Submitter : **Ms. Maria Blokdijk** **Date: 08/29/2007**

Organization : **HFHS/ Brother Rice high school**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10751-Attach-1.WPD

#10751

Dear Sir or Madam:

My name is Maria Blokdijk, and I work for Henry Ford Health Systems as a clinical/outreach athletic trainer. I am providing rehabilitation to our patients and my students at my high school.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Maria Blokdijk, ATC , PES-NASM

Submitter : Ms. Christie Plyler **Date:** 08/29/2007

Organization : MedNet America

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#10752

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

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

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

Submitter : **Sarah Vitale** **Date: 08/29/2007**

Organization : **University of Toledo**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am newly certified Athletic Trainer, working on my Master's Degree. I am in my first year of the Master's program and plan to pursue a career in Athletic Training upon my graduation.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Sarah R Vitale, ATC, LAT
Graduate Assistant

Submitter : xiaotao qian **Date:** 08/29/2007

Organization : ACI-LLc

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely

Xiaotao Qian

Submitter : Dr. Stephen Renick **Date:** 08/29/2007

Organization : Florida Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

X-rays are not just requested for subluxation detection in seniors. X-rays are necessary to rule out pathology, etc. If the patient has to be referred to their primary care provider to be able to have their x-ray study covered by CMS, there will be additional costs incurred by CMS for the primary care provider's office visit. Also, time will be wasted regarding the patient's care.

Submitter : **Dr. William Burleson** **Date: 08/29/2007**

Organization : **Lumberton Urology Clinic, PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-10756-Attach-1.DOC

#10756

Re: July 2, 2007 Medicare Physician Fee Schedule Proposed Regulations

Dear Ladies and Gentlemen of CMS

I am William R. Burleson, M. D. and am an Urologist in Lumberton, North Carolina. I have been practicing my specialty here for 36 years serving a relatively economically poor populous. Medicare and Medicaid patients represent approximately 65 per cent of this practice. I also am an owner in a joint venture LLC that provides lithotripsy services for our patients here. Our lithotripsy service encompasses and treats the majority of the patients in eastern North Carolina out of two mobile units. This venture started in 1985 of which I was a part encompassing approximately 23 years of service. In 1985, this new technology changed the face and approach to treatment of various types of ureteral and renal stones. Prior to the innovation open surgery hospitalization and significant post-operative down time was the standard of care for many of the stones we now treat with ESWL. After this new innovation settled in, I was able to do less and less open procedures and more noninvasive lithotripsy to accomplish the same purpose. I have not done any open stone cases for the past 15 years and only a hand full between 1985 and 1990. Our Lithotripsy LLC has maintained the highest quality of medical care and mobile units have allowed improved patient access, updating and advancing the technology as it became available along with stringent QA and outcome programs.

I have read the proposal and I am concerned that if these changes are made, they may lead to complete dissolution of this entity, which is a very important contributor to quality stone care and treatment of patients in eastern North Carolina as it is across the country. Our LLC lithotripter units are under contracts with the area hospitals in eastern North Carolina and these mobile units are able to bring the latest and best treatment to patients in eastern North Carolina's rural areas maximizing the resource. It not only improves the quality of care but also decreases hospital cost and saves third party payers money by sharing the expensive equipment and technology among many hospitals and clinics.

I certainly understand the CMS concerns about the potential for fraud and abuse. However, I believe it is important to discern between diagnostic and therapeutic modalities. Diagnostic procedures can certainly be over utilized but this should not be a problem and I don't believe there has been any abuse in the therapeutic modalities such as lithotripsy. I do not believe over use of lithotripsy has ever been a problem since we are treating symptomatic stones, or stones that if left alone, could result in dire circumstances medically for the patient.

Another point of concern to me was the percentage fee prohibition. The percentage fee arrangement is fair and the best option for the vendors and for the hospitals or ASUs in that both of these share the market risk. Some of the hospitals, especially in rural

North Carolina, have low volume in regards to lithotripsy and the fee per case in these instances allows the hospitals to access the technology on a per case basis without large capital expenditures. Based on the Stark legislative history Congress intended to preserve the "per procedure fees" and I believe for a very good reason.

In summary, I hope CMS has the foresight to understand and recognize the importance of maintaining the integrity of these therapeutic treatments that have proven their merit over the past 23 years.

I would hope CMS can recognize the difference in potential for fraud and abuse in diagnostic modalities as opposed to therapeutic modalities such as lithotripsy. It is my belief that physician owned vendors should not be singled out and destroyed by unsubstantiated fear of abuse. I believe Lithotripsy LLC and other physician owned vendors have the knowledge and ability to provide high quality service efficiently at a savings to third party vendors, and at the same time, allowing the most expert state of the art care available anywhere. More specifically, I believe the loss of our LLC service for lithotripsy would negatively impact the quality of stone treatment care.
I feel the arrangements we have been able to develop with hospitals and clinics over the years, the "fee for procedure basis", and "percentage fee payments" should not be materially changed so that the valuable therapeutic treatment modalities can continue to be provided to the patients in this country.
Thanks for allowing me to express my concern on this topic.
Respectfully,

William R. Burleson, MD

Submitter : **Dr. Stephen Weddel** **Date: 08/29/2007**

Organization : **Longmont Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

Please extent your support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. Undervaluation of anesthesia services for medicare patients has reached a critical level.

Medicare payment for anesthesia services stands at just $16.19 per unit. This is a huge disparity from average reimbursement payments of $45 to $55 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Daniel Butler** **Date: 08/29/2007**

Organization : **Anesthesiolgy Group Associates,Inc.**

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 : **Dr. Marisa Rosol** **Date: 08/29/2007**

Organization : **Cleveland Clinic Foundation**

Category : **Physician**

Issue Areas/Comments

Medicare Telehealth Services

Medicare Telehealth Services

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.

Marisa A. Rosol D.O.

Submitter : **Dr. Julie Thompson** **Date: 08/29/2007**

Organization : **Affiliated Anesthesiologists**

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.

Julie Thompson, MD

Submitter : **Dr. Kirk Brumels** **Date: 08/29/2007**

Organization : **Hope College**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Kirk Brumels, and I an a NATABOC certified athletic trainer employed as a clinician and professor in the nationally accredited Athletic Training Education Program at Hope College in Holland, Michigan.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. I am concerned with both the care of patients as well as employment opportunities for health care professionals.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kirk Brumels, PhD, ATC
Associate Professor of Kinesiology
Head Athletic Trainer
Hope College
Holland, Michigan 49423

Submitter : **Mr. Matthew Foster** **Date: 08/29/2007**

Organization : **Detroit Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Matt Foster, and I am currently working in the clinical setting with the spinal cord injury population at the Rehab Institute of Michigan. I have been working here now for 1.5 years, since graduating from an accredited athletic training program. (Upper Iowa University)

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Matt Foster, ATC

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Matt Foster, and I am currently working in the clinical setting with the spinal cord injury population at the Rehab Institute of Michigan. I have been working here now for 1.5 years, since graduating from an accredited athletic training program. (Upper Iowa University)

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Matt Foster, ATC

Submitter : Mr. Michael Salat **Date:** 08/29/2007

Organization : St. John's Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Michael Salat and I am a Certified Athletic Trainer. I currently work in a sports medicine clinic providing preventive, post-injury, and post-surgical rehabiliation. I also provide coverage to an area high school for all athletic practices and competitions. On top of this I spend time educating the public about my profession and ways to better enhance their athletic endeavors. Due to the nature of my profession I am extremely concerned about about 1385-P.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As a certified athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Michael Salat, MS, ATC

Submitter : Dr. Joshua Mason **Date:** 08/29/2007

Organization : American Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Joshua J. Mason DC

Submitter : **Dr. John Patrick Bebawy** **Date: 08/29/2007**

Organization : **Dr. John Patrick Bebawy**

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 : Mr. Jason Carl **Date:** 08/29/2007

Organization : Trover Health System Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer with over twelve years of professional experience working in a large sports medicine clinic and covering high school athletics.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jason Carl, MA,ATC,CSCS
Senior Athletic Trainer
Trover Health System Sports Medicine

Submitter : **Dr. Michael Severson** **Date: 08/29/2007**

Organization : **Anesthesiology Consultants of Idaho**

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.

Regards,

Michael Severson, MD

Submitter : Mr. Randy Toth **Date:** 08/29/2007

Organization : Union Memorial Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-10768-Attach-1.TXT

10768

8/29/07

Dear Sir or Madam:

My name is Randy Toth and I employed as an athletic trainer (ATC) at Union Memorial Hospital in Baltimore, MD. For the past 5 years, I have provided clinical-outreach services to the Baltimore Blast Professional Indoor Soccer Club and perform evaluations and rehabilitation in our hospitals outpatient based clinic. Therefore, I have the privilege of interacting with a variety of health care professionals (i.e. physical therapists, orthopedic surgeons, physiatry, etc.). It is not uncommon for doctors or physical therapists to ask me for opinions and suggestions on their patients. As you can see, we promote scholarly interactions and the profession of athletic training is a unique entity. Therefore, it is easy to see how an ATC can play an integral role in patient care.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Randall J. Toth, MEd, ATC, CSCS, NASM-PES, CES

Submitter : Dr. Chris Falcon **Date:** 08/29/2007

Organization : Dr. Chris Falcon

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

"Technical Corrections"-the proposed change to the current policy allowing x-rays to be reimbursed when taken by an outside provider and then used by a chiropractor would drastically alter the ability of a chiropractor to properly diagnose, treat and at times refer a medicare patient. As the taking of the x-rays are of no direct financial benefit to the chiropractor, our interest is solely an one related to quality of care for our patients. The inability to directly refer patients to a radiologist would essentially just drive up the cost of the patient's health care by requiring an additional doctors visit to set up the x-ray referral. I am just not sure what this proposal is attempting to accomplish. Sincerely, Chris Falcon, D.C.

Submitter : **Dr. Stanley Rosol** **Date: 08/29/2007**

Organization : **Toledo Surgical**

Category : **Physician**

Issue Areas/Comments

Medicare Telehealth Services

Medicare Telehealth Services

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.

Stanley J. Rosol D.O.
Toledo Surgical-General Surgeon

Submitter : **Dr. Marisa Baorto** **Date: 08/29/2007**

Organization : **Dr. Marisa Baorto**

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.

Marisa Baorto, M.D.

Submitter : **Mr. Jamie Musler** **Date: 08/29/2007**

Organization : **Northeastern University**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Jamie Musler. I am an Athletic Trainer and educator working at Northeastern University.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. My referring physicians and patients depend on me to provide high quality and cost affective services in physical medicine and rehabilitation.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jamie L. Musler, MS, ATC

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 22, 2007
Mr. Kerry N. Weems
Administrator Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. BOX 8018
Baltimore, MD 21244-8018

Subject: Physician Self Referral Issues; Medicare Program; Proposed Revisions to Payment Polices under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

CMS must prohibit the delivery of physical therapy as an in-office ancillary service to protect the safety of its beneficiaries and to control healthcare costs. The intent of in-office ancillary services to facilitate care and increase convince of certain designated health services within the physicians practice appears to makes sense for diagnostic services. However, these benefits are not recognized with the delivery of physical therapy in a physician s office. Since the physician evaluates a patient prior to referring the patient to physical therapy, the service rarely facilitates the diagnosis of the patient. Due to the repetitive treatment frequency of most physical therapy services, convince of this designated health service is only recognized if the physician s office is near the patient s home. And while the intent of this exemption was not to improve physical therapy care, physician s operating in-office physical therapy will defend their exemption citing improved care through closer physician supervision. This is a weak argument because: 1.) Physicians are not educated in the use of physical interventions such as exercise, manual procedures and modalities to treat patients, therefore making supervision merely administrative. 2.) Physicians are rarely actually on-site and devoting time to physical therapy supervision 3.) The supervising physician in a group practice usually does not have knowledge of his/ hers partner s referrals.

Safety of CMS s beneficiaries should be the driving factor making CMS policy. But, the exemption of in-office ancillary physical therapy services are not as safe as independent clinic services. Physician owned practice tend to attract less qualified and less experienced clinicians. Physician groups in central Ohio attract young therapist through higher wages. But, most board certified therapist and therapist with significant clinical experience will not work for physician owned practice probably due to the ethical concerns with the practice. And when financial incentive is removed from referring patients, the physician is more likely to refer to a physical therapy practice that produces good outcomes. Less qualified therapist is not the only safety concern. Physician owned practices in Central Ohio are high volume clinics. Patient report less individual time spent with physical therapist and more time with ancillary staff or unsupervised.

Allowing the in-office ancillary exemption to continue is not fiscally responsible. Over utilization with physician owned practices is well documented. The OIG report in May of 2006 supports this statement. And CMS policy also indirectly affects healthcare cost. Many commercial payers reimburse physician owned practices higher rates for the same physical therapy services delivered by independent practices. With rising healthcare cost a national epidemic, terminating physical therapy as a DHS will only save CMS funds and set a precedent for other payers to follow.

Sincerely,

43065

Submitter : **Ms. Elizabeth Emeterio** **Date: 08/29/2007**

Organization : **Blount Memorial Hospital**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am a Certified Athletic Trainer who works in a comprehensive outpatient rehabilitation clinic in rural East Tennessee. Our clinic is a satellite of the only hospital in Blount County and treats a broad range of patients with varied diagnoses and insurance plans. People insured by Medicare make up about 35-55% of our patient population at any given time.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for our patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Elizabeth A. Emeterio, MS, ATC

Submitter : **Mr. John Mascola** **Date: 08/29/2007**

Organization : **West Essex School District**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is John Mascola. I am a Certified Athletic Trainer, with a bachelor s degree in biology from Rutgers University. For the last seven years I have been employed at West Essex Regional School District, in North Caldwell. In this capacity I am responsible for over 200 students, at both the high school and junior high school levels.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
John C. Mascola, ATC

Submitter : **Dr. shakeel Siddiqui** **Date: 08/29/2007**

Organization : **Baylor College of Medicine**

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 : **Dr. Kirk Bailey** **Date: 08/29/2007**

Organization : **Dr. Kirk Bailey**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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 : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would like to comment on the proposed rule for the 2008 Medicare physician fee schedule in regards to self referral (Stark) Law changes.

I strongly recommend that physicians not treat patients in their office as an ancillary service and it should not be payable incident to the physician services. I have been in practice as a physical therapist for 38 years and have practiced in many service situations. Although there are those that will always act in a professional, ethical manner, your own (Florida) investigation sadly demonstrates a substantial rate of fraud in physical therapy billing in physician offices.

The physical therapist is also at fault by allowing or being unaware of billing and documentation failures. They, too, can be lured by higher wages and benefits physicians can pay beyond rates allowed to an independent physical therapy practice (IPTP). This is prevalent, although therapists who allow such an arrangement are lowly regarded in our profession. They are financially rewarded and motivated. Physical therapy services are not provided by the best provider, but by the financially linked services. In such a physician owned practice (POP), the patient is not given a choice. A patient may insist on receiving care somewhere else, but the physician s office is often likely to be uncooperative with insurance and legal practice requirements to the patient and physical therapy provider.

The therapist in a POP can, of course, choose to act ethically, yet that is not often the case. The heart is deceitful above all things and beyond cure. Who can understand it? It then becomes your responsibility to provide law and regulation. Please prevent abuse, remove favoritism in practice provision and remove the incentive of referral for profit in an incident to physician billing loop hole of the Stark Law.

Sincerely,
07016

Submitter : **Dr. Donald Reno** **Date: 08/29/2007**

Organization : **Michigan Association of Chiropractors**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Technical Corrections

Technical Corrections

The proposed rule dated July 12 contains an item under the Technical Corrections section calling for the current regulation permitting a beneficiary to be reimbursed by Medicare for x-rays taken by a non-treating provider and used by a doctor of chiropractic to determine a subluxation to be eliminated. I am writing in strong opposition to this proposal.

I believe that this provision will severely hamper patient care. Subluxation detection does indeed rely on the use of x-ray. In some cases, the patient will require an x-ray to determine pathologic changes. And, findings of that type would require a referral for other treatment.

By limiting a DC from referring an x-ray, the cost to the Medicare patient will go up significantly due to the necessity of a referral to another provider (orthopedist, rheumatologist, etc.) for evaluation prior to referral to the radiologist as it is now. With fixed incomes and limited resources, Medicare patients may choose to forego 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,

Donald M. Reno, D.C.
Vice President

Submitter : Mr. Keith Davis **Date:** 08/29/2007

Organization : University of Pennsylvania

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I'm currently starting my 2nd year at a highly touted institution and in my 3rd year of being nationally certified. I get the chance to work with the very best and brighest student-athletes every day, and I'm thankful for that. Last year I received my Masters' of Education in Kinesiology from one of the top Athletic Training Universities in the country. My research project was an award finalest at our national convention and is currently in review for publication. Even though I am young, I am highly qualified at what I am trained to do.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Keith F. Davis, MEd, ATC

Submitter : **Mrs. Kasey Rolfes** **Date: 08/29/2007**

Organization : **Advanced Orthopaedic Specialists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am an athletic trainer currently employed in an orthopaedic clinic in Maryland. This office participates with all insurances, including the insurances for the less fortunate population, which most other offices in our area do not. Within this office I act as the sole provider of physical rehabilitation services under the direction and supervision of the physician. Although patients are always given a choice of where to have these services performed, many choose to receive them in our office due to the easy access to the physician during rehabilitation and the peace of mind that they are being treated exactly how the physician has ordered.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kasey Rolfes, MS, ATC, PES

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
8-28-2007

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

Mr. Kerry N Weems,

I am a outpatient physical therapist in a rural community that serves several surrounding communities. I have been a physical therapist for three years. My experience encompasses in and out patient settings in hospitals as wells as privately owned clinics. I am writing you this letter to comment on the July 12 proposed 2008 physician fee schedule rule. I will be focusing my comments on the physician self-referral and the in-office ancillary services exception.

I would urge action on your part to remove physical therapy services from the designated health service. This current system makes abuse and overuse of physical therapy services to easy in a system that is already strained. It is my belief that there is no overwhelming benefit for the Medicare patient to be treated in a physician owned physical therapy clinic. I do believe that there is an overwhelming benefit for the physician to own a physical therapy clinic due to the current law restricting a physical therapist from direct access to patients without a physician s referral. A patient may be referred to a physician owned clinic to enhance his financial gain not necessarily provide the best treatment possible for that patient. I would comment that the physician practice of referring patients to physical therapy treatment has become more about financial gain than what is best for the patient. For example, my patient had surgery and she was told that only their in-office physician owned facility was capable of getting a successful outcome for that particular surgery, so this patient was forced to travel three times a week for a month or more to a physician owned facility that was one and half hours away from her residence. I believe this is a prime example of abuse of the current rules and by no means does this protect patients from undue hardship and unethical decision making.

I believe that the continued growth of physician owned physical therapy clinics would create an environment for treating physical therapists to become complacent. The physical therapy clinic that is owned by non-physicians work to earn every referral with consistent good outcomes from the patient referred to the clinic by physicians. A non-physician owned clinic is made by its reputation and current good standing in the community and not by the deals for profit sharing and partial ownerships with referring physicians. I personally am driven to provide the best treatment possible with the knowledge available to me today to my patient because my professional and financial future depends on the outcomes I can achieve to foster continued growth and good relations with patients, physicians, and the community. If as a physical therapist you are provided with patients from a referring physician only because that physician will gain financial benefits from that referral then the referral becomes more about financial benefit and less about maximum physical benefit.

In closing, I appreciate the opportunity to state my thoughts about this subject matter. I also thank you for your careful consideration of this topic, Mr. Weems, because this decision could ultimately hurt patients and cause mass abuse of Medicare funds.

Regards,

Submitter : Christopher Hayden **Date:** 08/29/2007

Organization : Christopher Hayden

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

After 17 years of providing physical therapy I don't know of a single physician in my county/area (northern NJ) that directly performs physical therapy procedures in their offices. Yet I can tell you of the many physicians who own PT facilities and have office staff to provide PT to patients. These physicians have described to ma a situation in which they are "supplementing their revenue stream" because physician/medical services reimbursement fees are down". The physicians in my area have also opened surgical centers in an effort to capture "facility fees" from Medicare and other insurance providers. These physicians have told me that even if they secretly waive out-of-network deductibles and copays from their patients they still capture reimbursement that they have "otherwise would have missed". Most physicians are trained in providing medical procedures and to not directly perform physical medicine procedures. Physicians realize that physical medicine/ physical therapy procedures are time consuming,skilled, and proven effective. However, they do not value the skill directly-individually; they only wish to possess revenue-reimbursement that such services render.

