremendous benefit to patients. It therefore should be reimbursed separately. Changing the current system can only degrade the field of echocardiography and ultimately diminish care.

**Submitter :** Dr. Bernard Schrager  
**Organization :** Miami Cardiology Group  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

**Coding-- Additional Codes From 5-Year Review**

RE: CMS 1385 P, Proposed Physician Fee Schedule and other Part B Policies for CY 2008. CODING ADDITIONAL CODES FROM 5-YEAR REVIEW

As physicians who provide echocardiography services to Medicare patients and others in Miami, FL, I am writing to object to CMS's proposal to bundle Medicare payment for color flow Doppler (CPT 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color flow Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting) and for quantifying the severity of these lesions. In particular, color flow Doppler information is critical to the decision-making process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS's proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expense and physician work relative value units involved in performance and interpretation of these studies. The performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased as color flow Doppler's role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include color flow Doppler approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

Lawrence Blacher, M.D., F.A.C.C.  
Bernard Schrager, M.D., F.A.C.C.  
Curtis Hamburg, M.D., F.A.C.C.  
Paul Seigel, M.D., F.A.C.C.  
John Morytko, M.D., F.A.C.C.  
Fernando Mera, M.D., F.A.C.C.  
Jonathan Roberts, M.D., F.A.C.C.  
Robert Ullman, M.D.

**Submitter :** Dr. Michael Buchan  
**Organization :** Anesthesia Medical Group of Riverside, Inc.  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just \$16.19 per unit. This amount does not cover the cost of caring for our nation's seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations. At the present time my 20+ physician group finds it very difficult to recruit new physicians to our Southern California location because of our large Medicare population resulting in physician incomes significantly below the national average. When this is combined with high cost of housing and high taxes, it's a no win situation. If CMS wishes to have anesthesiologists care for the senior population it needs to provide market rates for payment.

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

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

Thank you for your consideration of this serious matter.

Michael J. Buchan, M.D.

**Submitter :** Dr. Peter Frommelt  
**Organization :** Medical College of Wisconsin  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding--Reduction In TC For Imaging Services**

**Coding--Reduction In TC For Imaging Services**

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a pediatric cardiologist who provides echocardiography services to Medicare patients and others in Wisconsin, I am writing to object to CMS's proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. Most importantly, color flow Doppler is critical in the accurate diagnosis of many other congenital heart disease, where flow patterns in the heart must be accurately characterized.

CMS's proposal to 'bundle' (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler's role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is 'intrinsic' to the provision of all echocardiography procedures. It is specifically utilized in key situations in pediatric cardiology, including assessment of a persistent ductus arteriosus in a neonate or infant with and without complex heart disease, shunting patterns in cyanotic heart disease, and definition of coronary artery anatomy in suspected anomalous coronary artery origins. It is a separate and vital piece of the puzzle, not a routine part of 'Doppler interrogation.' I have attached a review paper I wrote which details the use of color Doppler as a specific and critical tool in the assessment of congenital coronary artery abnormalities.

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

Peter C. Frommelt, MD  
Professor of Pediatric Cardiology  
Children's Hospital of Wisconsin  
Medical College of Wisconsin  
Milwaukee, WI 53226  
414-266-2434

CMS-1385-P-5191-Attach-1.PDF

CMS-1385-P-5191-Attach-2.PDF



## Congenital coronary artery anomalies

Peter C. Frommelt, MD, FACC\*,  
Michele A. Frommelt, MD, FACC

*Division of Pediatric Cardiology, Department of Pediatrics, Medical College of Wisconsin,  
Children's Hospital of Wisconsin, 900 West Wisconsin Avenue, Milwaukee, WI 53226, USA*

Isolated congenital coronary artery anomalies have been described in approximately 1% of patients who undergo coronary angiography [1,2] and approximately 0.3% of patients at autopsy [3]. Traditionally, visualization of coronary artery anatomy has been obtained using invasive procedures, such as coronary angiography or transesophageal echocardiography [4–11]; the higher cost and increased risk that are associated with these procedures limit their usefulness as a screen for coronary anomalies. Although MRI [12–15] and CT [16] have shown promise as techniques to image coronary artery anatomy, transthoracic echocardiography has become the most important screening tool. Transthoracic echocardiography is risk-free, noninvasive, and widely available and continued improvements in ultrasound technology have made delineation of coronary artery anatomy possible in many children and adolescents.

Assessment of coronary artery anatomy has become an important component of the echocardiographic examination in many forms of congenital heart disease. This is especially critical in the preoperative evaluation of patients who have tetralogy of Fallot and d-transposition of the great arteries, where coronary anomalies are common and surgically important [17–20]. Reports of prospective identification of isolated coronary anomalies using transthoracic echocardiography have become more common in the literature and have helped to dispel the notion that coronary artery anatomy cannot be well-imaged using this technique. Echocardiographic findings in patients who have isolated coronary anomalies [21–34] have been well-characterized and the feasibility of detailed coronary imaging in patients who weigh more than 50 kg has been described [34]. The addition of color Doppler flow mapping as part of the echocardiographic examination is especially useful in identifying anomalous coronaries [23–27,34] because this tool can give the additional information of direction of flow in the anomalous vessel. Because symptoms, such as congestive heart failure, exercise-induced

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\* Corresponding author.  
*E-mail address:* pfrom@mcw.edu (P.C. Frommelt).

chest pain, and syncope can be related to congenital coronary anomalies in children and adolescents, focused interrogation of coronary anatomy using transthoracic echocardiography has become an integral part of the evaluation of any patient who presents with these complaints.

Although most isolated congenital coronary anomalies are noted as incidental findings [1–3], there can be a significant risk of myocardial ischemia, myocardial dysfunction, congestive heart failure, and sudden death in some of the anatomic subtypes of coronary artery anomalies that are related to the origin or course of the anomalous coronary [35–41]. This risk seems to be highest during childhood and adolescence; therefore, an understanding of these anomalies is important for the pediatrician and pediatric cardiologist. This article focuses on the anatomic features, mode of presentation, diagnostic findings, and surgical treatments that are available for the two most common types of isolated congenital coronary anomalies that are associated with myocardial ischemia during childhood: (1) anomalous origin of a coronary artery (AOCA) from the opposite sinus of Valsalva with an interarterial course between the great arteries and (2) anomalous origin of a coronary artery from the pulmonary artery. A brief discussion of coronary artery fistulous connections completes the article.

### **Anomalous origin of a coronary artery from the opposite sinus of Valsalva**

#### *Anatomic features*

AOCA from the opposite sinus of Valsalva has been associated with myocardial ischemia, ventricular arrhythmias, and sudden death, particularly when the anomalous coronary courses between the great arteries (Fig. 1) [34–40, 42–53]. Although AOCA from the noncoronary or posterior sinus of Valsalva has been described, it is rare and is not associated with myocardial ischemia or sudden death [36,37]. Similarly, AOCA can occur from the opposite sinus of Valsalva (either the right coronary artery arising from the left sinus or the left coronary arising from the right sinus of Valsalva) but is not associated with myocardial ischemia unless the anomalous coronary courses in between the great arteries [37,43]. When the anomalous coronary is interarterial, it can course within the myocardial sulcus between the great arteries (intramyocardial) [43] or within the anterior wall of the aorta between the great arteries (intramural) [34,54].

The mechanisms that lead to myocardial ischemia in the patient who has AOCA from the opposite sinus that courses between the pulmonary and aortic roots are unclear, but several theories have been proposed. The ostium of the anomalously arising coronary artery frequently is slitlike and likely compromises flow reserve [36]. In addition, the anomalous coronary artery usually arises at an acute angle from the aorta, rather than perpendicularly; this may alter flow patterns into that coronary artery bed [43]. Finally, it was hypothesized that the interarterial course places the anomalous coronary at risk of compression between the great arteries. This seems unlikely given the low pressure in the pulmonary

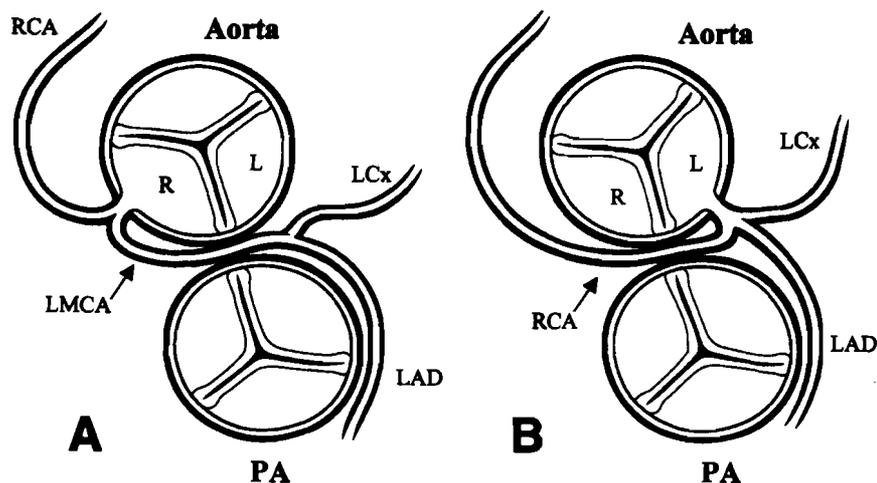


Fig. 1. Schematic diagram of the two forms of anomalous origin of a coronary from the wrong sinus that are associated with myocardial ischemia. (A) Anomalous origin of the left coronary artery (LCA) from the right sinus of Valsalva. (B) Anomalous origin of the right coronary artery (RCA) from the left sinus of Valsalva. In each case, the anomalous coronary can be seen coursing between the aorta and pulmonary artery (PA). With anomalous origin of the left coronary, the left main coronary artery (LMCA) arises from the right aortic sinus (R) and passes between the great arteries before dividing into its two usual branches, the left anterior descending (LAD) and left circumflex (LCx) coronary arteries. With anomalous origin of the right coronary, the right coronary artery (RCA) arises from the left aortic sinus (L) and passes between the great arteries before coursing in its usual distribution.

artery in normal individuals, even during exercise. The ischemia is more likely due to deformation of the anomalous coronary within the aortic wall during periods of systemic hypertension, particularly in patients who have an intramural course. Because wall tension is determined by the radius of a vessel, the aorta will have greater wall tension than the intramural coronary within the aortic wall which results in deformation of the coronary and diminished cross-sectional area. As aortic wall tension increases with increasing aortic pressure during exercise, the anomalous coronary becomes flattened and coronary reserve is reduced to a point where myocardial oxygen requirements are not met.

#### *Patient presentation*

Anomalous origin of the left coronary artery from the right sinus of Valsalva with the anomalous coronary coursing between the great arteries is rare (estimated incidence of 0.03%–0.05%) [1]; however, it is associated frequently with sudden cardiac death [35–40,42,43]. In two autopsies series that reviewed this form of AOCA, 29 of 38 and 36 of 49 patients died as a result of complications from the coronary anomaly [37,44]. Sudden cardiac death also was common and was associated frequently with exercise. In one series, all of the 23 patients who were younger than 20 years of age and had this anomaly died

suddenly during or shortly after vigorous exertion [44]. In patients who had this anomaly and had exercised-induced sudden cardiac death, 50% were asymptomatic without previous complaints of chest pain, palpitations, syncope, or an identified arrhythmia. Sudden death in older patients was much less common and cardiac death in the older group generally was associated with atherosclerotic disease. The lower risk of sudden death in older patients who had this anomaly likely is related to the fact that they rarely participate in high-intensity competitive sports.

Anomalous origin of the right coronary artery from the left sinus of Valsalva is more common (incidence estimated 0.1%) [1] and also is associated with sudden cardiac death [45–53]. In the largest review of this anomaly, 15 of 52 patients died as a result of complications from the coronary anomaly [38]. Thirteen of the 15 patients experienced sudden cardiac death and all 13 were asymptomatic without previous complaints of chest pain, palpitations, or syncope. In a separate series, 8 of 25 patients had sudden cardiac death with this anomaly; 6 of the 8 patients were younger than 33 years of age at the time of death [36]. These reviews suggest that anomalous origin of either coronary artery from the opposite sinus with an interarterial course carries a significant risk of sudden cardiac death, particularly for the young athlete, and that symptoms frequently are absent before the sudden death episode.

Patients can present with symptoms of myocardial ischemia; in our review of 10 children and adolescents who were identified prospectively with AOCA from the opposite sinus with an interarterial course, 40% had exercise-induced syncope, chest pain, or ventricular tachycardia that precipitated the cardiac evaluation [54]. All of these patients were participating in vigorous physical activity when symptoms developed and none was younger than 13 years of age at presentation; this suggests again that high-intensity exercise is a common trigger for myocardial ischemia in this disease. Sudden death is rare in children before adolescence unless there is associated severe coronary ostial stenosis at the origin of the anomalous coronary, when sudden death in infancy has been described [39,43,50,51].

#### *Diagnostic findings*

Transthoracic echocardiography has become an important noninvasive tool for prospectively identifying anomalous origin of the left coronary from the right sinus of Valsalva (Fig. 2) [28–32,34,54] and anomalous origin of the right coronary from the left sinus of Valsalva [27,33,54]. Identification of either anomaly requires focused two-dimensional and color Doppler imaging of the coronary arteries [34,54]. This is especially important when the course of the anomalous coronary is interarterial and intramural; the anomalous coronary can appear to arise normally from the appropriate sinus by two-dimensional imaging as it exits the aortic wall. In these patients, the intramural segment of the anomalous coronary often is suspected only after color Doppler interrogation of the aortic root identifies an abnormal color signal within the anterior aortic wall.

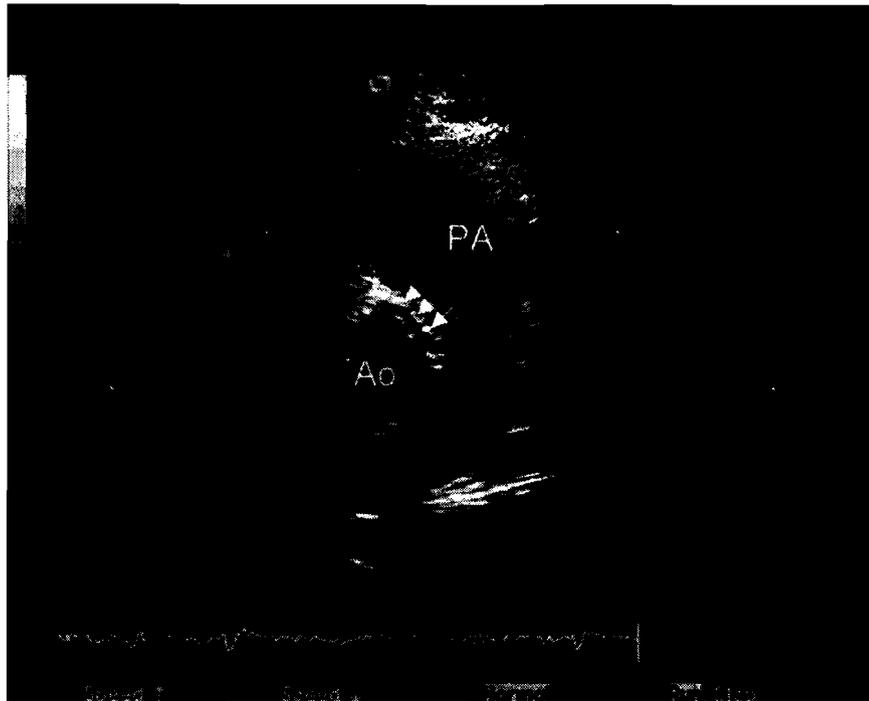


Fig. 2. Two-dimensional echocardiographic image from a short axis view in a patient who has anomalous origin of the left coronary artery from the right sinus of Valsalva and an intramural course of the anomalous coronary. The anomalous left coronary artery can be seen arising from the anteriorly positioned right sinus of Valsalva and coursing intramurally within the anterior aortic wall (*arrows*) between the aorta (*Ao*) and the pulmonary artery (*PA*) towards the left sinus of Valsalva.

Color Doppler also is useful in diagnosing AOCA from the opposite sinus with an intramural course because the technique can give the additional information of direction of flow in the intramural segment. This helps in differentiating whether the anomalous coronary arises from the right or left sinus. When the left coronary arises anomalously from the right sinus, a blue color Doppler signal will be seen in the intramural segment as flow moves away from the right sinus toward the more posteriorly positioned left sinus. This is the opposite of anomalous origin of the right coronary from the left sinus; a red color Doppler signal will be seen in the intramural segment as flow moves toward the right sinus from its origin in the left sinus.

Clinical examination, ECG, and chest radiograph are not helpful in diagnosing AOCA because ischemia and myocardial dysfunction typically do not occur at rest. Exercise testing with myocardial perfusion assessment may be useful when symptoms are present or the coronary anomaly is identified serendipitously, but a normal exercise stress test does not assure that the patient is risk-free. Two patients in our series were asymptomatic and had normal exercise testing but had significant coronary ostial stenosis at surgery [54]. Coronary angiography, ultra

fast CT and/or MRI may be necessary to delineate coronary anatomy in any patient who has suspicious symptoms in whom echocardiography is not definitive.