If a physician posses the skill and desire to provide physical therapy care to a patient - fine. However, any other situation that allows for a physical to own and bill for such service while utilizing any other personnel, or if they represent themselves as owners of "physical therapy companies/corporations"should be disallowed from participation in federal programs like Medicare. State, private insurance, workers comp, and automobile insurance should recognize the abuse and take appropriate action, too. I believe Centers for Medicare Services (CMS) should continue to limit the abuse of Medicare tax dollars not by cutting services, but by stopping the illegal and unethical draining of these dollars by covetous and greedy physicians and corporations. Please disallow physicians who own physical companies and corporations or who hire undertrained personnel (incident to services) to rpovide physical therapy services from participation in Medicare programs. Let's insure the survivability of the Medicare program.

Regards,

Chris Hayden, PT

Submitter : Mr. Ron Carroll **Date:** 08/29/2007

Organization : Arkansas State University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I have been a practicing athletic trainer for 32 years at Arkansas State University. I received my bachelor's degree and master's degree with specialization in athletic training. I am a licensed athletic trainer in the State of Arkansas. Athletic trainers are approved as health care providers on the Arkansas any willing provider legislation.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Ron Carroll MS, ATC, LAT

Submitter : **Dr. Jaekeum Ro** **Date: 08/29/2007**

Organization : **Sharon Hospital**

Category : **Hospital**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

LETTER

Dear Sir or Madam:

I am an Athletic Trainer, Certified and working at a Sharon Hospital in Sharon, CT. I am a Certified Strength and Conditioning Specialist and Emergency Medical Technitian.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education(with two Bachelor degrees, Two Master degreess, and a Doctoral Degree), clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jaekeum Ro, PhD, ATC, CSCS, EMT.

Submitter : Mr. Greg Gilmore **Date:** 08/29/2007

Organization : Central College

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Greg Gilmore and I am an athletic trainer and instructor at Central College in Pella, Iowa.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Greg Gilmore, MS, LAT, ATC, EMT-B

Submitter : **Dr. Vrunda pandya** **Date: 08/29/2007**

Organization : **nyu, department of anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Vrunda Pandya, MD
Department of Anesthesia, NYU
550 1st avenue
New York, NY 10026
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 : **Adam Wallace** **Date: 08/29/2007**

Organization : **Adam Wallace**

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.
Adam Wallace

Submitter : Dr. Michael McGee **Date:** 08/29/2007

Organization : Lenoir-Rhyne College

Category : Academic

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a faculty member in a CAATE Athletic Training Education Program in North Carolina. We have worked diligently to educate our students to perform the duties of the entry-level athletic trainer. Recent changes within CMS have negatively impacted the available employment setting for our graduates and current certified athletic trainers. More importantly, the recent changes and new proposals severely limit the public to the quality health care that a certified athletic trainer can provide.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for the patients that my students are prepared to assist.

As athletic trainers, we are qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. The education, clinical experience, and national certification exam ensure that our patients receive quality health care. State law and hospital medical professionals have deemed the certified athletic trainer to be qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professional that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, ad amy Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Michael R. McGee, EdD, LAT, ATC

Submitter : **Dr. Peggy Houglum** **Date: 08/29/2007**

Organization : **Duquesne University**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I am a physical therapist and an athletic trainer with experience in working in clinics and hospitals. For the past 30 years I have had the opportunity to see and work from "both sides of the fence". I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, even without my physical therapy background, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. Additionally, I can tell you from personal experience as one who teaches rehabilitation to athletic training students, that athletic trainers are well suited to perform rehabilitation tasks.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Peggy A. Houglum, PhD, ATC, PT

Submitter : **Dr. Mark Lounsbury** **Date: 08/29/2007**

Organization : **Dr. Mark Lounsbury**

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 support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. Finally, CMS has recognized the gross undervaluation of anesthesia services, and with this proposal the Agency is taking the first steps to address this 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, or about $65 per hour, to care for the most complex subset of our patients. This amount does not even remotely come close to covering the cost of caring for our nation s seniors. This is and will create an unsustainable system in which anesthesiologists will be forced away from areas with disproportionately high Medicare populations. In my practice currently, I would discontinue participating with Medicare now if not for our agreements with our facilities.

As you know, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation thereby beginning to correct 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 : Perry Bonomo **Date:** 08/29/2007

Organization : Madison Spine and Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attatchment

Submitter : Mrs. Meriah Hopstetter **Date:** 08/29/2007

Organization : Bangor Area School District

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Meriah Hopstetter. I am the Head Athletic Trainer at Bangor Area High School which has approximately 600 individual athletes in a school year. I have a Bachelor's degree from Penn State University and a Master's degree from East Stroudsburg University.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Meriah Hopstetter, M.Ed., ATC

Submitter : Dr. Jerel Eaton **Date:** 08/29/2007

Organization : Dr. Jerel Eaton

Category : Chiropractor

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

This proposed change is discrimitory for chiropratic patients. This change will cost them in time and money for duplication of services and of non necessary office visits to their medical/osteopathic physcian.

Submitter : **Mr. Tim Happel** **Date: 08/29/2007**

Organization : **Professional SportsCare & Rehab**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Tim Happel, I am an athletic trainer in the clinical/high school setting. I recently graduated from an NATA accredited university for athletic training Towson University. My daily responsibilities at my job include working in a PT clinic and at a local high school in the afternoons and weekends. This includes referring athletes to the proper people including PCP s, all specialty physicians, and my physical therapy office to assist my care of the athletes. This bill will severely hinder my ability to do my daily responsibilities.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Tim Happel, BS
Professional SportsCare & Rehab
Hammond High School
Head Athletic Trainer

Submitter : **Dr. Ryan Beall** **Date: 08/29/2007**

Organization : **Hancock Anesthesia Group**

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 : **Date: 08/29/2007**

Organization : **Bellin Health**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Jim Beversdorf, I m a Licensed Athletic Trainer, Performance Enhancement Specialist, and Certified Strength and Conditioning Coach, employed by Bellin Health Sports Medicine in Green Bay, WI. As an athletic trainer I m assigned to Pulaski HS where I m responsible for the sports medicine care of some 600 plus athletes on a yearly basis. As a performance enhancement specialist I work in our newly build XL Athletic Performance Center where I perform movement chain assessment on each of our athletes to assess how their bodies are working mechanically with the goal of improving deficiencies and improving overall athletic performance and reduction of injury. The services athletic trainers provide are vitally important to keeping these young athletes safe, healthy, and on the playing field.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
James R. Beversdorf, ATC, LAT, PES-NASM, CSCS

Submitter : **Dr. David Powell** **Date: 08/29/2007**

Organization : **American Society of Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:
I am writing to express support for the proposed increase to anesthesia payments under the 2008 Physician Fee Schedule. I work in a Community Hospital where access to care for seniors has been limited by providers ability to care for patients with the low CMS reimbursement. The RUC has recommended that CMS increase the anesthesia conversion factor by 32% (about $4.00 / unit). This would be a major step in correcting a long standing, undervaluation of anesthesia services by CMS.

The current reimbursement does not cover the cost for caring for our seniors and draws anesthesiologists away from hospitals like mine with large Medicare populations. It is imperative that CMS follow through with the proposal in the Federal Registry and immediately implement the increase in the anesthesia conversion factor as recommended by the RUC.

Thank you for your consideration,

David C. Powell M.D.

Submitter : **Ms. Laurel Horne** **Date: 08/29/2007**

Organization : **Ms. Laurel Horne**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a student at Plymouth State University in New Hampshire. Currently my educational focus is Athletic Training. I have three semesters left to complete my graduate degree and sit for the Athletic Training Exam (BOC).

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Laurel Horne (Athletic Training Student)

Submitter : **Dr. Papiya Sengupta** **Date: 08/29/2007**

Organization : **St Elizabeth's Medical Center**

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 : Dr. Edward Hoglund **Date:** 08/29/2007

Organization : Hoglund Chiropractic Center, P.A.

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

With all due respect to our lawmakers and your dedicated service to our country please allow me to comment on proposed nonpayment of radiology services ordered by Chiropractors.
After 21 years of practice, on numerous occasions, we have found problems on x-rays taken at our office or ordered by our office on medicare patients. These include abdominal aortic aneurysms (some that were surgical), significant acute spinal compression fractures and severe hip degeneration that we refer for surgery. We have also found patients with primary and/or metastasis spinal or pelvic cancers.
Dr. William Mayo of the Mayo Clinic once said, "The best interest of the patient is the only interest to be considered."
Thank you for your time and consideration on this matter.
Sincerely,
Edward W. Hoglund, D.C.

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist with 4 years of experience. I have practiced in multiple states and settings including pediatrics, outpatient orthopaedics, and nursing home care (none physician owned). Over the past 4 years I have seen a dramatic shift in the practice of Physical Therapy as physician owned clinics increase in prevalancy and I am concerned. These arrangements encourage financial incentive for patient referall and decrease quality of care to clients. High client volume and less time to spend with patients negativley effects outcomes and increases average visit per referral costing the patient and the insurance company. In addition great therapists who spend one on one time and care for patient outcomes struggle to compete. In my current outpatient practice I have no consistent orthopaedic physician referalls due to the fact that almost every orthopaedic M.D. in town owns their own practice. I will have individuals who live down the street ask if they can come here for therapy and physicicans say NO. How is this in the best interest of clients- to have to drive across town 3 times a weeks sometimes with severe injuries limiting driving abilities. As a therapist I pride myself on evidence based practice and individualized care. I feel because of this I can provide low cost effective treatment and great outcomes to patients. This can be demonstrated by the number of patients I have treated who had previously been seen in physician owned clinics for 4,6,8 weeks of Physical therapy without result. I have taken these same clients and in an average of 10-12 visits given them more results than they have seen in months. Why??? you may ask. As I said I hope some accounts to my philosophy of practice but additional reasoning may lay in the cuurent organization of healthcare structure. If physicians are receiving financial incentive for clients to receive longer treatment I feel it is easy for outcomes to be sacrafieed or simply overlooked. Additional arguments I have read regarding this issue lay in the importance of communication during P.T. plan of care. I challenge you to find a non-physician owned physical therapists who is not willing to provide any amount of communication and input to a physician to have good relationships in regards to what is best for a patient. I realize physician lobbying and power is much greater and more organized than other health care professionals and patients themselves, but I encourage you to really look at this issue in the light of what is truly best for the individual not the healthcare provider. Thank you for taking these considerations into account.

Submitter : **Mr. Brian Coles** **Date: 08/29/2007**

Organization : **IPSC Medical Clinic**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer that has spent 15 years, my entire career, working under the direction of a physician in an outpatient facility. My training and certification make me very qualified for this work have had great success in earning the trust of patients and physicians I work with. I currently work in an industrial on site rehabilitation facility for a power plant. I have a BS and MS degree and am certified as an Athletic Trainer (ATC)

I am writing today to voice my concerns and opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

I am very concerned that these changes will have a direct negative impact on the quality of health care my patients receive. It appears these changes have been initiated without proper feedback, investigation and or actual need. These proposed changes to the hospital Conditions of Participation limit patients and their access to providers.

As an athletic trainer, I am trained, certified and very qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. Utah State law have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

It would seem irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services; especially with the shorter of qualified providers in this country and specifically rural areas. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Brian L. Coles, MS, ATC, CSCS

Submitter : **Dr. Kenneth Heeringa** **Date: 08/29/2007**

Organization : **Dr. Kenneth Heeringa**

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.

Kenneth Heeringa, D.O.

Submitter : **Mr. Keith Naugle** **Date: 08/29/2007**

Organization : **University of Florida**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Keith Naugle, I am currently a faculty at the University of Florida's Undergraduate Athletic Training Program.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Keith Naugle MS ATC NSCA-CPT

Submitter : Dr. Mark Schur **Date:** 08/29/2007

Organization : Dr. Mark Schur

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

The proposed rule dated July 12 contained an itenm under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a nontreating provider and used by a DC to determine a subluxation,be eliminated. I AM WRITING IN STRONG OPPOSITION TO THIS PROPOSAL. While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "redflags", or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing i.e. MRI or for a referral to the appropriate specialist. By limiting a DC from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist,etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal. I STRONGLY urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Submitter : Mr. Steven Orme **Date:** 08/29/2007

Organization : Lebanon Valley College, Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Steven Orme and I work at Lebanon Valley College, in Annville, PA as a certified athletic trainer. I have received my BS in athletic training from Brigham Young University and my MEd from the University of Virginia.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Steven Orme, ATC,

Submitter : Dr. Chris Kelsch **Date:** 08/29/2007

Organization : United Health Chiropractic and Wellness

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

I strongly urge you to not repeal the right of chiropractors to refer to other physicians for X-rays. This has no benefit to patients and only harms their ability to get good chiropractic care. There is no medical basis for this decision. If you are going to do this think about the patients that you will be harming.

Submitter : Mr. Casey Christy **Date:** 08/29/2007

Organization : Mr. Casey Christy

Category : Health Care Provider/Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I have worked as a certified athletic trainer in a secondary school setting for 15 years. I also teach college athletic training courses as an adjunct instructor.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Casey Christy, MA, ATC, CSCS

Submitter : **Mr. Sean Hanrahan** **Date: 08/29/2007**

Organization : **Mr. Sean Hanrahan**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer with licensure to practice medicine in the states of Massachusetts and Virginia. I completed my MSEd at Old Dominion University, and currently work at The Apprentice School in Newport News, Virginia.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Sean Hanrahan, MSEd, ATC, CSCS

Submitter : **Dr. Matthew McCord** **Date: 08/29/2007**

Organization : **St. Joseph Mercy Health System, Ann Arbor, MI**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Matt McCord, MD
Director, Medical Education
Director, Acute Pain Service
St. Joseph Mercy Hospital
Dept. of Anesthesiology
Ann Arbor, MI

Submitter : Mr. Glenn Sumner **Date:** 08/29/2007

Organization : Southeastern Orthopaedics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

My entire comment is noted in the attached Word document.

CMS-1385-P-10812-Attach-1.DOC

10812

August 22, 2007

Department of Health and Human Services
Attention: CMS-1385-P

Re: Comments to CMS-1385-P, RIN 0938-A065
Federal Register Notice Vol. 72, No. 133/Thursday, July 12, 2007/Proposed Rules

Southeastern Orthopaedics (SEO), a 51 physician private orthopaedic practice located in Knoxville, Tennessee appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed changes presented in the above referenced Federal Register Notice. Our comments are related to section II. Provisions of the Proposed Regulation Related to the Physician Fee Schedule, M. Physician Self-Referral Provisions.

Physician Self-Referral Provisions

3. In-Office Ancillary Services Exception

SEO believes that the original intent of this exception which permits physicians to provide certain services in conjunction with the diagnosis and treatment of medical conditions is both appropriate and effective. Further, we agree with CMS in its desire for patients to receive a test or procedure only in a centralized building utilized by the group practice. We believe that services provided under the in-office ancillary services exception should be performed in a building where the core members of the group practice and their staff are present. Overall we believe the current definition of same building and centralized building should not be altered.

Regarding the challenge to the exception for the provision of physical and occupational therapy services, again SEO agrees with the original intent of Congress. We believe CMS is now being given misinformation refuting the benefits of this arrangement. Clearly, a physician develops physical therapy protocols based on his/her treatment plan, not the location or employment of the therapy provider. At SEO (as is true with most orthopaedic practices) we have documented evidence that our therapy utilization per patient is equal to or less than independent physical therapy providers. Plus, the convenience and familiarity afforded patients through physician provided services are well understood, if not obvious. In the case of orthotics, in-office ancillary service providers predominantly provide pre-fabricated or off-the-shelf products, avoiding the custom fabricated fees that are often associated with independent orthotics and prosthetics providers. This, of course, reduces the overall cost to Medicare as well as the out-of-pocket costs to patients.

11. Services Furnished "Under Arrangement"

We would like to urge CMS to use caution in altering the rules relating to services furnished "under arrangements" as stated in Sections 1832, 1835(b) (1), 1861 (e), and 1861 (w) (1) of the Act. In the document titled: United States Department of Health and Human Services, Final Report to the Congress and Strategic and Implementing Plan Required under Section 5006 of the Deficit Reduction Act of 2005, section IV, B. Align Physician and Hospital Incentives, it states, "Alignment of value-based purchasing incentives will allow physicians and hospitals to work together to share in rewards that reflect their joint activities in improving care." A radical change to the Services Furnished "Under Arrangement" exception could hinder the ability of hospitals and physicians to form joint venture arrangements that would mutually benefit hospitals and physicians, while reducing costs and allowing for more access to care for aging patients, and still fall within the federal government's Sustainable Growth Rate (SGR). Physicians can help with controlling the rising cost of health care, if they are looked at as contributors to a solution and not a cause of the problem. Prior to the establishment of Medicare, typically physicians we responsible for starting hospitals and other ancillary health care services to serve the community. There are many beneficial and cost effective patient services that will be adversely affected by a wide ranging corrective solution to a few suspect arrangements. Physicians and hospitals continue to receive reductions in their fee schedules to help Medicare stay within the SGR established by Congress. Eliminating one of the most effective mechanisms for providers to jointly work together to control costs and improve efficiencies should not be the response by CMS.

Southeastern Orthopaedics believes it is in its best interest and that of the community at-large to do everything possible to help ensure the availability of quality health care services for future generations. The majority of physicians are concerned about the rising cost of health care and the future of the hospitals where they work. Physician and hospital joint ventures can be beneficial, if they are properly structured, managed and reviewed, while being transparent to patients, payers and regulators. We would ask that CMS move with caution when changing a rule to address a concern like the growth of nuclear imaging, and not create the undoing of many beneficial joint ventures that fall within the "Under Arrangements" exception.

Sincerely,

Glenn D. Sumner
Chief Executive Officer

Submitter : Dr. William Becker **Date:** 08/29/2007

Organization : Ohio Society of Pathologists

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

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 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,

William J. Becker, DO MPH
President-Elect, Ohio Society of Pathologists

Submitter : **Ms. Sarah Earley** **Date: 08/29/2007**

Organization : **OU Medical Center**

Category : **Physician Assistant**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Sarah J. Earley, PA-C

Submitter : **Ms. Lori Shelley** **Date: 08/29/2007**

Organization : **Cleveland Clinic Foundation**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Lori Shelley. I am a nationally certified and state licensed athletic trainer. I have worked in the field of sports medicine for 18 years outside of my college education. Presently I am employed by the Cleveland Clinic Foundation as an athletic trainer. I perform physical rehabilitation at the clinical setting and sports medicine duties at an area high school. Decreasing the employment opportunities for athletic trainers will hurt many clients in need of our specialized training. Not to mention the care that athletes require/need. We complete tasks that ensure the safety pre/post injuries and typically have direct access to a physician(s) for communication concerning injured athletes. This is the basis of our education. Taking away the ability to employ ATC's because of insurance provisions will leave many without jobs and reduction in salaries. Not to mention leaving those participating in sporting activities without competent care.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Lori Shelley, MA, ATC/L #194
Athletic Trainer
Cleveland Clinic Foundation

Submitter : **Dr. Kellie Kulow** **Date: 08/29/2007**

Organization : **Kulow Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Kellie Kulow, D.C.

Submitter : Dr. allen hager **Date:** 08/29/2007

Organization : Dakota Clinic / Innovis

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I am writing in strong opposition to the removal of reimbursement by Medicare for radiology studies taken by a non-treating provider and then used by a Doctor of Chiropractic. Radiological studies are a vital part of patient assessment especially in this population. Quick and immediate attention serve as best practice in the treatment of common complaints this population group. I currently work in a multidisiplinary practice with many subspecialty providers all having the ability to refer for radiological studies. Why would you limit one speciality group over the other? To eliminate the ability to refer to a qualified Radiologist utilizing an important diagnostic tool would jeopardize the quality of care and add additional cost as these patients would need to visit other providers to obtain the needed service.

Therefore I recommend that you to table this proposal, in the best interest for this patient population receiving quality care.

alh

Submitter : Mr. William H. Dwight **Date:** 08/29/2007

Organization : Dwight Orthopedic Rehabilitation Company

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a licensed physical therapist of 27 years, a taxpayer and a voter, I strongly urge CMS to correct the loophole in the in office ancillary services exception process which allows physicians to refer and profit from physical therapy services they own, regardless of setting. The reasons are fundamental.

All medical services ordered by physicians should be for the purposes of diagnostics or for the good of the patient. By allowing physicians to profit from the referral of patients to their owned services, the underlying legitimacy of the referral is tainted.

Referral for profit physician owned settings have resulted in heavy utilization of physical therapy which has lead, ironically, to greater scrutiny of therapy services provided in every environment except the physician offenders.

Physicians Cherry-pick the better paying insurances, especially Medicare, and send HMO s and other lesser paying, but more utilization conscious payer based patients to independent providers.

This is an important opportunity for CMS to act responsibly and send a message of legitimacy in health care to physicians. This will assist in controlling costs, promoting appropriate care for the right reasons and better serving Medicare subscribers.

As an administrator whose position is to set policy in the public interest, I hope you will act on this clear and appropriate opportunity to close this loophole and bring greater legitimacy back to my profession.

Thank you for your consideration.

Sincerely,

William H. Dwight, PT

Submitter : Ms. Scott Heinerichs **Date:** 08/29/2007

Organization : West Chester University (PA)

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Scott Heinerichs and I am a professor and athletic trainer at West Chester University. For the past seven years, I have taught undergraduate athletic training students courses necessary for their BS degree in athletic training in addition to serving as a clinician for our intercollegiate football team. We do all of our evaluations, rehabilitations pre and post operatively on campus.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Scott Heinerichs MAT, ATC
Instructor Dept. of Sports Medicine
West Chester University
West Chester, PA 19380
sheinerichs@wcupa.edu

Submitter : Mrs. Rita Taylor **Date:** 08/29/2007

Organization : NovaCare Rehabilitation

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Rita Taylor and I am a Certified Athletic Trainer, working in Pennsylvania. I have a Master of Science degree and work for NovaCare Rehabilitation as a contract Athletic Trainer to a Secondary School as well as working in the Physical Therapy Clinic 10 hours a week.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Rita Taylor, ATC, M.S.

Submitter : Matthew Cook **Date:** 08/29/2007

Organization : Saco Bay Orthopaedic and Sports Physical Therapy

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

My name is Matthew C. Cook and I am an Athletic Trainer. I work for Saco Bay Orthopaedic and Sports Physical Therapy in Southern Maine. We are an outpatient physical therapy clinic consisting of 9 locations throughout the southwestern area of Maine. I am also the Athletic Trainer at Thornton Academy, a private high school located in Saco, Me.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Matthew C. Cook ATC CSCS

Submitter : Mr. Robert Neighbors **Date:** 08/29/2007

Organization : ATI physical therapy

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer working for ATI Physical Therapy and a local High School. I provide rehabilitative services in an outpatient PT clinic and I also provide Sports Medicine coverage to a local high school. I have two degrees from Western Illinois University (B.S. Physical Education/Athletic Training, M.S. Physical Education/Sports and Exercise Psychology).

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Rob Neighbors MS,ATC

Submitter : **Dr. Michael Driver** **Date: 08/29/2007**

Organization : **Ozark Anesthesia Assoc.**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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.

Michael Driver, MD.

Submitter : **Dr. Barbara Dabb** **Date: 08/29/2007**

Organization : **Dr. Barbara Dabb**

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 : Dr. sid johnson **Date:** 08/29/2007

Organization : Dr. sid johnson

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

It is very important to maintain competitive fees for the medicare program. Not paying a competitive amount will only lead to fewer and fewer providers willing to accept medicare patients. In turn this will lead to a lower standard of care for a particular people. This is inherently wrong and should not be tolerated. Please pay the providers a fair amount. The amount of time and schooling they have gone through is reason enough to provide them a fair return, not to mention it will increase the quality of care our patients can receive.

Submitter : Dr. R Glenn Hessel **Date:** 08/29/2007

Organization : Little Company of Mary Hospital

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 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 Evergreen Park, IL as part of a 3-pathologist group based in-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 -- especially urologists -- 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,

R Glenn Hessel, MD

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

$65 per hour. That s what you pay anesthesiologists to care for seniors in this country. If I could opt out of Medicare right now I would because I lose money on every patient I care for. How can the system expect us to continue this subsidy we are providing TO the government.

Add to this, the unrestrained medico-legal climate in this nation, and I hope one can see the irony that I could lose all that I own in a lawsuit, meritless or not, and yet get paid a paltry $65 an hour. Skilled tradesman get paid better with no risk whatsoever.

Unless the CMS addresses this gross undervaluation of anesthesia services, I hope the market forces direct us towards non-participation in the Medicare system. At least then, I don t get paid, I can write off the care on my taxes as charity. It is just that bad.

If this RUC recommendation is approved , I hope it is just a first step towards bringing our valuation in line with the other health care providers in the Medicare system.

Thank you for your consideration in this matter.

Submitter : **Dr. Maulik Parikh** **Date: 08/29/2007**

Organization : **NorthStar Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
-Maulik Parikh, MD

Submitter : Mr. Troyce Solley **Date:** 08/29/2007

Organization : St. Edward's University

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

I am an assistant Athletic trainer at St. Edwards University. I currently hold Texas licensure as an athletic trainer and am NATA Certified. I obtained my bachelor degree in Exercise and Sports Science from Texas State University and a Master's of Exercise Physiology from the University of Texas at Arlington.

Submitter : **Dr. annemarie Norenberg** **Date: 08/29/2007**

Organization : **Dr. annemarie Norenberg**

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. Caroline Barry** **Date: 08/29/2007**

Organization : **Colorado Proffesional Medical**

Category : **Device Industry**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Caroline R Barry. I have been a certified athletic trainer. Currently I provide care to medicare and medicaid patients by setting up and explaining Constant Passive Motion DME's.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Caroline R Barry, ATC

Submitter : **Dr. Lebron Cooper** **Date: 08/29/2007**

Organization : **Dr. Lebron Cooper**

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 : Dr. Joseph Merckling **Date:** 08/29/2007

Organization : New York State Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1385-P-10833-Attach-1.DOC

10833

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

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Sincerely,

Dr. Joseph Merckling
Merckling Family Chiropractic P.C.
Member Board of Directors for New York State Chiropractic Association, District 7
Member of Bellport Chamber of Commerce
16-2 Station Road
Bellport, NY 11713
(631) 286-2300

Submitter : **Michelle Johnson** **Date: 08/29/2007**

Organization : **Michelle Johnson**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Michelle Johnson, D.C.

Submitter : **Dr. Darren Galambos** **Date: 08/29/2007**

Organization : **American Society of Anesthesiologists**

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.

Darren J Galambos DO
Mercy Medical Center
Department of Anesthesiology
Canton OH

Submitter : **Dr. Blair Stott** **Date: 08/29/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.
Sincerely
Blair Stott, MD
Anesthesia Consultants of Indianapolis

Submitter : **Dr. Michael Driver** **Date: 08/29/2007**

Organization : **Ozark Anest Assoc**

Category : **Physician**

Issue Areas/Comments

Impact

Impact

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:

My group is facing an increasing disparity in medicare payer mix annually. We service a large rural Missouri area and northern Arkansas. The current fee payment doesn't even cover the cost of patient care. It has become more and more dificult to attract, hire, and maintain doctors in numbers sufficient to provide for our patients as well. Please consider this payment increase.
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 Driver, MD.

Submitter : **Dr. Diane Head** **Date: 08/29/2007**

Organization : **U of Wisconsin-Madison**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. John Taylor** **Date: 08/29/2007**

Organization : **University of California, San Francisco**

Category : **Physician**

Issue Areas/Comments

Background

Background

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.

John Taylor, MD
Assistant Clinical Professor
Department of Anesthesia and Critical Care
University of California, San Francisco

Submitter : David Ingbar MD **Date:** 08/29/2007

Organization : American Thoracic Society

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10843-Attach-1.PDF

#10843

Carl C. Booberg
Executive Director
American Thoracic Society

Gary Ewart
Director
Government Relations

Fran Du Melle
Director
International Activities

Washington Office
1150 18th Street, N.W.
Suite 300
Washington, D.C. 20036-3816
Phone: (202) 296-9770
Fax: (202) 296-9776
Internet: www.thoracic.org

National Headquarters
61 Broadway
New York, NY 10006-2747
Phone: (212) 315-8600
Fax: (212) 315-6498
Internet: www.thoracic.org

Official Journals

American Journal of Respiratory and Critical Care Medicine ®

American Journal of Respiratory Cell and Molecular Biology®

Proceedings of the American Thoracic Society

Internet: www.atsjournals.org

August 31, 2007

Herb B. Kuhn
Acting Director
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
7500 Security Blvd., Mail Code C5-01-14
Baltimore, MD 21244-1850

Re: CMS-1385-P Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2008

American Thoracic Society Comments address: SGR and proposed negative (-9.9%) update of the conversion factor; Budget Neutrality; Equipment Utilization and Interest rates; Pricing of High Cost Medical Supplies; Multispecialty Practice Physician Survey TRHCA-Section 101(b): PQRI; Therapy Cap

Dear Mr. Kuhn:

On behalf of the members of the American Thoracic Society (ATS), I want to express our appreciation for the opportunity to comment on the proposed rule regarding Medicare's proposed revisions to payment policies under the Physician Fee Schedule for calendar year 2008 and other changes to payment under Part B published on July 12, 2007. The ATS represents over 18,000 physicians, researchers, and allied health professionals, who are actively engaged in the diagnosis, treatment and research of respiratory disease and critical care medicine. We are most interested in quality care and access to care for the beneficiaries you represent, and those patients we serve.

The ATS offers the following comments.

SUSTAINABLE GROWTH RATE (SGR) AND PROPOSED -9.9% Update

As expected, a 9.9 percent across the board cut of the conversion factor for the Medicare physician payments was announced in this rule. Previously, Congress has intervened to put the SGR formula aside and mandate a Medicare conversion factor. ATS continues to believe the SGR formula is seriously flawed and needs to be replaced. The SGR continues to not be dealt with and is the source of the problem for the yearly negative updates to the MPFS. CMS continues to underestimate the impact of National and Local Coverage Decisions on increased spending on physician services under Medicare. Additional funding needs to be added to the MPFS for all the ancillary costs associated with new preventive benefits being added for beneficiaries. As stated in our previous comments, , the ATS strongly support the removal of the costs of Medicare-covered physician-administered drugs from the SGR calculation. CMS must use its discretionary authority to remove the costs of Medicare-covered physician-administered drugs from the SGR calculation, which have increased from $1.8 billion in 1996 to $8.1 billion in 2005 and an estimated $8.5 billion in 2006. The vast majority of the medical community has commented on this issue and remains frustrated that the SGR-adjustment to the Medicare physician fee schedule has not been made.

BUDGET NEUTRALITY/FIVE-YEAR REVIEW WORK ADJUSTOR

The ATS strongly opposes the work adjuster and agrees with AMA and other medical specialty societies that the -11.8 percent work adjustor be eliminated. Budget neutrality adjustments should be made in the conversion factor, not in relative work values. . Additional monies need to be infused into the Medicare program, because the additional preventive services that have been added increase utilization.

EQUIPMENT USAGE PERCENTAGE ASSUMPTIONS

The ATS recommends that the 50 percent utilization rate for all equipment be increased. We believe the original ABT studies showed utilization of 70 percent, and that is a more correct number to use in your calculations.

EQUIPMENT INTEREST RATE ASSUMPTIONS – COST OF CAPITAL ASSUMPTIONS

CMS uses an interest rate of 11 percent in pricing medical equipment. We support the AMA RUC letter that the utilization rate be reviewed frequently and that CMS spell out exactly the assumptions made in assigning a utilization rate.

PRICING OF HIGH COST DISPOSABLE MEDICAL SUPPLIES

The ATS supports the AMA RUCs letter that indicates that the 50 medical supplies priced at or above $200 be reported separately with a J-code, or individually identified within the payment bundle and repriced annually.

PHYSICIAN PRACTICE INFORMATION SURVEY DATA

The ATS agrees with the AMA RUC position that CMS utilize recent, reliable, and consistent practice expense data for all specialties and health care professionals. We are most concerned that we had previously asked to perform a practice expense study, and were told that CMS would not accept the data because we were beyond the deadline. So we would be very concerned that radiology be given such a substantial increase when we were told we would not be able to do a study and have the results reviewed. This request was after the 8 specialties provided their data to CMS, and before AMA contracted with Gallup for the current multispecialty practice expense survey.

TRHCA-SECTION 101(b): PQRI

ATS has encouraged its members to participate in the 2007 PQRI initiative, and believe that very few members have been able to participate because of the significant cost to the practice, which is not compensated by the 1.5% incentive to participate. Pulmonary has eight measures on the 2007 list of performance measures: two each for COPD and Asthma, and four for Pneumonia. ATS is pleased to see Inquiry regarding Tobacco Use, and Advising Smokers to Quit on the Table 20-Additional AQA Starter-Set Measures on the list for 2008 PQRI (page 38202) quality measures. Especially with the transitioned G0375, G0376 codes into CPT for smoking cessation counseling on January 1, 2008. The ATS continues to encourage the membership to be aware of these smoking cessation counseling codes and use them for patients requiring this service.

The ATS appreciates the opportunity to comment on the proposed rule under the Medicare Physician Fee Schedule. Should you or your staff have any questions, please do not hesitate to contact me or Gary Ewart at gewart@thoracic.org or 202-296-9770.

Sincerely,

David H. Ingbar

David H. Ingbar, MD
President, American Thoracic Society

Cc: Kenneth Simon, MD, CMS
Edith Hambrick, MD, CMS
ATS Clinical Practice Committee
Diane Krier-Morrow, ATS Consultant

Submitter : **Ms. Melissa Zinsmeister-Wilgus** **Date: 08/29/2007**

Organization : **Columbus Children's Sports Medicine**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Melissa Wilgus and I am a Certified Athletic Trainer in the state of Ohio.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Melissa Zinsmeister-Wilgus, MS,ATC,CSCS

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

We are an independent physical therapy practice in Sioux City, IA. We currently employ 5 physical therapists. For 12 years we have received between 15 and 30 referrals per month from an independent orthpedic surgeon in town. In May of 2007 this surgeon joined a large physician group that owns a physical therapy clinic. Since his departure from independent practice his referrals to our clinic have plumeted. He is a very busy orthopedic surgeon who routinely refers to physical therapy. In August of 2007 we received 1 referral from him. Other independent physical therapists in the area report the same story. In fact patients we have previously seen have reported to us that they have been encouraged to switch to this Dr.'s group practice. There have been many reports that the patients are not given a choice unless they demand it even if they have been happy with where they have previously received therapy, in our clinic or elsewhere. The following shows our referrals for the year from this particular orthopedic surgeon.
January 20,
February 18,
March 16,
April 22,
May 8,
June 5,
July 4,
August 1.
Now that he is a member of a large surgical group whose aggressive policy of keeping all services in house has greatly affected our independent practice as well as other independent practices in the area. The intensity of this policy has escalated to the point where they are setting up physical therapy clinics in other locations. It appears they are trying to eliminate all other choices for health care in our area.

Submitter : **Dr. Kari Bakeris** **Date: 08/29/2007**

Organization : **Bakeris Family Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Kari Bakeris, DC
Coralville, IA

Submitter : **Mr. Charles Liggett** **Date: 08/29/2007**

Organization : **Spanaway Lake High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

LETTER

Dear Sir or Madam:

I am a Certified Athletic Trainer working in Washington State at a High School.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Charles L. Liggett MS, ATC

Submitter : **Mr. Marcus Homer** **Date: 08/29/2007**

Organization : **Intermountain Healthcare**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Marcus Homer and I am a certified athletic trainer. I work for Intermountain Healthcare in St. George, Utah. I work part time in a physical therapy clinic with a physical therapist and I also work at an area high school representing Intermountain Healthcare as an athletic trainer. I have ample experience in my field including employment at the university level, professinal sports and clinical levels. I have earned a bachelors degree in athletic training and spanish. Also, I have a master of science in education degree. Along with my National Athletic Trainers' Association certification and state licensure I know that I am qualified to work as a qualified healthcare professional in physical medicine and rehabilitation.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Marcus Homer ATC/L, MSEd

Submitter : **Mr. John Pomponio- Careccia** **Date: 08/29/2007**

Organization : **Poly Prep Country Day School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is John Pomponio- Careccia and I am a Certified Athletic Trainer at Poly Prep Country Day School. I have been certified for almost 1 year and hold a Masters Degree in Sports Medicine/Athletic Training. I provide first aid, theraputic exercises and perform clinincal evaluations for almost 1000 kids ranging from 6th grade thru 12th grade on a daily basis.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

John Pomponio-Careccia, MS ATC

Submitter : Dr. Christian Robertozzi **Date:** 08/29/2007

Organization : American Podiatric Medical Association

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10850-Attach-1.DOC

#
10850

September 11, 2007 Deleted: August 29, 2007

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

Re: Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Mr. Kuhn:

On behalf of the American Podiatric Medical Association (APMA), the national association representing more than 11,000 podiatric physicians and surgeons, I am pleased to submit comments on a variety of issues addressed in the proposed rule published July 12, 2007, which proposed changes to the Medicare physician fee schedule (PFS) and other Medicare Part B payment policies.

Additional Codes from the 5 Year Review of Work RVUs

As discussed in the CY 2007 PFS final rule with comment period, CMS deferred for one year the decisions on proposed changes to the work RVUs for 58 codes from the 5 Year Review, either because they had not yet received the RUC recommendation or because CMS suggested that the RUC re-evaluate the original recommendation. These additional codes are still considered part of the 5 Year Review. CMS proposes to accept all but one of the RUC recommendations, an acceptance rate of 98 percent. We believe the high acceptance rate is a reflection of the RUC's competence in determining the value of physician work through a deliberative and equitable process that involves all specialties, including podiatric medicine. We are proud to be a part of this process and we commend CMS for recognizing the RUC's value in the ongoing maintenance of the physician fee schedule.

Included in the list of additional codes from the 5-year review are seven codes that describe initial nursing facility care, subsequent nursing facility care and an annual nursing facility assessment (CPT codes 99304-99310). Included in this family of codes are services that are commonly performed by podiatrists. We strongly recommend acceptance of the RUC recommendations in the final rule for these and other codes for which CMS proposes to accept the RUC's recommendations.

Proposed Conversion Factor Update for 2008

We continue to be concerned about the impact of the sustainable growth rate (SGR) formula on payments for services under the fee schedule. Ironically, any increases in work RVUs for the codes described above will be largely offset by the proposed -9.9 percent update of the conversion factor for 2008. While we do not have evidence of a significant increase in the number of podiatrists who have placed limits on new Medicare patients, we are concerned that could change if payments for all services are reduced nearly10 percent across the board in 2008. Clearly, if a reduction of this magnitude is put into place, beneficiary access to physicians' services will be adversely affected.

We urge CMS to use its discretion to revise the calculation of physician expenditures and to support efforts in Congress to replace the SGR policy. Specifically, we do not think physician expenditures should include the cost of prescription drugs furnished incident to a physician's service because including them in the estimates of spending under the fee schedule holds physicians accountable for an expense that is largely outside their control and one that is rising very rapidly. In addition, we believe that the estimate of physician expenditures should be adjusted to account for increased outlays related to new national coverage decisions. In our view, there is no difference between a change in law that extends Medicare coverage and a change in national coverage policy initiated by CMS.

Budget Neutrality/Five-Year Review Work Adjuster

The Medicare statute requires that increases or decreases in relative value units (RVUs) for a year may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. In 2007, CMS created a new "work adjuster" to ensure budget neutrality following the implementation of the improved work RVUs from the 2005 Five-Year Review of the RBRVS, despite the vigorous opposition of virtually every specialty society. For 2008, again CMS proposes to apply a work adjuster (0.8816 or -11.8 percent) to all work RVUs to maintain budget neutrality rather than adjust the conversion factor.

We are opposed to the use of a work adjustor for the following reasons:

- It adds an extra element to the physician fee schedule payment calculation that creates confusion and questions among the public who have difficulty using the RVUs to determine a payment amount that matches the amount actually paid by Medicare
- Adjusting the work RVUs affects the relativity of services. For example, if the work RVUs are adjusted as proposed, it will disproportionately affect codes with physician work that are commonly performed by podiatrists, such as E/M services and surgical procedures.
- Adjusting the work RVUs has an adverse impact on other payers who use the Medicare RVUs and their own conversion factors.

We recommend elimination of the work adjustor and an adjustment of the conversion factor to maintain budget neutrality.