### *Surgical therapy*

Generally, surgical repair of AOCA has been reserved for patients who have known symptoms of myocardial ischemia. Multiple surgical techniques have been used, including coronary bypass graft placement [55–59], patch enlargement of the anomalous coronary origin [34], reimplantation of the anomalous coronary to the appropriate sinus [60,61], and unroofing of the intramural segment of the anomalous coronary [54,62–65]. The unroofing procedure has several advantages over other coronary repair techniques: (1) it relieves potential ostial stenosis at the origin of the anomalous coronary by unroofing the common wall between the aorta and anomalous coronary; (2) it unroofs the interarterial segment of the anomalous coronary, so that the risk of compression of that segment is removed; and (3) it creates a large neo-orifice of the anomalous coronary in the appropriate sinus that arises perpendicularly, rather than obliquely, from the aortic root. Ideally, this technique is suited for the patient who has an intramural course of the anomalous coronary; early results seem to be promising [54].

The management of asymptomatic patients who have AOCA remains controversial. The risk of late coronary insufficiency after coronary repair must be weighed against the risk of sudden death. We have adopted a strategy that is dictated by the course of the anomalous coronary. We believe that all patients who have an intramural course of the anomalous coronary should have surgical intervention using the unroofing technique. In asymptomatic children, this procedure is done electively after the age of 10 because the risk of sudden death before adolescence seems to be low. In patients who have an intramyocardial course of the anomalous coronary, neither unroofing nor reimplantation is possible because of the fixed and remote nature of the anomalous coronary as it courses within the muscular sulcus between the great arteries. The other surgical options are suboptimal because there is a significant risk of late graft failure with bypass grafting, particularly in an adolescent or young adult; patch augmentation does not relieve the interarterial course of the anomalous coronary. For those reasons, we would reserve surgical intervention in that patient group to those who have symptoms or signs of myocardial ischemia on exercise testing.

## **Anomalous origin of a coronary artery from the pulmonary artery**

### *Anatomic features*

Anomalous origin of the left coronary artery from the pulmonary artery (ALCAPA) is a rare congenital abnormality; it occurs in approximately 1 in 300,000 children [66]. The anomalous left coronary usually arises from the main pulmonary artery [41], although anomalous origin from the right pulmonary

artery also has been described [26,67]. It then courses adjacent to its normal aortic origin near the left aortic sinus before branching in the usual left coronary distribution. Because coronary artery flow is dependent on the diastolic pressure gradient between the vessel that supplies the coronary and the myocardial bed that it perfuses, patients who have this anomaly are at risk for left ventricular ischemia when diastolic pulmonary artery pressures decrease. Typically, this occurs with the transition from fetal to neonatal circulation after birth; infants who have ALCAPA often present early in life with left ventricular dysfunction secondary to myocardial ischemia/infarction. Perfusion in the left coronary bed in all patients who have ALCAPA is retrograde and is supplied by way of collateral circulation from the normally-arising right coronary artery off the higher pressure aorta.

#### *Patient presentation*

The timing of presentation during childhood is variable and is related to adequacy of collateralization from the right coronary artery [41]. Symptomatic infants present with clinical findings of congestive heart failure and echocardiographic features of a severe dilated cardiomyopathy (Fig. 3). Early presentation is associated with limited collateral coronary circulation from the right coronary artery and left ventricular ischemia/myocardial infarction. Left ventricular dysfunction with progressive chamber dilatation results and leads to tachycardia, tachypnea secondary to pulmonary venous congestion, hepatomegaly secondary to systemic venous congestion, and failure to thrive. The clinical picture mimics the presentation of a patient who has a dilated cardiomyopathy; therefore, ALCAPA must be excluded in all children who are diagnosed with dilated cardiomyopathy. This is especially important because ALCAPA, unlike most causes of dilated cardiomyopathy, is treatable with potential complete recovery of myocardial function after surgical intervention [68].

Patients who are diagnosed later in childhood often are asymptomatic and usually present because of a heart murmur or cardiomegaly on chest radiograph [26]. Later presentation is associated with significant collateral coronary circulation that preserves left ventricular function. Ischemic injury still occurs, most commonly to the mitral papillary muscles. This can result in papillary muscle fibrosis, mitral valve prolapse, audible mitral insufficiency, and progressive left ventricular chamber dilatation. Sudden death, particularly with exercise, has been described [41] and likely is related to limited coronary reserve with development of pathologic ventricular arrhythmias during times of increased myocardial demands.

#### *Diagnostic findings*

Prospective identification of ALCAPA using echocardiography has been well-described and this technique should be diagnostic in most patients [26]. Two-dimensional imaging may provide direct visualization of the anomalous coronary

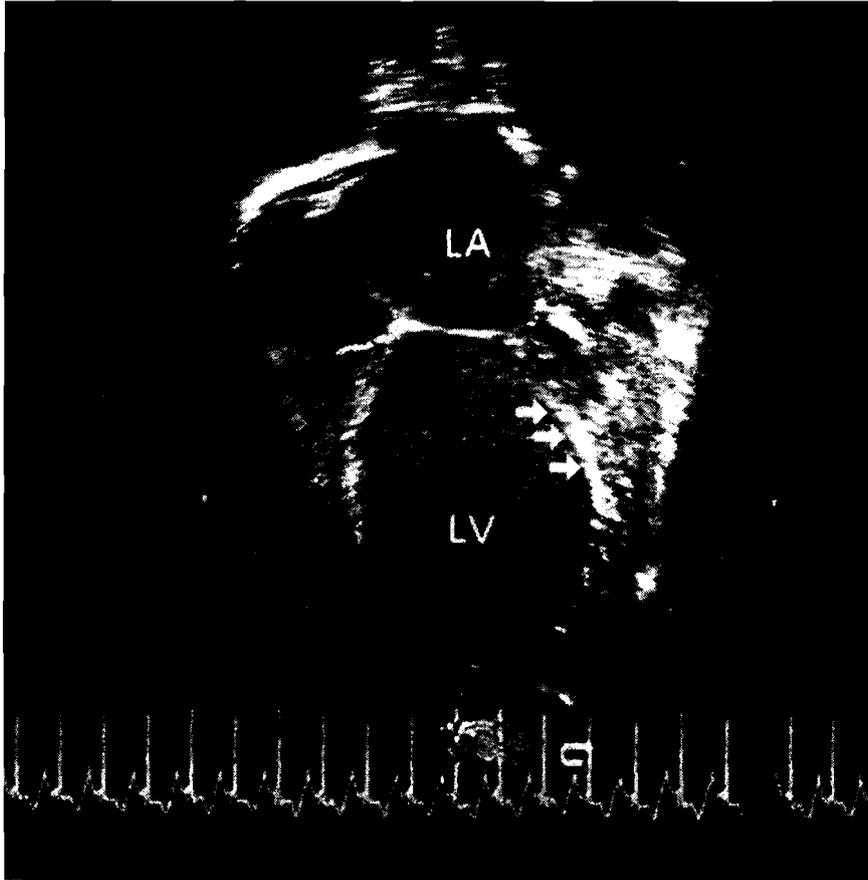


Fig. 3. Two-dimensional echocardiographic image from a four-chamber view in an infant who has anomalous origin of the left coronary artery from the pulmonary artery and resultant dilated cardiomyopathy. There is dramatic dilatation of the left atrium (LA) and left ventricle (LV) with echobright, fibrotic changes of the mitral papillary muscles (arrows) secondary to chronic left ventricular ischemia.

insertion into the pulmonary artery (Fig. 4), but recognition of associated echocardiographic findings is critical to the diagnosis in most patients who have this anomaly. Most patients will have significant right coronary artery dilatation [26,69] because of the obligate collateral circulation that is needed to perfuse the left ventricular myocardium; however, this may not be striking in the infant who has limited collateralization and presents early with a severe dilated cardiomyopathy. The right coronary is dilated dramatically and appears tortuous in older children and adolescents who present later (Fig. 5) because they frequently have adequate collateral coronary circulation to maintain left ventricular perfusion and function. In addition, these coronary collaterals can be identified using color Doppler flow mapping as abnormal diastolic flow signals within the



Fig. 4. Two-dimensional echocardiographic image from a short axis view in a infant who has anomalous origin of the left coronary artery from the pulmonary artery. The anomalous left coronary artery (LCA) can be seen arising from the pulmonary artery (PA), whereas the mildly dilated right coronary artery (RCA) can be seen arising from its normal position off the aorta (AO).

myocardium of the ventricular septum [26]. This can be helpful in identifying the older, asymptomatic patient in whom this diagnosis is not suspected initially; diastolic ventricular septal color Doppler signals can be the first echocardiographic clue of ALCAPA in these children.