Physician Self-Referral Provisions

APMA believes the Stark law exists to eliminate incentives to make referrals for services to the Medicare program. Congress authorizes CMS to create exceptions so that the typical and desirable practice of medicine doesn't trigger a Stark violation. APMA encourages CMS to remember that some arrangements improve patient care or the efficiency of health care delivery more than they might create a risk for improper referrals. APMA is concerned that CMS will restrict practices that benefit patient care and health care delivery at a much greater level than they create a risk for incentivizing referrals. If CMS knows of outliers abusing the system with referrals, then CMS should use education and intervention first and, if necessary, then turn to criminal or civil law enforcement, to address the individual problem. CMS shouldn't change the rules merely on the theory that there could be abuse.

Therapy Standards and Requirements

CMS proposes updated qualification requirements for physical therapists (PTs), occupational therapists (OTs), physical therapy assistants (PTAs) and occupational therapy assistants (OTAs). CMS also proposes an expanded grandfathering policy under which PTs, OTs, PTAs or OTAs who meet their respective State qualifications (or have received State recognition as PTs, OTs, PTAs or OTAs) before January 1, 2008 would not have to meet these updated qualifications.

In the proposed rule, CMS states that "It is not our intention to modify the policy that requires physical therapy, occupational therapy, and SLP services furnished incident to a physicians service to meet all the standards and conditions (except licensure) that apply to therapists, as this policy is based on the section 1862(a)(20) of the Act. Rather, it is our intention to assure that Medicare payment is made only for physical therapy, occupational therapy, and SLP services provided by personnel who meet qualifications, including consistent and appropriate education and training relevant to the discipline, so that they are adequately prepared to safely and effectively treat Medicare beneficiaries."

We appreciate this clarification and support the proposed changes related to education and training. We also support the proposal to replace the current 30-day recertification requirement for outpatient therapy with a 90-day recertification requirement. The 30-day recertification requirement is an unnecessary burden that has not been shown to limit therapy services.

Percentage Change in the Medicare Economic Index (MEI)

The Medicare Economic Index (MEI) is a measure of the cost of providing medical care. The MEI values a "market basket" of inputs to the price of health care (salaries, equipment, services, etc) to assess annual changes in the price of health care. The MEI is used, in conjunction with the Sustainable Growth Rate formula to update the Medicare physician fee schedule on an annual basis. The proposed rule includes a preliminary estimate of the expected MEI update for CY 2008. The forecasted increase in the MEI is 1.9 percent, which includes a forecasted 1.5 percent productivity offset.

We object to the proposed 1.5 percent productivity offset which we believe is significantly overstated. The expansion of Medicare reporting requirements for PQRI (and other CMS initiatives) has reduced productivity in physicians' offices. As described below, we support the Physician Quality Reporting Initiative (PQRI). However, successful reporting requires a significant new commitment by physicians and their office personnel. We ask that CMS consider the adverse impact of the CMS reporting requirements on physician productivity when the final MEI is calculated for 2008 and reduce the size of the productivity offset.

Physician Quality Reporting Initiative (PQRI)

In Part II, Section T(c)(vii) of the proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes to include measures in the final 2008 Physician Quality Reporting Initiative (PQRI) quality measures selected from those listed in Table 22 that are currently under development by the American Podiatric Medical Association (APMA) and that achieve National Quality Forum (NQF) endorsement or American Quality Alliance (AQA) adoption by November 15, 2007:

- Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation
- Diabetic Foot and Ankle Care, Peripheral Arterial Disease: Ankle Brachial Index (ABI) Measurement
- Diabetic Foot and Ankle Care, Ulcer Prevention: Evaluation of Footwear.

Diabetes is the leading cause of lower extremity amputations, which are detrimental to a Medicare beneficiary's quality of life as well as expensive for the Medicare program. Despite widespread agreement among public health and medical experts that an amputation could be prevented if a patient with diabetes receives quality foot and ankle care, the number of amputations continues to rise. The three quality measures developed by the APMA would encourage physicians and other practitioners to evaluate diabetic patients for possible peripheral neuropathy, measure the ABI of diabetic patients for possible PAD, and evaluate footwear of diabetic patients to prevent ulceration. The evaluations and measurement can identify diabetic patients who have a particularly high risk of lower extremity complications. The identification of patients who need appropriate foot and ankle care would help address a gap in care that has allowed the number of amputations to increase. Thus, the APMA believes that these three quality measures should be included for reporting in the 2008 PQRI, and encourages CMS to facilitate approval of all three measures by the NQF or the AQA prior to November 15, 2007.

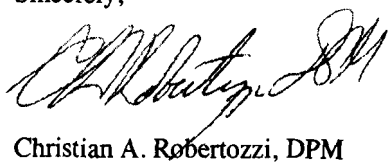
The proposed rule lists the measures in Table 22 as "Podiatric Measures." We respectfully request that the title be revised to "Diabetic Foot and Ankle Measures" so that other practitioners who treat diabetic patients will immediately recognize that these clinically important measures are available to them under the PQRI.

We greatly appreciate CMS' recognition of the APMA work in this area. We also commend the CMS staff who have worked closely with us to refine the measures and to have them considered for endorsement by the relevant organizations.

Conclusion

The APMA appreciates the opportunity to offer these comments. If you require additional information, please contact Rodney Peele, Assistant Director for Health Policy and Practice, at (301) 571-9200, extension 230.

Sincerely,



Christian A. Robertozzi, DPM
President, American Podiatric Medical Association

Submitter : Dr. Nike Taylor **Date:** 08/29/2007

Organization : Taylor Chiropractic

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Re: 410.32 Section 1861 (r)(5): The proposed rule dated 7/12 contained an item underthe technical corrections section calling for the removal of the paragraph that allows payment for an x-ray ordered by a non-treating physician when a Doctor of Chiropractor will use the x-ray. I am in strong opposition to this proposal. While x-ray is not required to detect subluxation, in some cases the patient clinically requires an x-ray to rule out other pathologies or conditions that may require a change in the type of treatment required, alert the DC to recommend other imaging procedures, i.e. MRI, CT, a referral to a different type of practioner. By restricting a Doctor of Chiropractic from referring directly to a radiology facility, the cost of health care increases because an additional doctor's visit is required to obtain the prescription for the x-ray; the patient, who is likely in pain, needs to make a trip to another doctor's office, the testing and treatment is delayed. I stronly urge you to table this proposal. These xs-rays, if needed are an integral part of the treatment plan of Medicare patients and it is ultimately the patient that will suffer should this proposal become a standing regulation. Sincerely, Dr. Nike Anne Taylor

Submitter : Mr. Tony Curry **Date:** 08/29/2007

Organization : VA medical Center/Veterans Affairs

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

I am asking that you reject to the proposed"Therapy standards and requirements in the CMS regulations (docket #1385-P).
I work in the VA medical rending therapy to veterans.This would jeopardize the services I now render to needy vets.
As a Kinesiotherapist, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, and Registered status insure that my patients receive quality health care.
Sincerely,
Tony Curry, RKT

Submitter : **Dr. helmut cascorbi** **Date: 08/29/2007**

Organization : **Case University Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I urge that the increases of Mewdicare reimbursement be implemented. Most academic departments of Anesthesiology are in dire financial straits.The training of fururc Anesthesiologists and anesthetic care in the USA in the future is in jeopardy! HF Cascorbi,MD,PhD, Professor of Anesthesiology.

Submitter : **Renee Breault** **Date: 08/29/2007**

Organization : **Johnson State College**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Renee Breault, and I am a certified athletic trainer at Johnson State College in Vermont. I have been an ATC for 5 years, and have recently furthered my education earning a Master of Science in Performance Enhancement, and Injury Prevention focused on all populations. With my Masters I also earned a certification as a Performance Enhancement Specialist (PES).

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Renee A. Breault, MS, ATC, PES

Submitter : **Ms. Nancy Runyon** **Date: 08/29/2007**

Organization : **St Joseph Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My Name is Nancy Runyon and I am employed as an Athletic Trainer by St. Joseph Medical Center in Reading, PA. I received my masters dgree in education and have been certified as an EMT for over 20 years. My qualifications surpass that of others in the same setting as myself.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Nancy E. Runyon, M. Ed, ATC, EMT

Submitter : **Mrs. Jeanie Neumeyer** **Date: 08/29/2007**

Organization : **Vanderbilt Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007

Dear Sir or Madam:
My name is Jeanie Neumeyer, and I work at the Vanderbilt Orthopaedic Institute in Nashville, TN. I, along with 18 other Certified Athletic Trainers, work in outpatient therapy as well as provide medical coverage to local high schools . We are all individuals with Master s Degrees, NATABOC certification, and state licensure. Our rehabilitation model is one of the most efficient in the country and provides the patient the best care available as Athletic Trainers are utilized as a team member with our physical therapists. The extensive training and education that we as athletic trainers have in the area of orthopaedics is a perfect fit in outpatient therapy and far surpasses that of a PTA or PT tech.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, national certification, and licensure ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is a disservice for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,

Jeanie M. Neumeyer, ATC/L
Athletic Trainer
Vanderbilt Orthopaedic Institute
MCE, South Tower, Suite 3200
Nashville, TN 37232

Submitter : Dr. steven lysak **Date:** 08/29/2007

Organization : greenville anesthesiology p a

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : Dr. David Oliver **Date:** 08/29/2007

Organization : Anesthesiology Consultants of Columbia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please support the RUc recommendation for a 32% increase in anesthesiologist payments from Medicare, correcting the initial undervaluation of our services. Thank you for addressing this. We look forward to continuing to be able to care for our elderly.

Submitter : **Dr. Jonathan Beathe** **Date: 08/29/2007**

Organization : **Hospital for Special Surgery**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. richard Bend** **Date: 08/29/2007**

Organization : **Mich. Chiro. Assn. International Chiro. assn.**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Dear Govt. Employee, Believe it or not some of us citizens cannot afford the cost of x-ray or other examination fees so removing this option from us will create yet another governmental hardship on those of us who can least afford it. I believe this idea is mis-guided thinking on some accountants part and penny wise pound foolish. Maybe you should leave the doctoring to the Doctors and Quit meddeling.
Dr. Bend

Submitter : Mr. Steven Foley **Date:** 08/29/2007

Organization : Mt. Mansfield High School

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern,

I'm an Athletic Trainer in Vermont currently working at a small high school. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Steven M Foley

Submitter : **Dr. Gopal Gadodia** **Date: 08/29/2007**

Organization : **Atlantic CardioLink**

Category : **Other Health Care Provider**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

See Attached

CMS-1385-P-10862-Attach-1.PDF

#10862

ATLANTIC CardioLink

1305 SOUTH HICKORY STREET
MELBOURNE, FLORIDA 32901
(321) 952-9009
FAX (321) 952-9005

August 28, 2007

Herb B. Kuhn, Deputy Administrator (Acting)
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Proposed Revisions to Payment Policies Under the Physicians Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Mr. Kuhn:

On behalf of Atlantic CardioLink and our 13 individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the ***"Resource-Based PE RVU's"*** section of the above referenced July 2, 2007 Proposed Rule. We are specifically concerned with the 2008-2010 PE RVU's established for non-facility outpatient cardiac catheterization procedure codes and the significant negative impact that could result for our practice and our patients if these values are finalized for the 2008 Physicians Fee Schedule.

Atlantic CardioLink is an IDTF located in Melbourne, Florida, which was established in 1999 for outpatient cardiac cath services. This facility has 13 physicians successfully utilizing its services. Atlantic CardioLink operates with just one cath lab suite in which we perform about 1,000 procedures per year.

Atlantic CardioLink is a founding member of the Cardiovascular Outpatient Center Alliance (COCA) and as such we have actively been involved in the work that COCA has accomplished this year to collect and submit direct and indirect cost data to the AMA's Practice Expense Review Committee (PERC) of the Relative Value Scale Update Committee (RUC). Unfortunately, this process did not allow all of COCA's data to be considered and resulted in PE RVU recommendations to CMS that severely undervalued the direct and indirect costs associated with providing these procedures to our patients.

It is apparent from the July 2, 2007 Proposed Rule that CMS has accepted the RUC recommendations without considering the detailed direct cost information that COCA provided to CMS in May 2007. The PE-RVU values set out in the July 2 Proposed Rule would result in a draconian cut in reimbursement for cardiac catheterizations performed in

practice or IDTF locations. For example, if the 2007 conversion factor is applied to the technical component of the primary three CPT codes for a Left Heart Cath (93510TC, 93555TC, and 93556TC) the reimbursement in 2008 would be cut by **32%** and when fully implemented the total reimbursement would be reduced by **49%**. These reductions would undoubtedly result in the closing of the majority of non-facility outpatient cardiac catheterization labs in the country forcing all patients who now benefit from improved access and lower costs into more acute hospital settings.

It has also come to my attention recently that reimbursement for outpatient hospital APC rates (code 0080) have been proposed to receive an increase of **11.19%** for 2008 while the equivalent procedure performed in an outpatient IDTF setting will receive a decrease in reimbursement by **32.18%**.

I am requesting that CMS review the additional cost data provided by COCA and establish PE RVU's for outpatient cardiac catheterization procedures that more reasonably reflect the direct and indirect costs of providing these procedures. If the proposed RVU's are allowed to stand, the outcome will inevitably that will cost the Medicare program more in direct APC payments **and** Medicare patients more in higher deductibles and co-insurance.

Thank you for this opportunity to comment on this important issue.

Sincerely,

Gopal Gadodia, MD
Medical Director

Submitter : Dr. Margaret Sedensky **Date:** 08/29/2007

Organization : University Hospitals of Cleveland

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 : **Dr. Mark Lantz** **Date: 08/29/2007**

Organization : **Anesthesiology, PA**

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.

Mark S. Lantz, MD
12200 Orchard Hill
Eden Prairie, MN 55344
Anesthesiology, PA
952-929-1643

Submitter : **Mr. Daniel Hinely** **Date: 08/29/2007**

Organization : **Armstrong Atlantic State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Daniel R. Hinely and I am the head athletic trainer for Armstrong Atlantic State University in Savannah, GA. As the head athletic trainer I am responsible for the healthcare of all the student-athletes at AASU. My job is not an easy one and requires long hours, seven-day work weeks, traveling on buses for hours at a time, on top of making sure my athletes are stay healthy enough to compete at a high level. I take pride in what I do and in return my job has been very rewarding. My educational and professional background includes both bachelor s and a master s degrees, a national certification, as well as state licensure. I have devoted many years assuring that I practice my profession to the highest standards possible and hope that you recognize this as well.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Daniel R. Hinely, MEd, LAT, ATC

Submitter : **Andrea Jette** **Date: 08/29/2007**

Organization : **U-32 Junior-Senior High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Andrea Jette and I am a newly certified and licensed Athletic Trainer in the state of Vermont. I recieved my dream job as soon as I finished my 4 years of college at the University of Vermont. I am currently working at U-32 Junior-Senior High School as the Head Athletic Trainer and Assistant Athletic Director..

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Andrea Jette, ATC

Submitter : **Dr. Jerry Crawford** **Date: 08/29/2007**

Organization : **Gulf Shore Anesthesia Associates**

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.
Jerry Crawford, MD

Submitter : **Mr. Larry Johnson** **Date: 08/29/2007**

Organization : **Tulsa Hand Therapy**

Category : **Occupational Therapist**

Issue Areas/Comments

TRHCA-- Section 201: Therapy CapS

TRHCA-- Section 201: Therapy CapS

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

RE: CMS-1385-P

08/29/07

Dear CMS Representative:

I am writing this letter to express my concern regarding the proposed Medicare Fee Schedule (MPFS) revision that will dramatically affect the reimbursement of Physical and Occupational Therapy services provided to the elderly patients in my community.

This proposed method for reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care.

I understand that the AMA, the American Physical Therapy Association, and the American Occupational Therapy Association, as well as other organizations are preparing an alternative solution to present to congress. Please give this information much consideration and preserve these patients right to adequate and necessary medical care.

Sincerely,

Larry Johnson, MSA, OTR/L, CHT
Director

Submitter : **Dr. J. Michael Evans** **Date: 08/29/2007**

Organization : **Greenville Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

J. Michael Evans, M.D.

Submitter : **Dr. David Longnecker** **Date: 08/29/2007**

Organization : **Dr. David Longnecker**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Physician Payment for Anesthesia Services. See Attachment

CMS-1385-P-10870-Attach-1.RTF

#10870

August 29, 2007

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 write to support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has finally recognized the long-standing undervaluation of anesthesia services, and that the Agency plans to address this 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. Implementation of the RUC's recommendation would begin to address at least one of several disparities regarding physician payment for anesthesia services, and I support this initial step in the process.

To ensure that some of our sickest and most vulnerable patients (i.e., those eligible for Medicare) have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register and fully implement the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

David E. Longnecker, MD.

David E. Longnecker, MD
2 Horn Point Court
Annapolis MD 21403

Submitter : **Dr. Lydia Grondin** **Date: 08/29/2007**

Organization : **Fletcher Allent Health Care**

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 : **Mr. Doug May** **Date: 08/29/2007**

Organization : **McCallie School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Without outreach for athletic training many of our coutry's youth would have no care during athletic events. I see this everytime we compete vs other schools who do not have a full time athletic trainer at their institution

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for many.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my athletes receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring athletes receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their athletes. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Doug May,ATC
Athletic Trainer
McCallie School

Submitter : **Miss. Stephanie Lennon** **Date: 08/29/2007**

Organization : **Oak Ridge High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I am a certified and licensed athletic trainer at Oak Ridge High School in Orlando, Florida.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Stephanie A. Lennon, MS, NBCT, ATC, LAT

Submitter : **Mr. Jeff Kimak** **Date: 08/29/2007**

Organization : **Athletico LTD**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a graduate of Illinois State Univerisity and am a certified athletic trainer and have been for the past 14 years. I am currently employed by AthletiCo.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jeff Kimak, ATC

Submitter : **Mr. Bruce Bjornson** **Date: 08/29/2007**

Organization : **Mr. Bruce Bjornson**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

_Bruce Bjornson CRNA_____
Name & Credential
__3670 Brookfield Lane _____
Address
_Idaho Falls, Idaho 83404_____
City, State ZIP

Submitter : **Dr. Thomas Hill** **Date: 08/29/2007**

Organization : **North Carolina Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

Background

Background

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:
As President of the North Carolina Society of Anesthesiologists, I have visited 15 practices in rural areas of North Carolina, in the last 4 months. The percentage of the patient population insured under either Medicare, or Medicaid continues to grow in all of these practices. The physicians serving those patients are relying on income and support from CMS and the state-sponsored programs related to Medicaid. As the population continues to grow in North Carolina- it is clear that the retirement age percentage will rise disproportionately to the younger members. Our state faces a potntial shortage of physicians to care for these citizens.
I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.
Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit.
CMS can assist these rural practice physicians in sustaining the access to quality care through reimbursement improvement.
Thank you for your consideration of this serious matter.

Thomas R. Hill, MD
President, North Carolina Society of Anesthesiologists
Hickory, North Carolina

Submitter : **Dr. Andrew Goins** **Date: 08/29/2007**

Organization : **ASA Member**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Andrew Goins, D.O.

CMS-1385-P

Submitter : Mr. Scott DeGraff **Date:** 08/29/2007

Organization : AthletiCo, LTD

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I am a certified athletic trainer with a masters degree in athletic training and exercise physiology. I currently work for AthletiCo, Ltd., as an assistant athletic trainer. I have been an athletic trainer for 6 years in various settings from hospitals, to high schools, and even professional sports.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for many patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Scott DeGraff, M.S., ATC

Submitter : **Mr. Edward Duag** **Date: 08/29/2007**

Organization : **VA hospital Long Beach**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

RE: Docket #1385-P Therapy Standards and Requirements, Physician Self-Referral Provisions

BRIEF INTRO ABOUT SELF: I am Edward Duag and I am a Registered Kinesiotherapist @ the VA in Long Beach. I am currently working in the Driver training and Acute GMS clinics. I am certified as a Kinesiotherapist, have a BS in Kinesiotherapy, a minor in Psychology and am trained as a driver trainer.

I am writing today to voice my opposition to the proposed therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and other facilities proposed in Federal Register issue #1385-P. As a Kinesiotherapist, I would be excluded from providing physical medicine and rehabilitation services under these rules.

I am concerned that these proposed rules will create additional lack of access to quality health care for my patients. This is particularly important because my colleagues and I work with many wounded Veterans, an increasing number of whom are expected to receive services in the private market. These Medicare rules will have a detrimental effect on all commercial-pay patients because Medicare dictates much of health care business practices.

I believe these proposed changes to the Hospital Conditions of Participation have not received the proper and usual vetting. CMS has offered no reports as to why these changes are necessary. There have not been any reports that address the serious economic impact on Kinesiotherapists, projected increases in Medicare costs or patient quality, safety or access. What is driving these significant changes? Who is demanding these?

As a Kinesiotherapist, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, and Registered status insure that my patients receive quality health care. Hospital and other facility medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards and accepted practices.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the health care industry. It is irresponsible for CMS to further restrict PMR services and specialized professionals.

It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to reconsider these proposed rules. Leave medical judgments and staffing decisions to the professionals. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Edward Duag, RKT

Submitter : Ms. Linda Wappner **Date:** 08/29/2007

Organization : NATA

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Linda Wappner MS, ATC and I employed by Munising Memorial Hospital in Munising, MI. This is a rural community which struggles to fill Physical Therapy positions. We currently have a waiting list of 21 patients which will not be seen in the next 2-3 weeks. It has been frustrating in patient care due to the limitations CMS has placed on Athletic Trainers. I would encourage you to view the problems in rural communities before making these decisions.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Linda Wappner MS, ATC

Submitter : **Mr. Michael Fabbri** **Date: 08/29/2007**

Organization : **Henry Ford Health System**

Category : **Other Practitioner**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a Certified Athletic Trainer at Henry Ford Health System. My title as the Center for Athletic Medicine outreach coordinator makes me responsible for the athletic trainers that provide services to local high schools and other programs for the community to prevent injuries and to improve the health of those individuals. Another part of my job is to work together with our Physical Therapist to provide the best care for our patients. This includes meeting on a weekly basis to discuss the status of the patient and determine if any changes need to be made. This gives the patient the expertise of both our professions to help them recover from their injuries quicker and with less chance of re-injury. I have been a certified Athletic Trainer for 20 years. I graduated with a bachelor s degree in Sports Medicine that included courses in anatomy, physiology, therapeutic techniques, evaluation techniques and other medically related subjects. I was certified by the National Athletic Trainers Association (which is now the Board of Certification) in February 1986. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Michael A. Fabbri ATC

Submitter : **Jeff Martinez** **Date: 08/29/2007**

Organization : **University Sports Medicine**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Jeff Martinez. I am a Certified Athletic Trainer and the Supervisor of Sports Medicine for the University of Mississippi Medical Center in Jackson, Mississippi.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jeff Martinez, MAT, ATC
Supervisor of Sports Medicine
University of Mississippi Medical Center
2500 N. State St
Jackson, MS 39212
601-984-6519
jmartinez@orthopedics.umsmed.edu

Submitter : Mr. John Eaton **Date:** 08/29/2007

Organization : University of Pittsburgh at Bradford

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is John Eaton, I am a certified athletic trainer, and I am currently employed at the University of Pittsburgh at Bradford. I have been certified by the NATABOC for over 18 years and have worked in the clinical setting for 16 of those years. Due to all of the changes and issues with CMS, I was forced to find employment that would be secure for myself and my family (I am married and have 3 children). Additionally, I am taking graduate courses for my Masters degree while working full time.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for active individuals. As Baby Boomers continue to get older and stay active, they are likely to sustain musculoskeletal injuries that will require treatment and rehabilitation. It is unfair and unjustified to limit their access to qualified healthcare professionals for care, especially if they live in a rural area where their choices are few and limited already.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

John R. Eaton, ATC

Submitter : **Dr. Shanaj Khalique** **Date: 08/29/2007**

Organization : **Dr. Shanaj Khalique**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Shanaj Khalique,D.C.

Submitter : **Ms. Christina Mascaro** **Date: 08/29/2007**

Organization : **Andrews Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Sir or Madam:

My name is Christina Mascaro, currently a Certified Athletic Trainer and Clinical Assistant at Andrews Sports Medicine & Orthopaedic Center. I have completed a Bachelor's degree in Athletic Training and a Master's degree in Sport Management. In my position, I provide health care to medicare and medicaid patients each day under the supervision of a physician.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Christina Mascaro, ATC, MS

Submitter : **Dr. Kenneth Rogers** **Date: 08/29/2007**

Organization : **University of Pennsylvania**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

BRIEF INTRO ABOUT SELF ie. Where you work, what you do, education, certification, etc.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kenneth Rogers, PhD, ATC, CCRP

Submitter : **Miss. Lynn Toerge** **Date: 08/29/2007**

Organization : **Hampton School District**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,
I have been the Certified Athletic Trainer in the Hampton School District in Pittsburgh, PA for 25 years.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Lynn Toerge, ATC

Submitter : Mr. Peter Guilfoyle **Date:** 08/29/2007

Organization : Lyndon State College Athletic Training Department

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am the Head Athletic Trainer at a small college in the northeast region of vermont. Like all Athletic Trainers, I have a bachelors degree in sports medicine with a focus on athletic training. I am certified by the national athletic trainers association and hold a license to practice in the state of Vermont within the provisions of physical medicine and rehabilitation.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Peter A. Guilfoyle, ATC

Submitter : **Mrs. Kathleen Williams** **Date: 08/29/2007**

Organization : **Excel Sports Medicine**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:
My name is Kathleen Williams and I work for Community Mercy Health Partners in Springfield, OH. I am an athletic trainer in a clinical setting for physical therapy. I have a BS in Sports Medicine and a MA in Counseling. I am certified by the National Athletic Trainers Association to work as a Certified Athletic Trainer.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,

Kathleen M. Williams, MA, ATC, CSCS

Submitter : **Mr. Walter Smith** **Date: 08/29/2007**

Organization : **Indiana University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Walter Kip Smith and I am the Head Athletic Trainer at Indiana University. I am credentialed as having certification through the National Athletic Trainers Association Board of Certification and Licensed to practice Athletic Training in the State of Indiana.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Walter Kip Smith, MEd, LAT, ATC

Submitter : **Miss. Marcie Fyock** **Date: 08/29/2007**

Organization : **Clarion University of Pennsylvania**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I feel the CMS decision to change how hospitals staff their clinics and rehabilitation departments will negatively affect the athletic trainer who is currently working in this position and who is beyond qualified to be in this work setting. I am disappointed that this change has been proposed and I can only hope that the certified athletic trainer will be protected in this ordeal and that their qualifications will be respected and they will continue to include hospital clinics and rehabilitation departments as their employment settings. I will be very upset to see this change. The certified athletic trainer provides a tremendous service to the patients and clients that they interact with.

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I my past experience working for physcians, the providing doctors unethically refer all of their patients to physical therapy, using their own services exclusively. I have been in the unfortunate position of treating patients who did not require services, but the owner of the practice insisted on their treatment. The owner of the practice, the providing MD, also dictated frequency and D/C planning as well. Working for MD's in the past, I was required to treat 4-6 patients every hour and was granted approx 30-40 minutes for a new patient. In my experience I have witnessed MD's supplementing their lower reimbursement rates by employing PT's, increasing their productivity to irrational levels and providing a less than competitive salaries. As a new grad I was professionally burned out by a MD owned PT practice, an experience I have yet to fully recover from. I have treated pt's with untreatable diagnoses or with unreasonable expectations laid out by the referring provider. MD owned practices where I was employed have displayed zero regard for Medicare regulations, when they apply to one-on-one care versus group treatments. Being a physical therapist for only four years to date, I can honestly state that 99.9% of MD owned practices in my area practice in unethical manners, not only to their patients, but to their therapists as well. MD's do not concern themselves with the process of physical therapy and the demands on the therapists, only the bottom line. I have lost the enthusiasm I originally had for my profession for many reasons, but mostly secondary to my experiences working in MD owned clinics. I have been put in numerous unethical situations, provided poor care at times and made careless mistakes in these settings because of the unreasonable productivity demands of those practices. How can any therapist, never mind an entry level one, provide quality care to 4-6 patients at a time and grow as a professional. There are many aspects to healthcare that require scupulous examination, but the issue of physician self referral is an important one to those practicing as physical and occupational therapists. The MD's are infringing on our rights and practice acts, using their so-called superiority to justify their actions. Their practice methods need to be put into check and made to realize that physical therapy is not a financial tool, but a way to better the lives of all those who walk through our doors. Just examine the history of PT and roles we have played since WWI to realize the importance of PT's. We are the one's who are with the patients day in and day improving their function, while MD's reap the financial benefits. I hope my experiences, though limited, are helpful in examining this important and ethical dilemma that is severely effecting the practice of physical therapy.

Submitter : **Miss. Wendy Larson** **Date: 08/29/2007**

Organization : **Robert Packer Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Wendy Larson and I am a certified athletic trainer. I am employed by the Robert Packer Hospital and they contract me out to Towanda H.S. I received my B.S. at SUNY Brockport and then went on to complete the NATA's cerificatiion test to become a certified athletic trainer.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Wendy Larson, ATC, LMT (and/or other credentials)

Submitter : Dr. Kenneth Majkowski **Date:** 08/29/2007

Organization : RxHub, LLC

Category : Health Care Industry

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

See attachment

CMS-1385-P-10894-Attach-1.PDF

CMS-1385-P-10894-Attach-2.PDF

#10894

RXHUB™
Where the Prescribing Industry Connects

August 29, 2007

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Dear Sir or Madam,

RxHub, a leading supplier of content, connectivity and interoperability in the ePrescribing space, appreciates the opportunity to submit comments on the *Exemption to Foundation Standard Requirements for Computer-Generated Facsimiles* found starting on page 38194 of *proposed* rule CMS-1385-P dated July 12, 2007.

RxHub has reviewed the proposed rule to eliminate the exemption allowing computer generated faxes to transmit prescriptions with great interest. Because we are a utility that delivers data between payers, physician technology systems, pharmacy networks and pharmacies, this proposed ruling could potentially affect many constituents working with RxHub today. We have had numerous conversations as to how the proposed rule might affect our various participants and would like to take this opportunity to comment.

First and foremost, RxHub supports state and federal rulings that would accelerate the adoption and use of electronic prescribing. We feel that the general intent of this proposed regulation is to attempt to positively influence ePrescribing adoption and use. However, we feel that the proposed regulation is problematic as it is written for several reasons, as outlined below.

One issue with proposed rule is that the language is very unclear. The proposed rule as it stands does not precisely define what is meant by computer-generated faxes. In fact, the definition seems to vary throughout the document. We recommend that future guidance be clarified as to what is specifically meant by computer-generated faxing, so as to eliminate some of the confusion and problems this will create in implementation, as discussed below.

The timing of this proposed rule is problematic, due to the fact that the industry is working on an implementation timetable built around the requirements of ePrescribing standards adoption spelled out in the Medicare Modernization Act of 2003 (MMA). Having this exemption eliminated in 4/1/2009 when

380 St. Peter Street, Suite 530, St. Paul, Minnesota 55102 **PH** 651.855.3000 **FX** 651.855.3001 www.**RxHub**.net

the rest of the standards take effect may be more reasonable. How will this ruling affect the planned adoption date of April 1, 2009 of all the ePrescribing standards that will be promulgated by MMA? Will physicians be confused that this ruling is the new ePrescribing rule since it is tied to a differential reimbursement? MMA ePrescribing pilots suggest that the standards to be adopted in the next round of rulemaking in 2008 include Eligibility, Formulary and Benefits and Medication History in addition to the prescription transactions. A recent Gorman study on the Adoption of ePrescribing states that 70% of the economic value created by ePrescribing is derived in the decision support information delivered by the Eligibility, Formulary and Benefits and Medication History transaction standards. Why is only a subset of these standards being addressed early? It seems that since the implementation date of these additional standards is no more than 15 months later, CMS should be syncing up the implementation dates of all these standards as part of the overall ePrescribing implementation in the next round of rulemaking. We recommend that this exemption be eliminated in 2009, to be in sync with the adoption of standards emanating from the pilot testing as required by the MMA.

RxHub also believes that eliminating the computer-generated fax exemption at this time could seriously disadvantage both physicians and community pharmacies. Although this proposed rule seems to be aimed at increasing adoption by physicians, for example, physicians are at the mercy of their technology vendor to upgrade the vendor's ePrescribing module. A 1/1/2008 implementation date is unreasonable because most technology vendors have already planned and frozen releases well into 2008. As a result, physicians may be unable to comply with the proposed rule, even if they want to. Community independent pharmacies also have been slower to implement true EDI solutions. In our view, this proposed rule could significantly disadvantage the community independent pharmacy that does not have resources to implement a true EDI solution for the first time, uses a pharmacy technology vendor that has chosen not to implement a true EDI-solution for ePrescribing at this time that is NCPDP SCRIPT based, or would like to implement such a solution by January 1, 2008 ,but cannot do so because of resource constraints either by the pharmacy technology vendor or the transacting pharmacy network. In order to minimize the potential adverse effects on physicians and community pharmacies, RxHub again recommends that this exemption be eliminated in sync with the adoption of the other MMA ePrescribing standards.

These definitional and timing problems also create a variety of issues that may lead to unintended consequences in implementation. These will serve as barriers to ePrescribing adoption or create confusion in the industry, create workflow problems in pharmacies and physician offices and lead to potential enforcement problems. For example:

- Pharmacies must communicate prescription renewals and changes to clinicians. Will pharmacies that have implemented the NCPDP SCRIPT standard and can transact in an EDI format be prohibited from e-faxing to physician technology systems that are not NCPDP SCRIPT-enabled? In other words, must a pharmacy revert to paper faxing to this physician population? Will a pharmacy not implemented to the NCPDP SCRIPT standard be able to e-Fax a physician technology system that is also not implemented? This scenario would punish the NCPDP SCRIPT implemented pharmacy and may slow down the adoption by the Nation's pharmacies.

- In the reverse scenario, will physician technology systems that are implemented to the NCPDP SCRIPT standard need to send a paper fax to pharmacies that are not implemented to the NCPDP SCRIPT standard? Might physician technologies look to slow the process to implement to the ePrescribing standards in this case?
- How does the pharmacist or physician know if the fax received on their fax machine is e-fax generated or paper fax generated? If a NCPDP SCRIPT implemented pharmacy receives a fax from a NCPDP SCRIPT implemented physician technology vendor, how does the pharmacist know if the fax received on their fax machine is e-fax generated or paper fax generated? Is it legal for the pharmacy to accept a paper fax in such a case, but not an e-fax?
- Another issue is a potential increase in pharmacy workflow disruption. E-faxes can be utilized for other lines of business, for example, to deliver an ePrescription for a Medicaid or commercial insurance patient. The elimination of this exemption at this time for Medicare ePrescriptions could lead to workflow inefficiencies in pharmacies. Pharmacies have planned to be in compliance with all MMA ePrescribing standards at a later date. Allowing them to comply with the elimination of the exemption along with the adoption of all MMA ePrescribing standards seems to make more sense.
- What happens if there is not an agreement between a pharmacy and technology vendor, both of whom are NCPDP SCRIPT capable? Let us say, for example, that the physician technology vendor is requiring too high a price from a retail, mail order or specialty pharmacy for the delivery of an ePrescription (a common business scenario in today's environment). Will these trading partners need to revert to paper faxing rather than e-faxing? This seems like a step backwards.

Another major unintended consequence of this proposed rule is that it seems to create a potential enforcement problem in times of system outages. The language does not seem to allow computer-generated faxing when an ePrescribing network is "down," either due to technical problems or emergency situations, such as experienced in Hurricane Katrina. It seems that under such scenarios, computer-generated faxes should be allowed as a back-up. Unless this is permitted, future releases of ePrescribing technology might not include e-faxing capability when it could serve as a reliable back-up electronic prescription delivery mechanism. This could be detrimental to patients, pharmacies and payers. It also creates an additional and unnecessary enforcement burden for CMS. RxHub recommends that future guidance permit the use of computer-generated faxes in cases of emergency or other system outages.

Whereas ePrescribing is in early adoption in the ambulatory arena, ePrescribing in Long Term Care (LTC) is in its infancy. We urge CMS to consult with the appropriate LTC constituency prior to extending this ruling to Long Term Care. Workflows and transaction needs are unique in LTC ePrescribing, and a full assessment of the value of e-faxing in LTC should be undertaken.

Finally, RxHub would like to comment that the adoption of true ePrescribing is being slowed by the industry's inability to ePrescribe controlled substances. While we understand that this is outside the

scope of this proposed rule and outside the purview of CMS, we nonetheless urge CMS to continue to work with the Drug Enforcement Administration and the Department of Justice to resolve this major impediment to ePrescribing.

The rule needs to be well defined and the intentions need to be clear and address all possible scenarios in order to prevent negative unintended consequences.

Please do not hesitate to contact RxHub if you have further questions or require clarification.

Respectfully,

Kenneth E Majkowski, PharmD

Vice President, Clinical Affairs and Prduct Strategy

RxHub LLC

380 Saint Peter Street, Suite 530

Saint Paul, MN 55102

651-855-3051

ken.majkowski@rxhub.net

Maria Friedman, DBA

Director of Federal Affairs

RxHub LLC

380 Saint Peter Street, Suite 530

Saint Paul, MN 55102

301-933-6055

maria.friedman1@verizon.net

Submitter : **Date: 08/29/2007**

Organization :

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Hi My Name is Derek and I am Athletic Training student at Minnesota State University, Mankato. I am working extremely hard and am very interested in my field of practice.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Derek Stevens ATS

Submitter : **Date: 08/29/2007**

Organization : **AthletiCo**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern,

I am a Certified Athletic Trainer currently employed for AthletiCo; a company which provides fitness, performance , and rehabilitation services to a broad spectrum of individuals. I possess a BS degree in Kinesiology and currently I am working to obtain an MS degree in Clinical Exercise Physiology.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Rashina Bowden, ATC

Submitter : Jill Messling **Date:** 08/29/2007

Organization : Franciscan Skemp Healthcare

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

BRIEF INTRO ABOUT SELF ie. Where you work, what you do, education, certification, etc.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jill Messling, ATC)

Submitter : **Dr. Keith Khalil** **Date: 08/29/2007**

Organization : **Khalil Family Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

See Attachment

CMS-1385-P-10898-Attach-1.DOC

#10898

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

Re: "Technical Corrections"

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

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

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

I strongly urge you to table the 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.

Yours in Good Health

Keith J. Khalil D.C.

Submitter : **Ms. Erin York** **Date: 08/29/2007**

Organization : **St. Francis Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Erin York and I'm a certified athletic trainer that works in a hospital setting.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Erin York, ATC, LAT

Submitter : **Dr. Travis Muncy** **Date: 08/29/2007**

Organization : **Longmont Anesthesia Associates**

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.

Travis Muncy D.O.

Submitter : **Mrs. Rebecca Metrogen** **Date: 08/29/2007**

Organization : **BROAD Anesthesia**

Category : **Nurse Practitioner**

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 medical 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 anesthesia providers 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 medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. Frances Penick **Date:** 08/29/2007

Organization : Dr. Frances Penick

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Re: TECHNICAL CORRECTIONS

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

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

By limiting a Doctor of Chiropratic from referring for an x-ray study, the costs for patient care will go up, due to the necessity of a referral to another provider, for duplicative evaluation, before refering to the radiologist. People on fixed incomes may forego the x-rays and needed care because of the expense. If treatment is delayed illnesses that could be life threatening may not be discovered. It is the patient that will suffer as a result of this proposal.

I strongly urge you to table this proposal. X-rays, if needed, are integral to the overall treatment plan of Medicare patient. Ultimately it is the patient that will suffer if this proposal becomes a standing regulation.

Frances E. Penick, DC
Pine Hill, NJ

Submitter : Dr. Michael Elder **Date:** 08/29/2007

Organization : Michael D Elder, MD INC

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.

Michael Elder, MD

Submitter : **Dr. Carl Ramsey** **Date: 08/29/2007**

Organization : **Dr. Carl Ramsey**

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 : **Mr. Jonathan Ratliff** **Date: 08/29/2007**

Organization : **Athens Limestone Hospital SportsMedicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jonathan Ratliff and I currently serve as Director of SportsMedicine for Athens-Limestone Hospital in Athens, Alabama. In addition to being Director I am the Head Athletic Trainer for West Limestone High School. I received my bachelors degree in Athletic Training from The University of Alabama and my masters degree in Kinesiology from Louisiana State University. I am a certified and state licensed Athletic Trainer and have also received a National Provider Identifier. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jonathan Ratliff MS LAT ATC
Director of SportsMedicine
Athens-Limestone Hospital

Submitter : Dr. frederick Campos **Date:** 08/29/2007

Organization : American Society of Interventional Pain Physician

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment. Pain physicians will not be providing services to Medicare patients if the current trend continues.