Careful interrogation of the coronary artery origins and flow patterns is necessary to confirm the diagnosis of ALCAPA echocardiographically. Because the anomalous left coronary artery is perfused retrograde from the right coronary, spectral and color Doppler identification of retrograde filling of the left coronary [70] with abnormal diastolic flow signals in the pulmonary artery as the anomalous coronary empties into the pulmonary artery [71,72] are critical associated findings. Although mitral valve abnormalities are variable in patients who have ALCAPA, fibrotic changes of the chordae and papillary muscles (see Fig. 3) that are secondary to chronic ischemia with mitral valve prolapse and mitral insufficiency also are commonly associated findings [26]. Left ventricular dysfunction always should increase suspicion of ALCAPA; however, left ventricular function can be well-preserved, particularly in older children who have well-developed collaterals. ECG findings that are suggestive of myocardial infarction, particularly the presence of Q waves in leads I and aVL, may help to

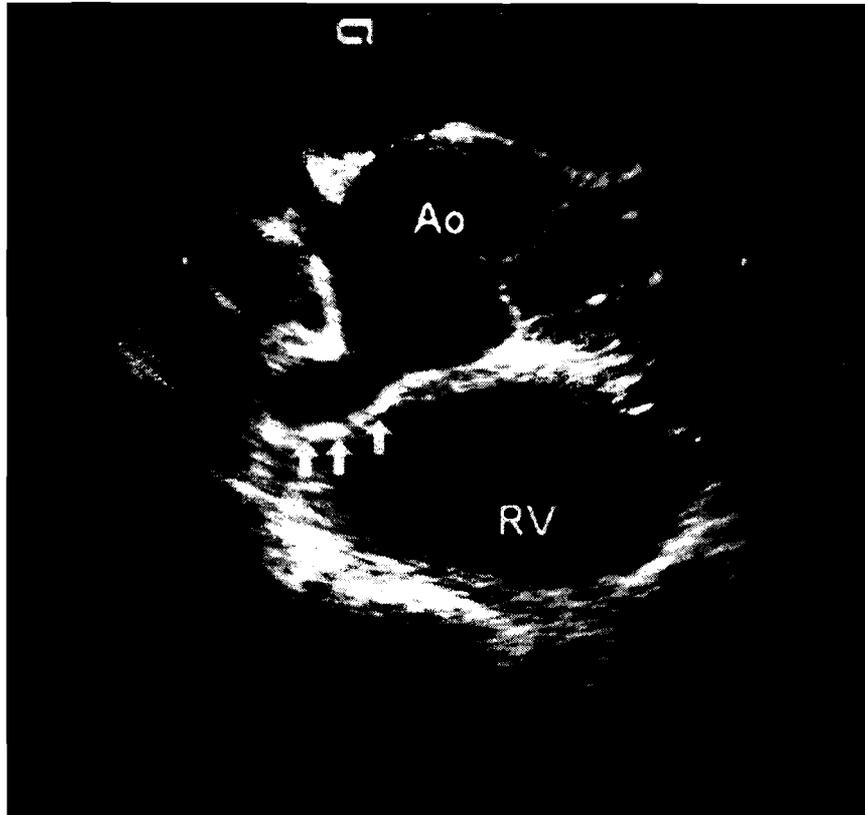


Fig. 5. Transesophageal echocardiographic image from a short axis view in an asymptomatic adolescent who has anomalous origin of the left coronary artery from the pulmonary artery undergoing surgical repair. The markedly dilated right coronary artery (arrows) can be seen arising from its normal position off the aorta (Ao); it measures 10 mm in diameter, more than three times the size of normal right coronary. This dilatation reflects the extensive coronary collateral formation that has developed to allow the right coronary to provide myocardial perfusion to the right ventricle (RV) and the left ventricle.

point to this diagnosis [73]. Cardiac catheterization with coronary angiography is the definitive confirmatory test and should be performed in any child in whom ALCAPA is suspected without clear delineation of the diagnosis by echocardiographic criteria.

#### *Surgical therapy*

Surgical treatment of ALCAPA has evolved over time; it has become obvious that the establishment of a two-coronary artery system that arises off the aorta is necessary for myocardial recovery and improved long-term survival [68]. Initial surgical techniques involved ligation of the anomalous coronary to prevent continued “steal” of left coronary flow into the pulmonary artery. This did not

alter left ventricular dependence on right coronary collateral circulation for left coronary artery perfusion [74] and resulted in significant surgical and late mortality. More recently, anomalous coronary implantation into the aorta or creation of an intrapulmonary tunnel that connected the aorta with the anomalous coronary have been used to provide antegrade flow from the aorta into the left coronary system [75–77]. Frequently, this approach results in dramatic remodeling of the left ventricle in patients who have marked dilatation and hypokinesis with progressive normalization of left ventricular function [68].

Late complications after surgical re-establishment of a two-coronary artery system include occlusion/stenosis of the reimplanted left coronary, abnormal myocardial flow reserve, and chronic mitral valve dysfunction. Occlusion or stenosis of the left coronary after surgery can result in myocardial ischemia and sudden death [78]. Attempts to quantify myocardial blood flow in patients who have ALCAPA after repair have demonstrated regional impairment in flow reserve [79]; assessment of flow reserve may allow identification of patients who have developed coronary stenosis or who are at risk for adverse ischemic events. Mitral insufficiency is common after surgery and the severity of the insufficiency may impact operative survival [68]. Because mitral papillary muscle ischemia and infarction are common with ALCAPA, recovery of mitral function is variable after surgery and frequently does not correlate with recovery of left ventricular function [80]. Late reoperation for mitral valve repair or replacement is required in a minority of patients who have chronic severe insufficiency.

### **Coronary artery fistulas**

Congenital coronary artery fistula (CAF) is a rare, isolated anomaly of the coronary artery system that is defined as a direct communication between a coronary artery and another vascular structure. The involved coronary usually arises normally from the aorta and connects to one of the intracardiac chambers, systemic veins, or pulmonary artery by way of a tortuous anomalous branch. Fistulas more frequently involve the right coronary artery and usually drain into one of the right heart chambers [81]. Symptoms and signs are dependent on the size of the fistulous connection; rarely, large fistulas can have a significant left-to-right shunt with resultant congestive heart failure and cardiomegaly in infancy [82]. Most patients who have CAF are asymptomatic in childhood and present because of a continuous murmur that is appreciated along the precordium. This murmur can sound similar to a patent ductus arteriosus, although its parasternal location frequently suggests a different etiology. Late complications have been described in older adults and include bacterial endocarditis, congestive heart failure, and angina [81,83,84]. Two-dimensional and color Doppler echocardiography usually are diagnostic and can identify the involved coronary and its site of drainage [23]. Surgical closure is safe and effective [85,86]. Recent advances in interventional techniques now allow closure of CAF in the cardiac catheterization laboratory with the use of detachable coils and balloons; this has become the initial

treatment of choice in children and adults [87–89]. Closure of the fistula is indicated when symptoms are present; the need for prophylactic closure in asymptomatic children to prevent late complications remains controversial.

### Summary

Congenital coronary artery abnormalities are rare, isolated anomalies that are important to recognize in childhood. Usually, isolated coronary anomalies are asymptomatic; however, certain forms are associated with myocardial ischemia, congestive heart failure, and sudden cardiac death in infants and children. Recognition of signs and symptoms that may indicate a congenital coronary artery anomaly should lead to additional testing, especially thorough evaluation of coronary artery anatomy using two-dimensional and color Doppler echocardiography.

### References

- [1] Yamanaka O, Hobbs RE. Coronary artery anomalies in 126,595 patients undergoing coronary arteriography. *Cathet Cardiovasc Diagn* 1990;21:28–40.
- [2] Topas O, DeMarchena EJ, Perin E, et al. Anomalous coronary arteries: angiographic findings in 80 patients. *Int J Cardiol* 1992;34:129–38.
- [3] Alexander RW, Griffith GC. Anomalies of the coronary arteries and their significance. *Circulation* 1956;14:800–5.
- [4] Gaither NS, Rogan KM, Stajduhar K, et al. Anomalous origin and course of coronary arteries in adults: identification and improved imaging utilizing transesophageal echocardiography. *Am Heart J* 1991;122:69–75.
- [5] Hsieh Y-K, Fu M, Wu C-J, et al. Anomalous origin of left coronary artery from right coronary artery (single coronary artery): diagnosis by transesophageal echocardiography. *J Ultrasound Med* 1996;15:169–71.
- [6] Vicente T, Lopez J, Valdes M. Usefulness of transoesophageal echocardiography in showing the route of anomalous coronary arteries. *Heart* 1996;75:183–4.
- [7] Alam M, Bryner J, Smith S. Transesophageal echocardiographic diagnosis of anomalous left coronary artery from the right aortic sinus. *Chest* 1993;103(5):1617–8.
- [8] Fernandes F, Alam M, Smith S, et al. The role of transesophageal echocardiography in identifying anomalous coronary arteries. *Circulation* 1993;88:2532–40.
- [9] Koh K. Confirmation of anomalous origin of the right coronary artery from the left sinus of Valsalva by means of transesophageal echocardiography. *Am Heart J* 1992;122(3):851–4.
- [10] Henson KD, Geiser EA, Billett J, et al. Use of transesophageal echocardiography to visualize an anomalous right coronary artery arising from the left main coronary artery (single coronary artery). *Clin Cardiol* 1992;15:462–5.
- [11] Smolin MR, Gorman PD, Gaither NS. Origin of the right coronary artery from the left main coronary artery identified by transesophageal echocardiography. *Am Heart J* 1992;123(4):1062–5.
- [12] McConnell MV, Ganz P, Selwyn AP, et al. Identification of anomalous coronary arteries and their anatomic course by magnetic resonance coronary angiography. *Circulation* 1995;92(11):3158–62.
- [13] Taylor AM, Thome SA, Rubens MB, et al. Coronary artery imaging in grown up congenital heart disease: complementary role of magnetic resonance and x-ray coronary angiography. *Circulation* 2000;101(14):1670–8.