CMS-1385-P-10906-Attach-1.DOC

#10906

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

Re: CMS-1385-P

Dear Mr. Weems:

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

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

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

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

RESOURCE-BASED PE RVUs

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

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

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

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

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

CPT Code	Anesthesiologists - 05	Interventional Pain Management Physicians

	(Non-Facility)	- 09 (Non-Facility)
64483 (Inj foramen epidural l/s)	59%	18%
64520 (N block, lumbar/thoracic)	68%	15%
64479 (Inj foramen epidural c/t)	58%	21%
62311 (Inject spine l/s (cd))	78%	8%

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

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

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

II. CMS Should Develop a National Policy on Compounded Medications Used in Spinal Drug Delivery Systems

We urge CMS to take immediate steps to develop a national policy as we fear that many physicians who are facing financial hardship will stop accepting new Medicare beneficiaries who need complex, compounded medications to alleviate their acute and chronic pain. Compounded drugs used by interventional pain physicians are substantially different from compounded inhalation drugs. Interventional pain physicians frequently use compounded medications to manage acute and chronic pain when a prescription for a customized compounded medication is required for a particular patient or when the prescription requires a medication in a form that is not commercially available. Physicians who use compounded medications order the medication from a compounding pharmacy. These medications typically require one or more drugs to be mixed or reconstituted by a compounding pharmacist outside of the physician office in concentrations that are not commercially available (*e.g.*, concentrations that are higher than what is commercially available or multi-drug therapy that is not commercially available).

The compounding pharmacy bills the physician a charge for the compounded fee and the physician is responsible for paying the pharmacy. The pharmacy charge includes the acquisition cost for the drug ingredients, compounding fees, and shipping and handling costs for delivery to the physician office. A significant cost to the physician is the compounding fees, not the cost of drug ingredient. The pharmacy compounding fees cover re-packaging costs, overhead costs associated with compliance with stringent statutes and regulations, and wages and salaries for specially trained and licensed compounding pharmacists bourn by the compounding pharmacies. The physician administers the compounded medication to the patient during an office visit and seeks payment for the compounded medication from his/her carrier. In many instances, the payment does not even cover the total out of pocket expenses incurred by the physician (*e.g.*, the pharmacy fee charged to the physician).

There is no uniform national payment policy for compounded drugs. Rather, carriers have discretion on how to pay for compounded drugs. This has lead to a variety of payment methodologies and inconsistent payment for the same combination of medications administered in different states. A physician located in Texas who provides a compounded medication consisting of 20 mg of Morphine, 6 of mg Bupivicaine and 4 of mg Baclofen may receive a payment of $200 while a physician located in Washington may be paid a fraction of that amount for the exact same compounded medication. In many instances, the payment to the physician fails to adequately cover the cost of the drug, such as the pharmacy compounded fees and shipping and handling. Furthermore, the claim submission and coding requirements vary significantly across the country and many physician experience long delays in payment.

We urge CMS to adopt a national compounded drug policy for drugs used in spinal delivery systems by interventional pain physicians. Medicare has the authority to develop a separate payment methodology for compounded drugs. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA") mandated CMS to pay providers 106% of the manufacturer's Average Sales Price ("ASP") for those drugs that are separately payable under Part B. The language makes clear that this pricing methodology applies only to the sale prices of manufacturers. Pharmacies that compound drugs are not manufacturers, and Congress never contemplated the application of ASP to specific drug compounds created by pharmacies. Accordingly, CMS has the discretion to develop a national payment policy.

We believe that an appropriate national payment policy must take into account all the pharmacy costs for which the physicians are charged: the cost of the drug ingredient, the compounding fee costs, and the shipping and handling costs. We stand ready to meet with CMS and its staff to discuss implementing a national payment policy.

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

I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge

CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

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

The sustainable growth rate ("SGR") formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

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

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

***

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

Sincerely,

Frederick A. Campos, MD
148 N Palmetto Ave.
Flagler Beach, FL 32136

Submitter : **Mr. Robert Blaser** **Date: 08/29/2007**

Organization : **Renal Physicians Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-10907-Attach-1.DOC

10907

10907

August 31, 2007

Herb Kuhn, Acting Director
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Medicare Program: Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008 and Other Changes to Payment Part B (CMS-1385-P) Proposed Rule

Dear Mr. Kuhn:

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease. We are writing to provide comments on selected portions of the 2008 Medicare Fee Schedule Proposed Rule.

RPA's comments will focus on the following issues:

- Work Relative Value Units (WRVUs) for Inpatient Dialysis Services
- Budget Neutrality/Five-Year Review Work Adjuster

Work Relative Value Units (WRVUs) for Inpatient Dialysis Services

RPA is writing to reiterate our concerns regarding the Agency's decision not to apply the increases in work relative value units (WRVUs) for evaluation and management (E&M) services recommended by the American Medical Association's Relative Value Update Committee (RUC) as part of the 2007 rulemaking cycle to the inpatient dialysis family of services.

As part of RPA's comments on the 2007 proposed rule, we noted that CMS indicated in the 2007 NPRM that the agency concurred with the RUC's recommendation to incorporate the full increase for the E&M codes into the surgical global periods for each CPT code with a global period of 010 and 090. RPA proceeded to state our belief that the outpatient and inpatient dialysis services that use E&M codes as "building blocks" or components of their valuation should have the full increases for the E&M codes incorporated into their values as well. This section of our comment concluded by noting that the inpatient service codes (CPT Codes 90935-90947) are reported to describe both hemodialysis and dialysis procedures other than hemodialysis with all E&M services related to the patient's renal disease on the day of the procedure. It should be noted that RPA is pursuing valuation of the outpatient dialysis family of services (represented by G-codes) through the RUC process, but we believe that the inpatient dialysis services should be administratively corrected by CMS.

To provide some historical background on this issue, in the Medicare Physician Fee Schedule Proposed Rule for CY 1995 published on December 8, 1994, and Transmittal 1776, Change Request 2321 of the Medicare Claims Manual, HCFA/CMS states in both documents that "we will bundle payment for subsequent hospital visits (CPT code 99231 through 99233) and follow-up inpatient consultations (CPT codes 99261 through 99263) into the fee schedule amounts for inpatient dialysis (CPT codes 90935 through 90947)." While follow-up inpatient consultations (CPT codes 99261 through 99263) have been deleted from the fee schedule for payment purposes, the subsequent hospital visit codes are of course still part of the fee schedule, and RPA urges CMS to add the increase for the mid-level subsequent hospital visit, CPT code 99232, to the work RVUs for the four inpatient dialysis codes. The increase in work RVUs for CPT code 99232 was 0.33 RVUs. Following is a chart providing the impact of the increases on the inpatient dialysis codes, and the impact of the increase on CPT code 99232, in order to allow for comparison on relativity basis:

CPT Code	2005 Work RVU	Proposed 2006 Work RVU	% Increase
99232	1.06	1.39	31%
90935	1.22	1.55	27%
90937	2.11	2.44	15%
90945	1.28	1.61	25%
90947	2.16	2.49	15%

As the chart indicates, all of the increases for the inpatient dialysis codes would be proportionately less than the increase for the mid-level subsequent hospital visit code. Further, these changes would help maintain relativity between the subsequent hospital visit code family and the inpatient dialysis code family (although it would not maintain this relativity at current levels). As RPA noted in its comments from last year on the

Five-Year Review pertaining to relativity, "as an example it is illustrative that in 2004 the reimbursement for CPT code 90935 was roughly equivalent to a level three subsequent hospital visit (CPT code 99233), and if left unchanged the proposed 2007 values will result in a reimbursement level that would be roughly equivalent to a level two subsequent hospital visit (CPT code 99232). Such a change in relativity does not have face-value validity."

For these reasons, RPA strongly urges CMS to upwardly adjust the work RVUs for each inpatient dialysis codes by 0.33 to maintain both equity and relativity with the E&M code family as noted above. RPA appreciates CMS' consideration of our recommendations regarding revaluation of the inpatient codes as we believe this issue is critically important to the future of the subspecialty, and accordingly we will be seeking to arrange a meeting with the responsible CMS leadership and staff to further address this issue.

Budget Neutrality/Five-Year Review Work Adjuster

RPA supports the comments of the AMA RUC and others in opposing CMS' use of a work adjuster to achieve budget neutrality in the fee schedule. Our stance is based on the following factors: (1) the long history of the Agency making changes of this nature through an adjustment to the conversion factor (CF); (2) the disruption in the relativity of the fee schedule services that is caused by the use of the work adjuster; (3) the fact that an adjustment to the CF is preferable because it recognizes that budget neutrality is mandated for monetary reasons, and thus the CF, as the monetary multiplier in the Medicare payment formula, is the most appropriate and transparent place to adjust for budget neutrality. **For these reasons, RPA strongly urges CMS to eliminate the work adjuster and make any necessary budget neutrality adjustments to the conversion factor.**

As always, we welcome the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation's ESRD patients, and we stand ready as a resource to CMS in its future endeavors. Any questions or comments regarding this correspondence should be directed to RPA's Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.

Sincerely,

A S Kliger

Alan Kliger, M.D.
President

Submitter : Dr. Damion Loperfito **Date:** 08/29/2007

Organization : Dynamic Care, Inc.

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P. Technical Corrections'
Please abolish this recommendation. Patients requiring x-rays for proper treatment should not be forced to see their primary medical doctor first for a referral. This is an unecessary cost burden for our seniors. Not reimbursing DC's for x-rays is limiting enough. Please do not add another obstacle in our treatment of Medicare patients. Thank you.

Submitter : Mrs. Jessica Hess **Date:** 08/29/2007

Organization : Ridgeview Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jessica Hess. I am a certified athletic trainer in the state of Minnesota. I work in the outpateint rehabilitation services setting for Ridgeview Medical Center, a hospital in Waconia, MN. Ridgeview also contracts my athletic training services out to an area college as well as high schools. I have an extensive education in the athletic training and exercise physiology fields to support my practice. Athletic trainers are medical professionals who are experts in injury prevention, assessment, treatment and rehabilitation, particularly in the orthopedic and musculoskeletal disciplines.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jessica Hess,MA,ATC

Submitter : **Date: 08/29/2007**

Organization :

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Jerome R. Schuler, DC

Submitter : Mrs. **Date:** 08/29/2007

Organization : Mrs.

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

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 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,
V.Rajaram

Submitter : Dr. Pat Aronson **Date:** 08/29/2007

Organization : Lynchburg College

Category : Academic

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a professor at Lynchburg College in Virginia. I have been an Athletic Trainer for over 25 years and I now teach courses in our accredited curriculum. I also place students with other health professionals; MDs, Physician Assistance, Physical Therapists, et. As a licensed Physical Therapy Assistant, I am very familiar with the PT setting.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Patricia Aronson, PhD, ATC, VATC, LPTA

Submitter : **Paul Tull** **Date: 08/29/2007**

Organization : **Paul Tull**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I am a CRNA in Arkansas. We are one of the lowest Medicare reimbursement rates in the US. Please consider this increase to bring us up to be able to compete with surrounding states.

Thanks for your considcration.

Sincerely,
Paul W. Tull, CRNA

Submitter : **Mrs. Kim Pruitt** **Date: 08/29/2007**

Organization : **Mrs. Kim Pruitt**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

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.

Kim Pruitt, BSN

Submitter : **Dr. Scott Semlow** **Date: 08/29/2007**

Organization : **Dr. Scott Semlow**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Scott R Semlow

Submitter : Dr. Mark Fritsch **Date:** 08/29/2007

Organization : Consultants in Pathology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am a board-certified pathologist who practices in a 20-physician single-specialty group practice. I believe that the proposed legislation embodied in CMS-1385-P (Proposed Revisions to Payment Policies Under the Physician Fee Schedule...) is a step in the right direction to curb physician self-referral. I believe that physicians should not be permitted to continue to make a profit from the provision of pathology services when they are not the actual provider of such services. Current law allows this abuse and increases healthcare costs for many patients.

Yours truly,

Mark A. Fritsch, M.D.
219 E. Lake Shore Dr.
Chicago, IL 60611

Submitter : Patricia Gilbert **Date:** 08/29/2007

Organization : Patricia Gilbert

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Hello,
I am a CRNA in Arkansas, and we are one of the lowest reimbursed states for Medicare. Pelase consider this inerease so that we may compete with surrounding states.
Have a nice day,
P. Gilbert, CRNA

Submitter : Mr. Kevin Ennis **Date:** 08/29/2007

Organization : Carolina Sportscare and Physical Therapy

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

See attachment.

CMS-1385-P-10918-Attach-1.TXT

Submitter : Dr. THOMAS BRALLIAR **Date:** 08/29/2007

Organization : AMERICAN SOCIETY OF ANESTHESIOLOGISTS

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 : Dr. Susan Polk **Date:** 08/29/2007

Organization : American Society of Anesthesiologists

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 : **Dr. Robert Nathan** **Date: 08/29/2007**

Organization : **Joint Council of Allergy, Asthma and Immunology**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Coding-- Payment For IVIG Add-On Code

Coding-- Payment For IVIG Add-On Code

See Attachment

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See Attachment

CMS-1385-P-10921-Attach-1.DOC

#10921

JCAAI

Joint Council of Allergy, Asthma and Immunology

50 N. Brockway Street
Suite 3-3
Palatine, IL 60067
Voice: 847-934-1918
Fax: 847-934-1820
E-Mail: info@jcaai.org

#10921

August 29, 2007

Submitted Electronically at
http://www.cms.hhs.gov/eRulemaking.

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue
Washington, DC 20201

Re: *Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008,* 72 *Fed. Reg.* 38,122 (July 12, 2007); (1)Coding-Payment for IVIG-Add-On Code (2)Physician Self Referral Provisions;

Dear Mr. Kuhn:

The Joint Council of Allergy, Asthma and Immunology (JCAAI) appreciates this opportunity to submit comments on the *Proposed Revisions to Payment Policies under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008,* as published in the July 12, 2007 Federal Register. JCAAI is an organization sponsored by the American Academy of Allergy, Asthma and Immunology and the American College of Allergy, Asthma and Immunology. It represents the interests of over 3,000 physicians board-certified in allergy and immunology.

IVIG

JCAAI supports the proposal to continue, for one-year, the add-on payment designed to compensate physicians for difficulty in the acquisition of IVIG. Allergists are still experiencing considerable difficulties locating and purchasing IVIG for their patients with immune deficiency disease. Therefore, we believe an extension of the add-on payment for another year is appropriate.

Physician Self-Referral Provisions

JCAAI has serious concerns regarding the proposed changes to the anti-markup and reassignment rules as they apply to the professional component of diagnostic tests. Allergists frequently perform pulmonary function tests in the office to evaluate their patients with asthma. These tests, which are typically done in conjunction with an office visit, have both a professional component and a technical component and can be billed separately or globally. However, this test is virtually always performed in the office in the context of a patient visit and not by an "outside supplier." In other words, unlike the technical component of imaging or other diagnostic services which are often performed in freestanding centers or facilities – the technical component of pulmonary function tests is performed in the allergist's office by office clinical staff and then interpreted by the allergist. The results of the test are typically used in diagnosing and treating the patient during the office visit that usually occurs on the same day and during the same patient

Although the majority of allergists are engaged in full-time practice, it is not unusual for an allergist to work either part-time or as a contractor to an allergy or multi-specialty practice. Under the proposed rule, allergy groups that bill, under a reassignment, for their part-time or independent contractor physicians would be required to include on the claim the amount of that physician's "charge" to the group. Failure to include such a charge would result in denial of payment. This requirement would be virtually impossible to meet because allergists, whether employees or contractors, are not paid by the individual service. The proposed rule puts groups in the impossible position of having to assign a "charge" to a service for which there is no charge and risk false claims liability or not include a charge and not be paid for the service. Further, we question whether CMS has the legal authority to reimburse physician services (as opposed to diagnostic tests) based on a methodology that is different than that set forth in section 1848 of the Medicare statute which requires payment based on the lower of the fee schedule amount or the physician's charge to Medicare.

For these reasons, we strongly urge that CMS not extend the applicability of the anti-markup rule to physician interpretations of diagnostic tests. At the very least, an exception should be made for pulmonary function testing and other diagnostic tests that are performed as an integral part of a physician evaluation and management service.

****

We thank you for considering our comments. If you have questions, please feel free to contact our Washington representative, Rebecca Burke, at 202-872-6751.

Sincerely,

Robert A. Nathan, MD
JCAAI President

RAN/mjk

CMS-1385-P-10952 **Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies; Revisions to Payment Policies for Ambulance Services for CY 2008;**

Submitter : Mr. Curt Chase **Date & Time:** 08/29/2007

Organization : Blackwell Sanders LLP

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1385-P-10952-Attach-1.DOC

prohibition of provider-based joint ventures between hospitals and referring physicians. Pursuant to the provider-based rules, hospitals and physicians are able to create an equity joint venture that qualifies as a provider-based department of the hospital. However, because a department of a hospital is not able to obtain its own Medicare provider number and bill directly for its services, the joint venture entity provides the services to the hospital in exchange for a fee and the hospital bills Medicare for the service. Such arrangements are common for hospital surgery departments that are joint ventures with the hospital's surgeons. In these situations, the joint venture and the hospital can satisfy the provider-based rules and the contractual arrangement between the joint venture and the hospital meets the under arrangements rules.

If the definition of Entity is changed to include the joint venture entity described above that provides the DHS, the physician owners of the joint venture would have an ownership interest in a DHS Entity as opposed to a compensation arrangement with the hospital and the arrangement would fail to meet an exception under the Stark laws. The unintended effect of the proposed definitional change is inconsistent with the provider-based regulations and would prohibit many legitimate provider-based joint ventures.

3. **Certain Referrals and Services Should be Excluded from Changes**. The Stark analysis under the proposed regulations may be applied to various types of under arrangement service providers with varying consequences. The examples cited by CMS include clinical laboratory services, therapy, and radiology. However, to the extent the physician-owners of the newly defined DHS Entity are pathologists, radiologist or radiation oncologists (and such ownership corresponds to the service provided under arrangements with the Entity), no *referral* will occur to the Entity because of the statutory and regulatory exclusions from the definition of referral.[3]

In Stark II, Phase I, CMS excluded services personally performed by the referring physician from the definition of "referral".[4] CMS further commented that personally performed services are those services physically performed by the referring physician.[5] In the under arrangements context, cardiac catheterizations and other therapeutic services, including surgical procedures, are physically performed by the physician. Because cardiac catheterizations are personally performed by a referring physician, they are essentially provided as an extension of the physician's practice, similar to outpatient surgical procedures. If services such as cardiac catheterizations or outpatient surgery were preformed in an ASC or a physician's practice, they would not even qualify as DHS and would not be subject to Stark. However, these same services personally provided by a physician in a hospital setting (through a contractual arrangement that meets the under arrangements rules) are subject to Stark because the service is now considered a hospital inpatient or outpatient service. Therefore, we request that CMS clarify that these services constitute personally performed services excepted from the Stark definition of referral or exclude these types of service providers from the new definition of Entity.

---

[3] See 42 U.S.C. § 1395nn(h)(5)(C).
[4] See 66 Fed. Reg. 3 at 859 (Jan. 4, 2001).
[5] See id. at 871.

The blanket approach to redefining the definition of Entity captures all under arrangements deals (even those where the physician is personally performing the service) and excludes otherwise legitimate hospital / physician affiliations. There is little risk of overutilization or abuse of these types of services – which is why they are not subject to Stark as DHS when provided outside of the hospital setting. Moreover, the existing CMS definition of services provided under arrangement requires that medical necessity continue to be determined by and monitored by the hospital. Therefore, services personally performed by physicians, such as cardiac catheterizations and surgical procedures should be carved out of the definition of referral or not be included in the new definition of Entity. CMS should challenge such deals that it believes are resulting in care that is not medically necessary or being abused through the currently existing civil and criminal penalties protecting the system and not through a broad prohibition of otherwise legitimate arrangements.

4. **Lack of Clear Guidance Related to Application of Revised Definition of Entity**. The proposed revision to the Stark definition of Entity will also pose significant challenges in the application of the new definition in the under arrangements context. The challenge lies in determining whether or not an entity is deemed to have performed DHS and as such, would constitute a DHS Entity under the revised definition. CMS has clearly taken the position that a hospital department cannot contract out all of its patient care services through under arrangements contracts. Accordingly, some portion of the service will be provided by the hospital and some portion of the service will be provided by the under arrangement provider entity.

"Under arrangements" has become shorthand for a broad array of service contracts utilized in varying situations and CMS has provided no guidance regarding where the line exists in terms of what portion or type of services provided by an under arrangements provider is enough to constitute the performance of DHS under the revised definition of Entity. For example, what if a hospital department enters into a contract for management services, an equipment lease, a space lease, an employee lease for technical and ancillary personnel, or varying combinations of the previous four components from an under arrangements provider – is the third party entity "performing" DHS? Will the revised definition of Entity be met if an under arrangements entity provides the technical portion of a service under arrangement? What constitutes the technical portion of a service? Does it matter if the third party contracted entity is only providing one service (i.e., the equipment or the staff)? What if the only services being provided by the third party are management services? Is the management company "performing" DHS as an "Entity"? Due to the individual parties involved in each under arrangements relationship and the negotiations specific to each deal, the portion of the technical component provided "under arrangements" will vary significantly from deal to deal and at this point, no formal definition of "technical component" exists.

As a result of the uncertainties discussed above, it will be virtually impossible to determine if the proposed definition of Entity applies to any individual entity involved in any particular financial arrangement. Therefore, we request that CMS discard the proposed revisions to the definition of Entity to avoid the extreme complications related to the application and enforcement of such a vague and overbroad definition.

Submitter : **Alison Kotek** **Date: 08/29/2007**

Organization : **AthletiCo LTD**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer who graduated from Indiana University in 2004 with a BS in Kinesiology and an emphasis in Athletic Training. I am also a Personal Enhancement Specialist through the National Academy of Sports Medicine. I currently work in the Chicagoland area for AthletiCo, LTD. I work as an ATC and also as the Regional ATC Coordinator for downtown Chicago.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Alison Kotek, ATC, NASM-PES

Submitter : **Ms. Maureen Thompson** **Date: 08/29/2007**

Organization : **Salisbury University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Maureen Thompson and I am a certified athletic trainer. I am currently employed at Salisbury University in Salisbury, MD. I have a master's degree from James Madison University and two undergraduate degrees from Salisbury University.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Maureen Thompson, MS, ATC

Submitter : Mr. Mark Miller **Date:** 08/29/2007

Organization : OFC Back Care Center

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Dear Madam or Sir:

I am a practicing Physical Therapis and Athletic Trainer and have done so for 33 and 26 years respectively. I am currently in an outpatient clinical setting, having worked in a hospital setting previously. Thirty-one of my career years have been as a Director/ Manager of reab departments.

Today, I am contacting you regarding opposition to the therapy standards and requirements for staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. In doing so, I feel that these proposed rules will cause further lack of access for quality health care for patients.

Throughout my management carcer, it has been a constant challenge to recruit adequate staff to provide quality care. When staff shortages occurred, patients often did not receive their full compliment of treatments. Athletic Trainers are qualified to perform physical medicine and rehabilitation services. This is quantified through an A.T. education, clinical expericnce(s), as well as certification by a national examination. In addition, state law(s) and other medical professionals recognize these qualifications. This proposal, however, appears to ignore these standards and qualifications.

The staff shortages mentioned above, are more recognized in less populated areas. As a result, some clientele may receive sub-standared care regarding treatment frequency. A Certified Athletic Trainer is certainly qualified to provide treatment for conditions of musculoskeletal origin, and more importantly receive reimbursement for those services.

I respectfully encourage the CMS withdraw the proposed changed related to hospitals, clinics, and other Medicare Part A & B facilities and thus enable other health care professionals to participate in the management of day-to-day health care needs of clientele that justly deserve the care.

Respectfully submitted

Mark L. Miller, MS; PT; AT/R
Physical Therapist/Athletic Trainer

Submitter : **Dr. Lawrence Siegel** **Date: 08/29/2007**

Organization : **Stanford University**

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 delighted that CMS has recognized the 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 only $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

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

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

Thank you for your consideration of this serious matter.

Sincerely yours,
Lawrence Siegel, M.D.

Submitter : **Heather Brown** **Date: 08/29/2007**

Organization : **MVP Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Heather Brown and I am both a certified athletic trainer (ATC) and a physical therapist assistant (PTA). I currently work for MVP Physical Therapy in the clinic and the secondary school setting. I have a bachelor's degree in sports medicine from an accredited university and am licensed in the state of California as a PTA. Recently the state of Washington passed legislature to license the PTA as well as the ATC, and both will go into effect in July 2008. I am also a member of the NATA.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Heather Brown, ATC, PTA

Submitter : Mr. Steven Rothermel **Date:** 08/29/2007

Organization : Reading Berks Physical Therapy

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Steven Rothermel; I am a certified Athletic Trainer who works in a secondary school for a physical therapy clinic. I am there to provide emergency care and rehabilitation services to the school district that I work at. This is a very involved job as I have many different positions that I fill. I have a bachelor s degree in Athletic Training and a Masters degree in Education. To even become an Athletic Trainer I had to pass one of the most rigorous certification exams out there today. I work very hard to keep up my certification and to continuously learn new ideas and treatments in the medical world today.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Steven A Rothermel, MEd., ATC

Submitter : Mr. Michael Reitz **Date:** 08/29/2007

Organization : Mr. Michael Reitz

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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.

Michael Alan Reitz

Submitter : Dr. Alexis Carras **Date:** 08/29/2007

Organization : Dr. Alexis Carras

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

In a practice which has a large medicare patient population, the increased reimbursement will help us continue to provide patient care to medicare patients effectively.

Submitter : Mr. **Date:** 08/29/2007

Organization : Mr.

Category : Local Government

Issue Areas/Comments

Ambulance Services

Ambulance Services

Our organization provides emergency ambulance services to the communities which we serve. The proposed rule would have a severely negative direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. In addition, we believe this proposed rule will inappropriately provide incentives to seek signatures from patients who are in need of medical care and under mental duress. Additionally, this proposed rule would have a negative impact on wait times in the emergency room impacting our operations and the operations of emergency rooms throughout the country. We therefore urgently submit comments on ills of the proposed rule.

In summary, here are the points we would like you to consider:
? Beneficiaries under duress should not be required to sign anything;
? Exceptions where beneficiary is unable to sign already exist and should not be made more stringent for EMS;
? Authorization process is no longer relevant (no more paper claims, assignment now mandatory, HIPAA authorizes disclosures);
? Signature authorizations requirement should be waived for emergency encounters.

We understand that the proposed rule was inspired by the intention to relieve the administrative burden for EMS providers. However, the relief being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and the hospitals and would result in shifting the payment burden to the patient if they fail to comply with the signature requirements at the time of incident. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for emergency ambulance services.

Bill Huff
EMS Chief
Miramar Fire-Rescue
Miramar Fl.

Submitter : **Dr. Thomas Kennerly** **Date: 08/29/2007**

Organization : **Greenville Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Thomas Kennerly,M.D.

Submitter : **Joseph Seltzer** **Date: 08/29/2007**

Organization : **Joseph Seltzer**

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 : **Dr. David Reitz** **Date: 08/29/2007**

Organization : **Allina**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.

David Reitz, M.D.

Submitter : Theresa Cress **Date:** 08/29/2007

Organization : Nevada State Health Division

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

Kerry Weems, Acting Administrator

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

Mail Stop C4-26-05

7500 Security Boulevard

Baltimore, Maryland 21244-1850

RE: CMS-1385-P Proposed Revisions to payment policies under the physician fee schedule and other Part B payment policies for CY 2008

Comments:

The Physician Work RVU-CPT 77080 (DXA)

The Direct Practice Expense RVU for 77080 (DXA)

Indirect Practice Expense for DXA and VFA

Deficit Reduction Act

Dear Mr. Weems:

I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.

As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:

a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;

b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:

The equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;

The utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.

c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and

d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,

Theresa Cress
Arthritis Program Coordinator
Nevada State Health Division
4150 Technology Way, #101
Carson City, NV 89706

Submitter : Ms. Gay Anderson **Date:** 08/29/2007

Organization : Pinnacle Therapy Services (US Physical Therapy)

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

As a Certified Athletic Trainer, an educated, credientialed professional, I urge you to recognize our unique position as allied health workers. The National Athletic Trainers' Association represents our best interests. Unnecessary competition for physically active individuals is preventing patients from access to quality care for the sake of territory wars. Please see that patients come first.

Submitter : Mr. Scott Gardner **Date:** 08/29/2007

Organization : Ohio University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

August 29, 2007

Dear Sir or Madam:

At the present time, I am employed as an athletic trainer at Ohio University. I have been in this position for the last nine years. Prior to this, I worked for 10 years in a sports medicine clinic providing athletic training services to high school athletes.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Scott W. Gardner, MS, ATC, LAT

Submitter : **Dr. Tammy Gingerich** **Date: 08/29/2007**

Organization : **Dr. Tammy Gingerich**

Category : **Pharmacist**

Issue Areas/Comments

GENERAL

GENERAL

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. Hannah Reitz** **Date: 08/29/2007**

Organization : **Ms. Hannah Reitz**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.

Hannah Reitz

Submitter : Ms. Chandee Payne **Date:** 08/29/2007

Organization : Lenoir Rhyne College Athletic Training

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam: I am a junior Athletic Training student at Lenoir-Rhyne College. I plan to become a certified Athletic Trainer and work in the clinical setting at a hospital or clinic.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients. When I become certified as an athletic trainer in one year, I will be qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam will ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility. Sincerely, Chandee Payne, AT-student

Submitter : Dr. Troy Gingerich **Date:** 08/29/2007

Organization : Dr. Troy Gingerich

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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 : **Mrs. LaVerne Reitz** **Date: 08/29/2007**

Organization : **Mrs. LaVerne Reitz**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.

LaVerne Reitz

Submitter : Dr. THOMAS BRALLIAR **Date:** 08/29/2007

Organization : AMERICAN SOCIETY OF ANESTHESIOLOGISTS

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 : **Dr. william burk** **Date: 08/29/2007**

Organization : **greenville anesthesiology pa**

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 eare, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

William Burk

Submitter : **Ms. Cary Berthelot** **Date: 08/29/2007**

Organization : **Southeastern Louisiana University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Cary Berthelot and I am a Certified Athletic Trainer and hold a Master's Degree in Health and Kinesiology. I currently work in multiple settings as an atheltic trainer, including caring for a large number of high school and collegiate athletes. I have become quite interested and concerned in regards to some of the upcoming health care legislation.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Cary Lynn Berthelot, MA, ATC, LAT

Submitter : Dr. Robert Hochfelder **Date:** 08/29/2007

Organization : FCA

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Please do not alter the present status

Submitter : Ms. Judy Reitz **Date:** 08/29/2007

Organization : Ms. Judy Reitz

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

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.

Judy Reitz

Submitter : **Stefani Voudrie** **Date: 08/29/2007**

Organization : **Stefani Voudrie**

Category : **Other**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Stefani Voudrie, ATC

Submitter : **Mr. Lowell Reitz** **Date: 08/29/2007**

Organization : **Mr. Lowell Reitz**

Category : **Nurse Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

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.

Lowell Reitz, R.N.

Submitter : **Dr. Inho yoon** **Date: 08/29/2007**

Organization : **greenville Anesthesiology**

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.

Thank you,

Inho Yoon

Submitter : Mr. Curt Chase **Date:** 08/29/2007

Organization : Blackwell Sanders LLP

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1385-P-10952-Attach-1.DOC

#10952

Comments to Proposed Stark Regulations

Issue Area/Comments: Physician Self-Referral Provisions

The purpose of these comments is to express serious concerns with the proposed revisions to the Stark regulations published as part of the annual physician fee schedule update in the July 12, 2007 issue of the *Federal Register*. The proposed revisions have left healthcare attorneys and providers around the country attempting to interpret the proposed revisions and gauge the impact on various arrangements between physicians and hospitals - particularly under arrangements deals.

Comments.

1. **Negative Effect on Legitimate Under Arrangements Deals**. If the proposed revisions to the definition of Entity are adopted, the structure of many, if not all, contractual arrangements between physicians and hospitals that are set up to comply with the under arrangements rules will no longer be able to satisfy a Stark exception. If the proposed definition of Entity is expanded to include those entities that "perform" the DHS, the entity performing the under arrangement services will become a DHS Entity with which the physicians have a financial relationship to which they refer DHS and thus, the arrangement must meet a Stark exception. For Stark purposes, the physician would have an ownership interest in the Entity. There is no Stark exception available for such ownership arrangements and, therefore, the relationship between the physicians and the under arrangement provider would be in violation of the Stark laws.

   Under arrangements relationships can be cost-effective arrangements driven by appropriate quality of care and clinical indicators. As noted in the Preamble to the Stark II, Phase I regulations, "an 'under arrangements' relationship can avoid unnecessary duplication of costs and underutilization of expensive equipment."[1] The cost savings and clinical provider collaboration developed in under arrangements relationships are vitally important to promote the provision of high-quality, affordable healthcare services. Also as noted in the Stark II, Phase I regulations "prohibiting these arrangements would seriously disrupt patient care" as existing arrangements would be unwound leaving a potentially long-term critical void at many providers.[2]

   If CMS is concerned that under arrangements deals have gone too far and that physicians and hospitals are using the under arrangements rules where there is no legitimate reason for the arrangement, then the solution is to challenge such arrangements - not to put a stop to all under arrangements deals, which is the effect of the proposed regulations.

2. **Unintended Elimination of Provider-Based Joint Ventures**. If the revision to the definition of Entity is adopted as currently proposed, it will result in the unintentional prohibition of provider-based joint ventures between hospitals and referring physicians. Pursuant to the provider-based rules, hospitals and physicians are able to create an equity

[1] See 66 Fed. Reg. 3 at 942 (Jan. 4, 2001).
[2] See id.

joint venture that qualifies as a provider-based department of the hospital. However, because a department of a hospital is not able to obtain its own Medicare provider number and bill directly for its services, the joint venture entity provides the services to the hospital in exchange for a fee and the hospital bills Medicare for the service. Such arrangements are common for hospital surgery departments that are joint ventures with the hospital's surgeons. In these situations, the joint venture and the hospital can satisfy the provider-based rules and the contractual arrangement between the joint venture and the hospital meets the under arrangements rules.

If the definition of Entity is changed to include the joint venture entity described above that provides the DHS, the physician owners of the joint venture would have an ownership interest in a DHS Entity as opposed to a compensation arrangement with the hospital and the arrangement would fail to meet an exception under the Stark laws. The unintended effect of the proposed definitional change is inconsistent with the provider-based regulations and would prohibit many legitimate provider-based joint ventures.

3. **Certain Referrals and Services Should be Excluded from Changes**. The Stark analysis under the proposed regulations may be applied to various types of under arrangement service providers with varying consequences. The examples cited by CMS include clinical laboratory services, therapy, and radiology. However, to the extent the physician-owners of the newly defined DHS Entity are pathologists, radiologist or radiation oncologists (and such ownership corresponds to the service provided under arrangements with the Entity), no *referral* will occur to the Entity because of the statutory and regulatory exclusions from the definition of referral.[3]

In Stark II, Phase I, CMS excluded services personally performed by the referring physician from the definition of "referral".[4] CMS further commented that personally performed services are those services physically performed by the referring physician.[5] In the under arrangements context, cardiac catheterizations and other therapeutic services, including surgical procedures, are physically performed by the physician. Because cardiac catheterizations are personally performed by a referring physician, they are essentially provided as an extension of the physician's practice, similar to outpatient surgical procedures. If services such as cardiac catheterizations or outpatient surgery were preformed in an ASC or a physician's practice, they would not even qualify as DHS and would not be subject to Stark. However, these same services personally provided by a physician in a hospital setting (through a contractual arrangement that meets the under arrangements rules) are subject to Stark because the service is now considered a hospital inpatient or outpatient service. Therefore, we request that CMS clarify that these services constitute personally performed services excepted from the Stark definition of referral or exclude these types of service providers from the new definition of Entity.

The blanket approach to redefining the definition of Entity captures all under arrangements deals (even those where the physician is personally performing the service)

---

[3] See 42 U.S.C. § 1395nn(h)(5)(C).
[4] See 66 Fed. Reg. 3 at 859 (Jan. 4, 2001).
[5] See id. at 871.

and excludes otherwise legitimate hospital / physician affiliations. There is little risk of overutilization or abuse of these types of services – which is why they are not subject to Stark as DHS when provided outside of the hospital setting. Moreover, the existing CMS definition of services provided under arrangement requires that medical necessity continue to be determined by and monitored by the hospital. Therefore, services personally performed by physicians, such as cardiac catheterizations and surgical procedures should be carved out of the definition of referral or not be included in the new definition of Entity. CMS should challenge such deals that it believes are resulting in care that is not medically necessary or being abused through the currently existing civil and criminal penalties protecting the system and not through a broad prohibition of otherwise legitimate arrangements.

4. **Lack of Clear Guidance Related to Application of Revised Definition of Entity**. The proposed revision to the Stark definition of Entity will also pose significant challenges in the application of the new definition in the under arrangements context. The challenge lies in determining whether or not an entity is deemed to have performed DHS and as such, would constitute a DHS Entity under the revised definition. CMS has clearly taken the position that a hospital department cannot contract out all of its patient care services through under arrangements contracts. Accordingly, some portion of the service will be provided by the hospital and some portion of the service will be provided by the under arrangement provider entity.

"Under arrangements" has become shorthand for a broad array of service contracts utilized in varying situations and CMS has provided no guidance regarding where the line exists in terms of what portion or type of services provided by an under arrangements provider is enough to constitute the performance of DHS under the revised definition of Entity. For example, what if a hospital department enters into a contract for management services, an equipment lease, a space lease, an employee lease for technical and ancillary personnel, or varying combinations of the previous four components from an under arrangements provider – is the third party entity "performing" DHS? Will the revised definition of Entity be met if an under arrangements entity provides the technical portion of a service under arrangement? What constitutes the technical portion of a service? Does it matter if the third party contracted entity is only providing one service (i.e., the equipment or the staff)? What if the only services being provided by the third party are management services? Is the management company "performing" DHS as an "Entity"? Due to the individual parties involved in each under arrangements relationship and the negotiations specific to each deal, the portion of the technical component provided "under arrangements" will vary significantly from deal to deal and at this point, no formal definition of "technical component" exists.

As a result of the uncertainties discussed above, it will be virtually impossible to determine if the proposed definition of Entity applies to any individual entity involved in any particular financial arrangement. Therefore, we request that CMS discard the proposed revisions to the definition of Entity to avoid the extreme complications related to the application and enforcement of such a vague and overbroad definition.

Submitter : **Dr. William Hawk** **Date: 08/29/2007**

Organization : **Dr. William Hawk**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

William Hawk, M.D.

Page 1754 of 2934 August 30 2007 08:35 AM

Submitter : **Ms. Drhue Robinson** **Date: 08/29/2007**

Organization : **Evans High School**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

As a Certified Athletic Trainer and Health Care Administrator I am writing today to voice my OPPOSITION to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you WITHDRAW the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Drhue Robinson MS, ATC Licensed in Florida

Submitter : **Mr. Timothy Ridley** **Date: 08/29/2007**

Organization : **Meagher & Geer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.
Timothy Ridley

Submitter : Galina Davidyuk **Date:** 08/29/2007

Organization : BWH

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely, Galina Davidyuk

CMS-1385-P-10958

Submitter : Miss. Rebecca Rose **Date:** 08/29/2007

Organization : Carroll Sports Rehabilitation and Physical Therapy

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Rebecca Rose, ATC and I work in a clinic otureach position. I am a certified athletic trainer who works with a variety of athletes, but I also do fitness programs with a local assisited living, independent living facility. I have a bachelors degree and am certified by the Board of Certification for athletic trainers.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Rebecca Rose, ATC

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To: Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

I am a physical therapist that has been practicing for 10 years. I currently practice in the state of LA. I would like to comment on the potential for fraud and abuse that exists whenever physicians are able to refer Medicare beneficiaries (or any other beneficiary for that matter) to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. Don't get me wrong. I'm not saying that all physician-owned PT clinics are overutilizing PT services for their own financial gain. While it is not illegal, I think you would agree that physician-owned PT clinics can provide a serious ethical dilemma when they're concerned about their financial bottom line. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutilization of physical therapy services under the Medicare program, and enhance the quality of patient care. Also, physician direct supervision is not needed to administer physical therapy services. In fact, an increasing number of physician-owned physical therapy clinics are using the reassignment of benefits laws to collect payment in order to circumvent incident-to requirements. I appreciate your consideration of my comments. Thank you.