- [14] McConnell MV, Stuber M, Manning WJ. Clinical role of coronary magnetic resonance angiography in the diagnosis of anomalous coronary arteries. *J Cardiovasc Magn Reson* 2000;2(3): 217–24.
- [15] White CS, Laskey WK, Stafford JL, et al. Coronary MRA: use in assessing anomalies of coronary artery origin. *J Comput Assist Tomogr* 1999;23(2):203–7.
- [16] Sevrukov A, Aker N, Sullivan C, et al. Identifying the course of anomalous left coronary artery using contrast-enhanced electron beam tomography and three dimensional reconstruction. *Catheter Cardiovasc Interv* 2002;57(4):532–6.
- [17] Pasquini L, Sanders SP, Jonas RA, et al. Diagnosis of coronary artery anatomy by two-dimensional echocardiography in patients with transposition of the great arteries. *Circulation* 1987; 75:557–64.
- [18] Pasquini L, Parness IA, Colan SD, et al. Diagnosis of intramural coronary artery in transposition of the great arteries using two-dimensional echocardiography. *Circulation* 1993;88:1136–41.
- [19] Jureidini SB. Detection of coronary artery abnormalities in tetralogy of Fallot by two-dimensional echocardiography. *J Am Coll Cardiol* 1989;14:964–72.
- [20] Berry JM. Evaluation of coronary artery anatomy in patients with tetralogy of Fallot by two-dimensional echocardiography. *Circulation* 1989;78:149–56.
- [21] Koike K, Musewe NN, Smallhorn JF, et al. Distinguishing between anomalous origin of the left coronary artery from the pulmonary trunk and dilated cardiomyopathy: role of echocardiographic measurement of the right coronary artery diameter. *Br Heart J* 1989;61:192–7.
- [22] King DH, Danford DA, Huhta JC, et al. Non-invasive detection of anomalous origin of the left main coronary artery from the pulmonary trunk by pulsed Doppler echocardiography. *Am J Cardiol* 1985;55:608–9.
- [23] Sanders SP, Parness IA, Colan SD. Recognition of abnormal connections of coronary arteries with the use of Doppler color flow mapping. *J Am Coll Cardiol* 1989;13:922–6.
- [24] Holley DG, Sell JE, Hougren TJ, et al. Pulsed Doppler echocardiographic and color flow imaging detection or retrograde filling of anomalous left coronary artery from the pulmonary artery. *J Am Soc Echocardiogr* 1992;5:85–8.
- [25] Salzer-Muhar U, Proll E, Kronik G. Intercoronary collateral flow detected by Doppler colour flow mapping is an additional diagnostic sign in children with anomalous origin of the left coronary artery from the pulmonary artery. *Br Heart J* 1993;70:558–9.
- [26] Frommelt MA, Frommelt PC, Pelech AN, et al. Detection of septal coronary collaterals by Doppler color flow mapping is a marker for anomalous origin of the coronary artery from the pulmonary artery. *J Am Soc Echocardiogr* 1996;9:259–63.
- [27] Frommelt PC, Friedberg DZ, Frommelt MA, et al. Anomalous origin of the right coronary artery from the left sinus of Valsalva: transthoracic echocardiographic diagnosis. *J Am Soc Echocardiogr* 1999;12:221–4.
- [28] Stefanelli CB, Stevenson JG, Jones TK, et al. A case for routine screening of coronary artery origins during echocardiography: fortuitous discovery of a life-threatening coronary anomaly. *J Am Soc Echocardiogr* 1999;12:769–72.
- [29] Nowak B, Voigtlander T, Jolsch B, et al. Echocardiographic visualization of anomalous left main coronary arteries originating from the right sinus of Valsalva. *Int J Cardiol* 1994;46:67–73.
- [30] Daliento L, Gasoli G, Mazzucco A. Anomalous origin of the left coronary artery from the anterior aortic sinus: role of echocardiography. *Int J Cardiol* 1993;38:89–91.
- [31] Zeppilli P, dello Russo A, Santini C, et al. In vivo detection of coronary artery anomalies in asymptomatic athletes by echocardiographic screening. *Chest* 1998;114:89–93.
- [32] Maron BJ, Leon MB, Swain JA, et al. Prospective identification by two-dimensional echocardiography of anomalous origin of the left main coronary artery from the right sinus of Valsalva. *Am J Cardiol* 1991;68:140–2.
- [33] Erol C, Candan I, Sonel A, et al. Anomalous origin of the right coronary artery from the left sinus of Valsalva: echocardiographic diagnosis – a case report. *Angiology* 1987;38:268–70.
- [34] Frommelt PC, Berger S, Pelech AN, et al. Prospective identification of anomalous origin of left coronary artery from the right sinus of Valsalva using transthoracic echocardiography: importance of color Doppler flow mapping. *Pediatr Cardiol* 2001;22:327–32.

- [35] Liberthson RR, Dinsmore RE, Fallon JT. Aberrant coronary artery origin from the aorta. Report of 18 patients, review of literature and delineation of natural history and management. *Circulation* 1979;59(4):748–54.
- [36] Roberts WC. Major anomalies of coronary arterial origin seen in adulthood. *Am Heart J* 1986;111(5):941–63.
- [37] Frescura C, Basso C, Thiene G, et al. Anomalous origin of coronary arteries and risk of sudden death: a study based on an autopsy population of congenital heart disease. *Hum Pathol* 1998;29: 689–95.
- [38] Taylor AJ, Rogan KM, Virmani R. Sudden cardiac death associated with isolated congenital coronary artery anomalies. *J Am Coll Cardiol* 1992;20:640–7.
- [39] Lipssett J, Byard RW, Carpenter BF, et al. Anomalous coronary arteries arising from the aorta associated with sudden death in infancy and early childhood. *Arch Pathol Lab Med* 1991;115: 770–3.
- [40] Kragel AH, Roberts WC. Anomalous origin of either the right or left main coronary artery from the aorta with subsequent coursing between aorta and pulmonary trunk: analysis of 32 necropsy cases. *Am J Cardiol* 1988;62:771–7.
- [41] Wesselhoeft H, Fawcett JS, Johnson AL. Anomalous origin of the left coronary artery from the pulmonary trunk: its clinical spectrum, pathology, and pathophysiology, based on a review of 140 cases with seven further cases. *Circulation* 1968;38:403–25.
- [42] Herrmann MA, Dousa MK, Edwards WD. Sudden infant death with anomalous origin of the left coronary artery. *Am J Forensic Med Pathol* 1992;13(3):191–5.
- [43] Roberts WC, Shirani J. The four subtypes of anomalous origin of the left main coronary artery from the right aortic sinus (or from the right coronary artery). *Am J Cardiol* 1992;70(1):119–21.
- [44] Barth CW, Roberts WC. Left main coronary artery originating from the right sinus of Valsalva and coursing between the aorta and pulmonary trunk. *J Am Coll Cardiol* 1986;7:366–73.
- [45] Aoyagi S, Suzuki S, Kosuga K, et al. Anomalous origin of the right coronary artery associated with congenital bicuspid aortic valve. *Kurume Med J* 1991;38:199–202.
- [46] Roberts WC, Siegel RJ, Zipes DP. Origin of the right coronary artery from the left sinus of Valsalva and its functional consequences: analysis of 10 necropsy patients. *Am J Cardiol* 1982; 49:863–8.
- [47] Isner JM, Shen EM, Martin ET, et al. Sudden unexpected death as a result of anomalous origin of the right coronary artery from the left sinus of Valsalva. *Am J Med* 1984;76:155–8.
- [48] Berdoff R, Haimowitz A, Kupersmith J. Anomalous origin of the right coronary artery from the left sinus of Valsalva. *Am J Cardiol* 1986;58:656–7.
- [49] McManus BM, Gries LA, Ness MJ. Anomalous origin of the right coronary artery from the left sinus of Valsalva. *Pediatr Pathol* 1990;10:987–91.
- [50] Barth CW, Bray M, Roberts WC. Sudden death in infancy associated with origin of both left main and right coronary arteries from a common ostium above the left sinus of Valsalva. *Am J Cardiol* 1986;57:365–6.
- [51] Liberthson RR, Gang DL, Custer J. Sudden death in an infant with aberrant origin of the right coronary artery from the left sinus of Valsalva of the aorta: case report and review of the literature. *Ped Cardiol* 1983;4:45–8.
- [52] Mantovani E, Carraro R, Thiene G. Once again on juvenile sudden death due to anomalous origin of the right coronary artery from the left anterior sinus of Valsalva. A case report. *G Ital Cardiol* 1987;17(II):791–4.
- [53] Hanzlick R, Stivers RR. Sudden death in a marathon runner with origin of the right coronary artery from the left sinus of Valsalva. *Am J Cardiol* 1983;51:1467.
- [54] Frommelt PC, Frommelt MA, Tweddell JS, et al. Prospective echo diagnosis and surgical repair of anomalous origin of a coronary artery from the opposite sinus with an interarterial course. *J Am Coll Cardiol* 2003;42:148–54.
- [55] Mavroudis C, Backer CL, Muster AJ, et al. Expanding indications for pediatric coronary artery bypass. *J Thorac Cardiovasc Surg* 1996;111:181–9.
- [56] Thomas D, Salloum J, Montalescot G, et al. Anomalous coronary arteries coursing between the

- aorta and pulmonary trunk: clinical indications for coronary artery bypass. *Eur Heart J* 1991;12:832–4.
- [57] Kucera RF, Bowden WD, Thomas HM, et al. Anomalous origin of the right coronary artery from the left sinus of Valsalva: a case report. *Cathet Cardiovasc Diagn* 1986;12:334–6.
- [58] Brandt B, Martins JB, Marcus ML. Anomalous origin of the right coronary artery from the left sinus of Valsalva. *NEJM* 1983;309(10):596–8.
- [59] Ghosh PK, Agarwal SK, Kumar R, et al. Anomalous origin of right coronary artery from left aortic sinus. *J Cardiovasc Surg* 1994;35:65–70.
- [60] Bucsenec D, Messmer BJ, Gillor A, et al. Management of anomalous origin of the left coronary artery from the right sinus of Valsalva. *J Thorac Cardiovasc Surg* 1994;107(5):1370–3.
- [61] DiLello F, Mnuk JF, Flemma RJ, et al. Successful coronary reimplantation for anomalous origin of the right coronary artery from the left sinus of Valsalva. *J Thorac Cardiovasc Surg* 1991;102(3):455–6.
- [62] Mustafa I, Gula G, Radley-Smith R, et al. Anomalous origin of the left coronary artery from the anterior aortic sinus: a potential cause of sudden death. *J Thorac Cardiovasc Surg* 1981;82:297–300.
- [63] Donaldson RM, Raphael M, Yacoub MH, et al. Hemodynamically significant anomalies of the coronary arteries: surgical aspects. *Thorac Cardiovasc Surg* 1982;30:7–13.
- [64] Van Son JAM, Haas GS. Anomalous origin of left main coronary artery from right sinus of Valsalva: modified surgical treatment to avoid neo-coronary ostial stenosis. *Eur J Cardiothorac Surg* 1996;10:467–9.
- [65] Nelson-Piercy C, Rickards AF, Yacoub MH. Aberrant origin of the right coronary artery as a potential cause of sudden death: successful anatomical correction. *Br Heart J* 1990;64:208–10.
- [66] Keith J. Diseases of coronary arteries and aorta. In: Keith J, Rowe R, Vlad P, editors. *Heart disease in infancy and childhood*. New York: Macmillan; 1978. p. 278–9.
- [67] Tingelstad J, Lower R, Eldredge W. Anomalous origin of the right coronary artery from the main pulmonary artery. *Am J Cardiol* 1972;30:670.
- [68] Schwartz ML, Jonas RA, Colan SD. Anomalous origin of left coronary from pulmonary artery: recovery of left ventricular function after dual coronary repair. *J Am Coll Cardiol* 1997;30:547–53.
- [69] Koike K, Musewe NN, Smallhorn JF, et al. Distinguishing between anomalous origin of the left coronary artery from the pulmonary trunk and dilated cardiomyopathy: role of echocardiographic measurement of the right coronary artery diameter. *Br Heart J* 1989;61:192–7.
- [70] Holley DG, Sell JE, Hougren TJ, et al. Pulsed Doppler echocardiographic and color flow imaging detection or retrograde filling of anomalous left coronary artery from the pulmonary artery. *J Am Soc Echocardiogr* 1992;5:85–8.
- [71] King DH, Danford DA, Huhta JC, et al. Non-invasive detection of anomalous origin of the left main coronary artery from the pulmonary trunk by pulsed Doppler echocardiography. *Am J Cardiol* 1985;55:608–9.
- [72] Sanders SP, Parness IA, Colan SD. Recognition of abnormal connections of coronary arteries with the use of Doppler color flow mapping. *J Am Coll Cardiol* 1989;13:922–6.
- [73] Chang RKR, Allada V. Electrocardiographic and echocardiographic features that distinguish anomalous origin of the left coronary artery from pulmonary artery from idiopathic dilated cardiomyopathy. *Pediatr Cardiol* 2001;22:3–10.
- [74] Bunton R, Jonas RA, Lang P, et al. Anomalous origin of the left coronary artery from pulmonary artery: ligation versus establishment of a two coronary artery system. *J Thorac Cardiovasc Surg* 1987;93:103–8.
- [75] Takeuchi S, Imamura H, Katsumoto J, et al. New surgical technique for repair of anomalous left coronary artery from the pulmonary artery. *J Thorac Cardiovasc Surg* 1979;78:7–11.
- [76] Neirotti R, Nijveld A, Ithuralde M, et al. Anomalous origin of the left coronary artery from the pulmonary artery: repair by aortic reimplantation. *Eur J Cardiothorac Surg* 1991;5:368–73.
- [77] Grace RR, Angelini P, Cooley DA. Aortic implantation of anomalous left coronary artery arising from the pulmonary artery. *Am J Cardiol* 1977;39:608–13.

- [78] Backer CL, Stout MJ, Zales VR, et al. Anomalous origin of the left coronary artery: a twenty-year review of surgical management. *J Thorac Cardiovasc Surg* 1992;103:1049–58.
- [79] Singh TP, DiCarli MF, Sullivan NM, et al. Myocardial flow reserve in long-term survivors of repair of anomalous left coronary artery from pulmonary artery. *J Am Coll Cardiol* 1998;31:437–43.
- [80] Huddleston CB, Balzer DT, Mendeloff EN. Repair of anomalous left main coronary artery arising from the pulmonary artery in infants: long-term impact on the mitral valve. *Ann Thorac Surg* 2001;71:1985–9.
- [81] Lowe JE, Oldham HN, Sabiston DC. Surgical management of congenital coronary artery fistulas. *Ann Surg* 1981;194:373–9.
- [82] Hsieh KS, Huang TC, Lee CL. Coronary artery fistulas in neonates, infants, and children: clinical findings and outcome. *Pediatr Cardiol* 2002;23(4):415–9.
- [83] Liberthson RR, Sagar K, Berkoben JP, et al. Congenital coronary arteriovenous fistula: report of 13 patients, review of the literature and delineation of management. *Circulation* 1979;59:849–54.
- [84] Sunder KR, Balakrishnan KG, Tharakan JA, et al. Coronary artery fistula in children and adults: a review of 25 cases with long-term observations. *Int J Cardiol* 1997;58:47–53.
- [85] Kamiya H, Yasuda T, Nagamine H, et al. Surgical treatment of congenital coronary artery fistulas: 27 years experience and review of the literature. *J Card Surg* 2002;17(2):173–7.
- [86] Cheung DLC, Au WK, Cheung HHC, et al. Coronary artery fistulas: long-term results with surgical correction. *Ann Thorac Surg* 2001;71:190–5.
- [87] Dorros G, Thota V, Ramireddy K, et al. Catheter-based techniques for closure of coronary fistulae. *Catheter Cardiovasc Interv* 1999;46:143–50.
- [88] Reidy JF, Anjos RT, Qureshi SA, et al. Transcatheter embolization in the treatment of coronary artery fistulas. *Am J Coll Cardiol* 1991;18:187–92.
- [89] Hartnell GG. Embolization in the treatment of acquired and congenital abnormalities of the heart and thorax. *Radiographics* 1993;13:1349–62.

**Submitter :** Dr. Prakash Patel  
**Organization :** Lewistown Hospital  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Payment For Procedures And  
Services Provided In ASCs**

Payment For Procedures And Services Provided In ASCs

Sir/Madam,

It is inappropriate to consider Color doppler as part of routine Doppler exam. It requires extra time on part of physician and sonographer to do this procedure. Also there are validated formulas to evaluate Valvular heart diseases with color doppler which adds to the information gained by simple doppler. Please do not cut payments on color doppler.

If I may suggest- please consider asking physicians to pass appropriate exam necessary to read Echo/Doppler/color doppler. There are lots of physicians who are not board certified and read these tests. That is better way to control the cost.

With increasing inflation physicians have a hard time adjusting their cost structure of clinics.

Thank you for your considerations.

Prakash Patel, MD FACC

**Submitter :** Dr. Stephen Berens  
**Organization :** Stephen C. Berens, M.D.  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

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 :** John Schmedtje  
**Organization :** Roanoke Heart Institute  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

**Coding-- Additional Codes From 5-Year Review**

Please reconsider the proposal to bundle color/Doppler codes into echo codes. These Doppler tests involve an extra commitment and extra time for both sonographer and reader. They have RVU's attached to them for a reason, based on evidence collected for years. We do not order color/Doppler on every patient, but it is a very important part of the echo exam in most patients. The provider should be paid on the basis of work performed for the patient. Thank you for your consideration.

**Submitter :** Dr. Norman Silverman  
**Organization :** Lucile Packard Hospital \_ Stanford University  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Payment For Procedures And Services Provided In ASCs**

Payment For Procedures And Services Provided In ASCs

Besides the tremendous value of Doppler Color Flow in general, is is extremely valuable in children with congenital heart disease. This test requires more complicated equipment, additional knowledge for interpretation and takes a great deal of extra time for the technician to acquire and for the physician to interpret. There is no question that CMS has consistently undervalued this test and I protest your considering bundling this test with other ultrasound changes. Rather than decrease any reimbursement for the color study. I suggest that on a relative value system - the reimbursement should actually be increased substantially!

**Submitter :** Dr. Kirk Dise  
**Organization :** Anesthesia Associates of Lancaster  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Kirk R. Dise, MD

**Submitter :**

**Date:** 08/07/2007

**Organization :**

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P  
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sherwood Anderson

**Submitter :** Dr. paul siddoway  
**Organization :** Dr. paul siddoway  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding-- Additional Codes From  
5-Year Review**

**Coding-- Additional Codes From 5-Year Review**

Dear Sirs,I am writing this comment in regards to the proposed elimination of color flow doppler code and the plan for bundling into all other echo base codes.This would have a serious impact on practice expense for echocardiography.The additional time for the sonographer and physician would potentially eliminate this as a valuable tool for patient care.I can tell you for sure that this type of data allows for optimal patient care and this type of information frequently allows for outpatient management of problems and keeps patients out of the hospital.This is also a study that is not always ordered for follow up of cardiac conditions.The reimbursement for echocardiography has declined over the past 20 years that I have been in practice and further reductions would potentially eliminate this as a valuable tool for patient care.Care for all patients would suffer and as the population ages this type of change in reimbursement would ultimately increase the need to hospitalize more patients and thus drive up health care costs more.If this reduction in payment occurs the patients will once again lose out and our ability to provide good services to medicare patients will deteriorate.Best Regards,Paul Siddoway,M.D.Butte,Montana.

**Submitter :** Dr. Dean Hawley  
**Organization :** Indiana University School of Medicine  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist, forensic pathologist, and a member of the College of American Pathologists. I practice in Indianapolis, Indiana as part of academic Department of Pathology and Laboratory Medicine at the Indiana University School of Medicine where I am a tenured professor of pathology.

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

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

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

Sincerely,

Dean A. Hawley, M.D.

Tenured Professor of Pathology

Forensic Pathologist

**Submitter :** Dr. Christopher Bee  
**Organization :** Colorado Pathology Associates  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Loveland and Greeley, Colorado as part of an 8-person, private practice pathology group that provides service for two community hospitals while also owning an independent cytology laboratory.

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

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Sincerely,

Christopher S. Bec, MD

**Submitter :** Mr. Michael Bohl  
**Organization :** Radiology Group, PC, SC  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1385-P-5201-Attach-1.DOC



File Code: CMS-1385-P

Issue: Physician self-referral rules for diagnostic tests

To Whom It May Concern:

Since self-referral will not be prohibited those physicians that engage in it should, at a minimum, be required to follow the American Medical Association's (AMA's) ethics policy governing self-referral. AMA policy E-8.032 Conflicts of Interest: Health Facility Ownership by a Physician states that physicians should:

1. Disclose their investment interest to their patients when making a referral;
2. Provide a list of effective alternative facilities if they are available;
3. Inform their patients that they have free choice to obtain the medical services elsewhere; and,
4. Assure their patients that they will not be treated differently if they do not choose the physician-owned facility.

Unfortunately, few, if any physicians follow the AMA's policy. In my opinion, it is very likely that there is not a single self-referring physician in the state of Iowa following it.

Please read the attached letter I wrote to the Iowa Hospital Association (IHA) in which I relate several anecdotes of problematic physician behavior and its adverse impact on patients. I ask IHA to encourage the Iowa Board of Medical Examiners to require observance of this policy. I have also been in contact with the Iowa Attorneys General Office. Unfortunately, the neither office is likely to take any action, perhaps because they are not empowered to do so.

If you were to implement such a rule I have a few words of caution: You should also discuss how and when such disclosures and choices should be presented to the patients, without which self-referring offices would likely bury disclosure and patient choice in their forms and never directly address these issues with patients. While it might be acceptable to disclose financial interests upon check-in, patients should be presented with a list of choices only after the decision to order an exam is made. Self-referring physicians (or their staff) should also be required to present a list all providers to the patient (including the self-referring physician's site), and make sure the patient understands they are free to choose any provider on the list without consequence.

If you are looking for a model, you have to look no further than hospitals which are required to disclose their financial interests in home health agencies and offer their patients a choice of providers. This requirement has worked and served the public well. A similar requirement for self-referring physicians, if properly enacted, would at least lead to a more open, transparent, and honest transaction.

If you have any questions or would like to discuss this with me I may be reached at 563.344.6788 or at [mbohl@rgimaging.com](mailto:mbohl@rgimaging.com).

Sincerely,

Michael Bohl, Executive Director  
Radiology Group, PC, SC  
1970 E. 53<sup>rd</sup> St.  
Davenport, Iowa 52807



7/5/2007

Iowa Hospital Association  
ATTN: Maureen Keehale  
100 E. Grand  
Des Moines, Iowa 50309

Dear Ms. Keehale,

Thank you for taking time to speak with me. As I indicated during our conversation, I encourage the Iowa Hospital Association (IHA) to contact the Iowa Board of Medical Examiners and Iowa Attorneys General office and support requiring physicians and physician groups to

1. Disclose their financial interest in imaging equipment and imaging centers; and
2. Require them to present the patient with a list of alternative imaging providers from which the patient may choose when they order an imaging exam.

Unfortunately, even though the American Medical Association's ethics policy E-8.032 Conflicts of Interest: Health Facility Ownership by a Physician states that

"Physicians are free to enter lawful contractual relationships, including the acquisition of ownership interests in . . . equipment" but that "physicians should disclose their investment interest to their patients when making a referral, provide a list of effective alternative facilities if they are available, inform their patients that they have free choice to obtain the medical services elsewhere, and assure their patients that they will not be treated differently if they do not choose the physician-owned facility."

few, if any physicians follow the AMA's policy. I would go so far as saying that I doubt there is a single physician group in the state which owns imaging equipment that provides patients with such a list.

Why should the IHA be interested in this issue? First and foremost, the IHA should be interested because of its patient advocacy role. The AMA issued its ethics policy for a reason – they recognized that physicians have an inherent "conflict of interest" (the AMA's words) when they both determine the need for an exam and own the equipment that it is performed on. In fact, Iowa hospitals are required to provide just such a disclosure and offer alternatives to patients when they own and operate home health agencies. Second, in virtually every community in which one or more physicians own imaging equipment, one of the alternatives patients should have is the freedom to go to their local community hospital for their exam. I believe that many patients, if given a choice, would choose to have their local community hospital if provided a choice. Self-referring physician's failure to follow the AMA's ethics guidelines, which instruct them to provide patients choice, likely results in a loss of substantial revenues for these local hospitals. Third, the conflict of interest described by the AMA is real and is adversely affecting patients, physicians, and hospitals. In the end, all I am asking for is the introduction of a little transparency into these transactions where there is currently none.

Over the past year or two I have had several anecdotes related to me detailing abuses in these conflict of interest settings. I will relate three of them that are particularly germane to this discussion. The first anecdote was related to me by one of our employees whose husband went to a local physician who owns his own MRI. The physician told the man he needed an MRI. The man requested to have the exam performed at a local full-service imaging facility. The doctor told him it would take two weeks to have it done where the man requested to go (in reality the imaging center could have performed it that day or on

any subsequent day convenient for the patient). When the patient left the office he thought he was going to the imaging center he requested. He was surprised to find out that the doctor had instead scheduled it at the MRI center he owned even though he had specifically requested to have it somewhere else.

The second anecdote was related to me by a physician who witnessed the event. In this case a physician was called in to see an elderly man at a local Quad City hospital in Illinois (the man lived in Illinois). The physician told the man he needed a CT scan and instructed the patient to drive to his office in Iowa to have it rather than scheduling it at the hospital where the physician was seeing the patient, and which was near to the patient's home. The physician told the patient that he had a "high quality scanner" in his office. However, the hospital has an equal, if not more sophisticated, scanner. There is only one reason the physician directed this elderly man to his office – conflict of interest. At a minimum, the physician should have given this elderly man a choice to have it at his local hospital.

I will keep my third anecdote short. I am personally aware of a patient whose doctor ordered a CT scan and was told by the doctor it would be scheduled at his office. The patient, having a long-standing personal and professional relationship with a local imaging facility requested to go there. The physician became irate and told her that she had to have it at his office, then he turned and slammed the door behind him as he left the room, leaving the patient literally in tears.

These anecdotes raise many issues.

1. In no case did these physicians disclose their financial interest;
2. In no case did these physicians provide a list of alternatives to the patient;
3. Direct patient requests were either ignored, or worse, the physician became irate when the patient asked to go elsewhere;
4. Patients are being inconvenienced by being required to have their tests at the ordering physician's office instead of the facility of their choice (i.e., the nearby local community hospital); and,
5. I have had no reports of physicians who have an imaging conflict of interest following the AMA code of ethics guidelines by providing a list of alternatives to their patients without being prodded by the patient.

This is a serious and widespread issue. It is my understanding that the Iowa Board of Medical Examiners is scheduled to discuss this issue at its September meeting. I encourage the IHA to contact the Iowa Attorneys General office and Iowa Board of Medical Examiners and voice support for mandating full disclosure and the provision of alternatives to patients when the physician has a conflict of interest. The IHA may even want to seek a change in state law during the next legislative session.

If you have any questions or would like to discuss this with me I may be reached at 563.344.6788 or at [mbobl@rgimaging.com](mailto:mbobl@rgimaging.com). You may also discuss this issue with Bob Brammer, Iowa Attorneys General Office, 515 281-5165; Theresa Weeg, Iowa Attorneys General attorney representing the Medical Board, 515 281-5328; or Ann Mowery, Executive Director, Iowa Board of Medical Examiners, 515 242.3268.

Sincerely,



Michael Bohl, Executive Director  
Radiology Group, PC, SC  
1970 E. 53<sup>rd</sup> St.  
Des Moines, Iowa 52807

**Submitter :** Dr. James Peterson  
**Organization :** Duke Cardiology of Raleigh  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

Dear Mr. Kuhn:

As a cardiologist who provides echocardiography services to Medicare patients and others in Raleigh, North Carolina, I am writing to object to CMS's proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS's proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler's role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

James W. Peterson, MD  
 Duke Cardiology of Raleigh

**Submitter :** William R. Jacobs MD  
**Organization :** Loyola Medical Center  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Color flow imaging is not done with every 2D echo. It is unnecessary and requires considerable tech and interpreter time, which would be wasted if color flow imaging were unnecessary. When indicated, color flow imaging is valuable; it is usually obvious to the person who orders the test whether or not color flow imaging should be done. It should be done whenever spectral Doppler is done.

**Submitter :**

**Date: 08/07/2007**

**Organization :**

**Category : Physician**

**Issue Areas/Comments**

**Coding--Reduction In TC For  
Imaging Services**

Coding--Reduction In TC For Imaging Services

Kindly re-evaluate the issue of combining color doppler with other echocardiography testing. I have been performing echoes for 37 years and have seen it save lives and improve living conditions.

Color doppler is an add-on to usual echo procedures and involves significant laboratory expenditure of time and money to perform. Making it part of the complete procedure will significantly reduce our ability to provide adequate service to our community.

**Submitter :** Dr. Sarah Schafer  
**Organization :** Carriage Town Chiropractic  
**Category :** Chiropractor

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1385-P-5205-Attach-1.DOC

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

Re: "TECHNICAL CORRECTIONS"

The proposed rule dated July 12<sup>th</sup> in the *Federal Register* contained an item under technical corrections that would eliminate patient reimbursement for X-rays taken by a radiologist or other non-treating physician and then used by a doctor of chiropractic. I am writing in strong opposition to this proposal.

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

While Medicare does not reimburse chiropractors for taking X-rays, eliminating their option to refer the patient to a D.O., M.D., or radiologist for an X-ray will significantly increase the cost to the Medicare patient due to the necessity of a referral to an orthopedist or rheumatologist for evaluation prior to referral to the radiologist as it is now. With fixed incomes and limited resources, Medicare patients may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.

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

Sincerely,  
Sarah D. Schafer, D.C.

**Submitter :** Mr. Andre Koretsky  
**Organization :** The Reading Hospital and Medical Center  
**Category :** Other Health Care Professional

**Date:** 08/07/2007

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

As a cardiac sonographer with 15 years of experience in echocardiography, I firmly believe that the proposal to discontinue separate Medicare payment for Color Doppler effective January 1, 2008 is wrong. Color Doppler is used to quantify the severity of cardiac lesions (from shunts to valvular disease). However, it is NOT intrinsic to all echocardiography procedures.

In my lab, we perform studies every day that do not require the use of Color Doppler. For example, in stress echocardiography we use this modality no more than 5% of the time.

When used, Color Doppler requires special training: cardiac sonographers are trained to perform it with special skills and when needed; cardiologists are trained to interpret it accurately. In fact, there is a special section dedicated solely to Color Doppler in both the Cardiologists' and Sonographers' Echocardiography boards. I urge you to refrain from finalizing the proposed bundling of Color Doppler into echocardiography procedures.

Sincerely, Andre Koretsky, RDCS

**Submitter :** Dr. Edward Hockaday

**Date:** 08/07/2007

**Organization :** Dr. Edward Hockaday

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** Ms. Carol Mortier

**Date:** 08/07/2007

**Organization :** ASE

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I am a sonographer and do not use color flow on every study I perform. The "color flow Doppler" code should not be bundled with the echo code as is proposed. The color flow Doppler component of the echocardiogram is a separate entity which is time consuming to perform and interpret. Carol Mortier, RDCS, FASE, RVT

**Submitter :** Dr. Jittikom Jantarasami  
**Organization :** Chesapeake Anesthesia Associates  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Resource-Based PE RVUs**

· Resource-Based PE RVUs  
See attached letter.

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 :** Dr. Joseph Craft  
**Organization :** James J. Spadaro, MD, LLC  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Coding--Reduction In TC For  
Imaging Services**

**Coding--Reduction In TC For Imaging Services**

Dear Sir or Ma'am:

I am writing in opposition to the proposed bundling of color flow Doppler during echocardiography into all the other echo base codes. Despite the fact it has been quite useful diagnostically for decades, the field of echocardiography continues to evolve at a very rapid pace. The technical skill and time required to perform a thorough echo is constantly increasing. Often color doppler techniques are important to such studies, but not always. Color doppler is an add-on feature, and must be treated that way by reimbursing entities like CMS. If color doppler is to be bundled, then reimbursement for echocardiography studies must be increased to account for the technical skill required and technologist time dedicated to producing high quality studies.

Please continue to support outstanding cardiovascular diagnostics by giving appropriate credit for added work.

Respectfully submitted,  
Joseph A. Craft III, MD  
Cardiologist  
St. Louis, MO

**Submitter :** Dr. Charles Freeman

**Date:** 08/07/2007

**Organization :** Dr. Charles Freeman

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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Thank you for your consideration of this serious matter.

**Submitter :** Dr. david krivan  
**Organization :** Southern AZ VA Heathcare System  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

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

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

August 7, 2007

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

David Krivan, MD  
Staff Anesthesiologist  
SAVAHCS

**Submitter :** Dr. Carl Minami  
**Organization :** Physicians Medical Laboratory-AEL  
**Category :** Physician

**Date:** 08/07/2007

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

To Whom it May Concern:

I appreciate the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008." I am a board certified pathologist and a member of the college of American Pathologists. I practice in Morristown, TN as an independent practitioner overseeing two laboratories, a reference laboratory and a hospital laboratory.

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

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

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

Sincerely,

Carl M. Minami, M.D.  
Physicians Medical Laboratory  
1045 S Cumberland  
Morristown, TN 37813