Submitter : **Dr. chistopher boukedes** **Date: 08/29/2007**

Organization : **greenville anesthesiology**

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.

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work

undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

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

Thank you for your consideration of this serious matter.

Sincerely,

Christopher G. Boukedes

Submitter : **Mr. josh hardin** **Date: 08/29/2007**

Organization : **Mr. josh hardin**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Josh Hardin and I am an ATC/L working out of a hospital providing care and coverage for a high school.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Josh Hardin, ATC/L

Submitter : **Mr. Robert Ridley** **Date: 08/29/2007**

Organization : **Mr. Robert Ridley**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.

Robert Ridley

Submitter : **Ms. Valerie De Vos** **Date: 08/29/2007**

Organization : **Stange Chiropractic Clinic**

Category : **Other Technician**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

By limiting this process, the costs for patient care will go up significantly due to the necessity for the patient to also have a visit with their medical physician to in turn order the same study the chiropractor is requesting, even if the patient has no intension of seeking any other services from the medical physician. This appears to be duplicative in nature. I also note from experience that there can be a lengthy delay in scheduling these appointments, sometimes exceeding 2-3 weeks. In many instances, this type of delay causes unnecessary pain and suffering for the patient and delays their recovery time, again necessitating a longer course of treatment. Many of these patients have fixed incomes and very limited financial resources and may then choose to forgo x-rays and necessary treatment. If treatment is delayed, illness that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as the result of this proposal.

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

Sincerely,

Valerie J. De Vos, CA,LRT
Office Manager

Submitter : Mr. Chris Thein **Date:** 08/29/2007

Organization : Institute for Athletic Medicine

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer and Emergency Medical Technician working in the Minneapolis area. I am employed by an area hospital and I am assigned to a high school to provide Athletic Training services to an area high school in which I am responsible for over 2000 athletes.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and the proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Chris Thein, MS, ATC, EMT

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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 : Mr. Peter DeVault **Date:** 08/29/2007

Organization : Epic Systems Corporation

Category : Health Care Industry

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Please see the attached document.

CMS-1385-P-10966-Attach-1.PDF

#10966

August 15, 2007

Dear Sirs,

As one of the first and largest providers of Electronic Medical Records systems in the United States, with customers who write electronic medication orders for tens of millions of Americans, we welcome the opportunity to comment on the proposed rule that would eliminate the exemption for computer generated faxes from the Medicare Part D e-prescribing requirements.

We believe that e-prescribing is the safest and most secure method for communicating prescriptions to pharmacies, and many of our customers are pioneers in the field. We support the push to make electronic prescriptions the standard for the country. However, we believe that eliminating the ability to fax prescriptions by January 2009 is too soon and that a date of January 2010 would remove undue hardship on many healthcare providers who are still planning for and implementing the new technology.

While most of our customers have expressed a strong interest in pursuing standard electronic prescription writing, the full implementation of that technology is not trivial, and such projects are often competing for resources with other important efforts such as providing the electronic medical records system to all of their providers. Planning and implementing an electronic prescription solution takes months of time and assumes that a customer is using the appropriate software versions to take advantage of the technology. Upgrading to those versions can often take as much or more time than the implementation of those new features.

While January 2010 would still be a challenge for some of our customers, it's a challenge that could be met. January 2009 would be too soon. This would mean that many of our large customers who currently very successfully fax prescriptions to pharmacies today would have to revert to paper prescriptions after the proposed rule takes effect. This would be a very unfortunate consequence of a premature date: computer-generated faxes are in almost all cases safer, more secure, and more convenient than printed prescription.

Furthermore, it has been the experience of our customers who use full electronic prescribing standards that the electronic prescribing network is not currently ready in all markets. Third-party intermediaries required for robust electronic prescription communications, such as SureScripts and RxHub, often have inaccurate or missing data about local pharmacies because they rely on the pharmacies themselves to provide this information. This inevitably results in failed ePrescribing transactions. Also, not all pharmacies have implemented the receiving side of the ePrescribing solution. Our customers are skeptical that these and other gaps could be completely eliminated in the short timeframe allowed in the proposal.

Finally, all of our customers who currently use certified ePrescribing standards to communicate prescriptions report that, in a significant number of cases, ePrescription transactions fail for a variety of reasons. In these situations, computer-generated faxing

has been an invaluable back-up mechanism. Eliminating faxing as a back-up would result in delayed and missed prescriptions, which presents an unnecessary risk to patient safety. We recommend that even after the final ePrescribing requirement date that computer-generated faxing still be allowed as a back-up for communicating prescriptions in the event that the fully electronic system fails for any reason for a particular transaction.

Thank you for your consideration of these recommendations. We look forward to a time in the near future when patients have the safety, security, and convenience benefits that fully electronic prescription writing promises, as do our customers.

Sincerely,

Peter DeVault
Director of Integration and Interoperability
Epic Systems Corporation

Submitter : Ms. Otto Reitz **Date:** 08/29/2007

Organization : Ms. Otto Reitz

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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.

Otto Reitz

Submitter : **Dr. Jonathan Friend** **Date: 08/29/2007**

Organization : **Saint John Anesthesia Services Inc. Tulsa Oklahoma**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. richard carithers** **Date: 08/29/2007**

Organization : **greenville anesthesiolgy pa**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

R. Alan Carithers

Submitter : **Mrs. Faith Roberts** **Date: 08/29/2007**

Organization : **Munson Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I am a Certified Athletic Trainer employed by Munson Medical Center in Traverse City Michigan. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitaion in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting. I am more concerned that these proposed rules will create additional lack of access to quailty health care for my patients.
As an Athletic Trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially thise in rural areas, to further restrict their ability to receive those services. The flexible current standards fo staffing in hospitals and other rehab facilities are pertinent in ensuring patients receive the best and most cost effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rual clinics, and any other Medicare Part A or B hospital or rehab facility.

Sincerely
Faith Roberts, ATC

Submitter : **Dr. Andrew Knight** **Date: 08/29/2007**

Organization : **Medical Anesthesia Consultants Medical Group, Inc**

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.

Andrew A. Knight, MD

Submitter : Dr. Mark Koukkari **Date:** 08/29/2007

Organization : Dr. Mark Koukkari

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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.

Mark Koukkari M.D.

Submitter : **Dr. Michael Bialos** **Date: 08/29/2007**

Organization : **Mount Sinai Shool of Medicine, New York, NY**

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.

Michael Bialos, MD

Submitter : **Dr. richard knox** **Date: 08/29/2007**

Organization : **greenville anesthesiology**

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.

Thank you,

Richard Knox

Submitter : **Ms. Megan Gullery** **Date: 08/29/2007**

Organization : **Pleasant Valley High School**

Category : **State Government**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Megan Gullery and I am a Certified Athletic Trainer at Pleasant Valley High School in Chico, California. I have recently graduated from California State University, Long Beach and have been a National Athletic Trainers' Association Member (NATA) since March 2006

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Megan Gullery, ATC

Submitter : **William Hartenbach** **Date: 08/29/2007**

Organization : **William Hartenbach**

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. This is especially true in my area of Florida where the combination of declining reimbursement and increasing costs of providing Medicare patients with quality care is forcing many of us to look elsewhere or consider abandoning the care of medicare patients.

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.

William Hartenbach, M.D.
1501 S. Pinellas Ave.
Tarpon Springs, FL 34689

Submitter : **Dr. Jeffrey Hoover** **Date: 08/29/2007**

Organization : **Central OKC Anesthesia**

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.

Jeffrey Hoover, MD

Submitter : **Dr. Willard Koukkari** **Date: 08/29/2007**

Organization : **Dr. Willard Koukkari**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.

Willard Koukkari

Submitter : **Dr. Horatius Roman** **Date: 08/29/2007**

Organization : **MCG**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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 : Mrs. Karen Iehl-Morse **Date:** 08/29/2007

Organization : University of Illinois Urbana-Champaign

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a NATABOC certified athletic trainer at the University of Illinois Urbana-Champaign. I have both a B.S. and M.S. from the University of Illinois. Additionally I am a licensed athletic trainer in the State of Illinois.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Karen Iehl-Morse, M.S., ATC

Assoc. Athletic Trainer

Submitter : Ms. Marcia Koukkari **Date:** 08/29/2007

Organization : Ms. Marcia Koukkari

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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.

Marcia Koukkari

Submitter : Dr. Allen Hayman **Date:** 08/29/2007

Organization : York Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely;

Allen Hayman, M.D.

Submitter : **Dr. Harsh Sachdeva** **Date: 08/29/2007**

Organization : **Overton brooks va medical center**

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 : Mr. Stephen Joseph **Date:** 08/29/2007

Organization : Trinity Rehabilitation @ Pinnacle Point

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would encourage CMS to rectify a growing problem that was suspected to be a future problem when physicians were allowed to keep physical therapy services in their offices as an exclusion to the Stark legislation.
As a practicing physical therapist, I have seen the direct consequence of this action, especially from the patients that I have eventually had to work with after several months of failed "therapy" provided from a physicaians office.
By adding physical therapy to this legislation, you are making a statement that the physicians had their chance and blew it by beeing greedy and not offering speedy and effective treatment options to their clinets as was promised.
By eliminating this "profit center" you have helped return focus to patient care and not how much money can we make on this service.
Thank you for your time,
Steve Joseph PT

Submitter : **Mr. Edrian Hairston** **Date: 08/29/2007**

Organization : **Western Carolina University**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Edrian Hairston, I am an Assistant Athletic Trainer at Western Carolina University.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Edrian J. Hairston, MS, ATC, LAT

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

In order to prevent misuse and fraud, I would like to suggest that you remove Physical Therapy from the in-office ancillary services exception to the Physician self-referral laws. It is a well proven fact that competition is good for business and in this case good for the patient. If Physicians automaticallly refer to their clinic, they could very well be providing a sub-standard product and in turn the patient will not be receiving quality treatment. Patients should be allowed to choose a PT Clinic and not have "suggestions" by the Physicians effect their selection. In addition, if a Physician run clinic does not provide a particular service, the patient will not get what they need. Another issue is the money received by the Physicians and the choice to refer patient that have ample money or insurance coverage to their clinic. They can choose who they want to refer based on money and not what the patient needs. This is just bad for quality all around. I would like you to consider closing this loophole - it is the ethical choice to make.

Submitter : Mr. Sean Bagbey **Date:** 08/29/2007

Organization : Orthopedics and Sports Medicine

Category : Health Care Provider/Association

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am Sean Bagbey, I am working in Western Kentucky in an Orthopedic Specility office that services most of NW Kentucky.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Sean Bagbey,
Masters in Health Service Administration
Certified Athletic Trainer
Physical Therapy Assistant
Certified Specialist in Functional Assessments
Certified Specialist in Health Ergonomics

Submitter : Mr. Adam Tarr **Date:** 08/29/2007

Organization : Carle Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I currently work at Carle Sports Medicine in Champaign, IL. Through Carle, I also serve as Head Athletic Trainer at Champaign Centennial High School here in town. I went to Eastern Illinois University and recieved a bachelors degree in Physical Eduation with an option in Athletic Training. I have now gone on pass my certification examination and begin practicing as an athletic trainer in the area.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Adam Tarr, ATC (and/or other credentials)

Submitter : **Mr. Vernon Reitz** **Date: 08/29/2007**

Organization : **Mr. Vernon Reitz**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.

Mr. Vernon Reitz

Submitter : Mr. Greg Watson **Date:** 08/29/2007

Organization : Immaculata High School - Athletic Training

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Gregory Watson and I am a certified athletic trainer at Immaculata High School in Somerville, NJ. This will be my 4th year at the high school, where I also teach physical education and health. I am the only athletic trainer on site, where I take care of 15 varsity and junior varsity athletic teams. Each student-athlete with an injury is diagnosed and treated by myself and an orthopedic physician, who comes regularly to the school for injury updates.

I have been an athletic trainer for 11 years helping professional, collegiate, and high school athletes with their various health care needs. I have a bachelors degree from the University of Rhode Island and a masters degree from Columbia University.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Gregory J. Watson, MA, ATC

Submitter : **Ms. Elizabeth Ridley** **Date: 08/29/2007**

Organization : **Ms. Elizabeth Ridley**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.

Elizabeth Ridley

Submitter : **Mr. Michael LaMere** **Date: 08/29/2007**

Organization : **Prevea Sports Medicine Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an athletic trainer who works for a sports medicine clinic in Green Bay, WI. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Michael T LaMere,MS,ATC, NASM-PES

Submitter : Dr. Alicia Vollmers **Date:** 08/29/2007

Organization : Total Wellness Chiropractic Clinic, P.C.

Category : Chiropractor

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

"Technical Corrections"
As a practicing chiropractor, the bill currently being proposed that would eliminate patient reimbursement for x-rays taken by a radiologist or other non-treating physician and then used by a chiropractor will significantly our ability to treat Medicare patients. If they have to visit their primary doctor in order to get the xrays, that will drive the cost of health care even higher, when we are obviously trying to decrease the cost of health care as it continues to rise. X-rays, when needed, can allow us to identify any contraindications to adjustments or indicate when additional diagnostic tests will be necessary.

Submitter : **Mrs. Angela Dahl** **Date: 08/29/2007**

Organization : **Drake University**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Angie Dahl I am a certified athletic trainer at Drake University in Des Moines Iowa. I have a Master's Degree and am in my 9th year of athletic training.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Angela R. Dahl MPA,ACSM HF-I, LAT, ATC

Submitter : Dr. Jeffrey Coston **Date:** 08/29/2007

Organization : Park Ridge Anesthesiolgy Services, PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10997-Attach-1.DOC

#10997

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

August 29, 2007

Dear Ms. Norwalk:

I am writing to express my support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

Your office receives many "boiler plate" prewritten letters. I wanted to share my support for this modest increase to anesthesia providers in my words.

Park Ridge Anesthesiology Services was formed in 1985 and has served a mostly rural and older population in western North Carolina ever since. We have seen our services increase to Medicare and Medicaid patients with the influx of more people retiring to our area as well as a large number of Latino immigrants settling in the communities of Hendersonville and Fletcher, NC.

We had a 61 percent combined Medicare and Medicaid payer mix for July 2007, the most recent month that data is available to us. This percentage varies a bit month to month but is an accurate reflection of our overall demographics. The proposed increase **(CMS-1385-P Anesthesia Coding)** from CMS would certainly help our situation.

I strongly urge CMS as well as Congress to find a viable, fair solution to the rapidly building healthcare crisis our great country is facing. I wish you every success in your capacity as Acting Administrator for the Centers for Medicare and Medicaid Services.

Thank you for your thoughtful consideration of this issue and your service to the United States of America.

Dr. Jeffrey Coston
President, Park Ridge Anesthesiology Services, PA

Submitter : Mrs. Joanne Milano **Date:** 08/29/2007

Organization : Long Trail Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Submitter : Ms. Kathy Thompson **Date:** 08/29/2007

Organization : Northfield Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

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.

Kathy Thompson R.N.

Submitter : **Date: 08/29/2007**

Organization : **Watertown Area Health Services**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Noah Eckl, and I am a Licensed Athletic Trainer practicing in the state of Wisconsin.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Noah Eckl;MS,ATC,LAT,CSCS
Licensed and Certified Athletic Trainer
Watertown Area Health Services

Submitter : **Dr. Kevin Paape** **Date: 08/29/2007**

Organization : **Healing Arts Chiropractic, PC**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Paape

Submitter : Dr. Richard Locke **Date:** 08/29/2007

Organization : Dr. Richard Locke

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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.

Richard Locke

Submitter : **Dr. Richard Wear** **Date: 08/29/2007**

Organization : **Pacific Anesthesia**

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 : **Mrs. Heidi McClellan** **Date: 08/29/2007**

Organization : **Rehab GYM**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My Name is Heidi McClellan, I am a licensed athletic trainer in the state of Vermont, I have worked in an outpatient Orthopaedic clinic setting for the past 12 years treating patients of all ages.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Heidi McClellan,ATC, CSCS

Submitter : **Mrs. Judy Locke** **Date: 08/29/2007**

Organization : **Mrs. Judy Locke**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.

Judy Locke

Submitter : **Mr. Kent Falb** **Date: 08/29/2007**

Organization : **Professional Football Athletic Trainers Society**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

40 Veranda Lane
Aiken, SC 29803
August 29, 2007

To Whom It May Concern:

I have been active as an athletic trainer since 1958 and have been a Certified Athletic Trainer since 1970. From 1966 to 2000 I was employed by the Detroit Lions as their Head Athletic Trainer. My professional education includes a BS degree in Adaptive Physical Education and I also attended Physical Therapy School. Prior to my retirement my professional my activities included being President of the Michigan Athletic Trainers Society, President of the Professional Football Athletic Trainers Society and lastly I served on the Board of Directors followed by two terms as President of the National Athletic Trainers Association. Because of this I am able to speak with professional knowledge, experience and from a state and national leadership perspective.

I am writing this letter to voice my strong opposition to the proposed changes in therapy standards and requirements with regard to staffing positions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am extremely concerned that these proposed changes to the hospital, clearly Conditions of Participation have not received the proper and usual vetting. I am even more concerned that these proposed rules will create an unnecessary and unfortunate additional and absence of access to quality health care for the American public.

During my professional career I was dually credentialed as a PT and ATC. Speaking as a certified athletic trainer, I believe that I was equally qualified to perform physical medicine and rehabilitation services, which is not the same as physical therapy. My education as an athletic trainer, clinical experiences, and national certification examination ensure that my patients and or athletes received quality health care. State law and hospital medical professionals have deemed me qualified to perform these services. Regrettably, I strongly oppose the proposed changes because I consider them to be an attempt to blatantly circumvent these existing standards and unfairly restrict access to appropriate medical care.

The American public is acutely aware of the lack of access and work force shortage to fill therapy positions. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in our rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospital and other rehabilitation facilities are paramount to ensure that patients receive the best and most cost-effective treatment available.

With my prior leadership responsibilities and health care experience, I am of the belief and opinion that these proposed changes are without clinical or financial justification. Furthermore, CMS has been lobbied and influenced by another health care professional who is more concerned about guarding and protecting their patient population and revenue than providing the public with the most appropriate and affordable health care services. I strongly encourage the CMS to reconsider the recommendations made by those professionals who are promoting these recommendations for purely self-serving reasons that will, in effect, establish a monopoly for those providers. I, therefore, respectfully request that you withdraw the proposed referenced changes related to hospital, rural clinics and any Medicare Part A or B hospital or rehabilitation facility.

Respectfully submitted,

Kent P. Falb, ATC
Past NATA President

Submitter : Ms. Jill Campbell **Date:** 08/29/2007

Organization : Results Chiropractic and Rehabilitation,P.A.

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Medicare needs to increase their reimbursements to healthcare professionals and patients. Their rates are well below those of other insurance providers while the cost of treating those patients continues to rise. It is time Medicare progresses with the times and reimburses at a rate that reflects the overall increase of cost of living.

Therapy Standards and Requirements

Therapy Standards and Requirements

Many of the therapies that Medicare patients need such as electrical stimulation, intersegmental traction and diathermy as well as many others are not covered under their plan. This is an integral and necessary part of the process of getting patients better and it is their right as American citizens to get the best healthcare possible.

Submitter : **Dr. Terry Gebhardt** **Date: 08/29/2007**

Organization : **Colorado Physical Therapy Specialists**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The "in-office ancillary services" has created a loophole that facilitates abusive referral arrangements. Physicians who have a financial interest in a physical therapy clinic are more likely to refer to that clinic and more likely to recommend more visits than necessary. Since Medicare beneficiaries are required to have a physician referral for physical therapy, they have a captive referral base of physical therapy patients in their office. Physicians may argue this arrangement allows for greater communication between the therapist and physician. That may be the case, but we can have close proximity without the physician having a financial interest in the physical therapy practice. I have had Medicare patients who have been told by their surgeon the physical therapy services had to be performed at his clinic. He did not even give the patient an option. This is wrong and leads to abuse of the system. Furthermore, physician direct supervision is not needed to administer physical therapy services. Physical therapists are autonomous medical professionals and should be the only ones who can own a physical therapy clinic. Similarly, I can't own a dental office or a law firm without being a dentist or an attorney.

Thank you for your time and consideration of my comments.

Sincerely,
Terry Gebhardt, PT, DPT, OCS, FAAOMPT

Submitter : **Mr. Tom Wright** **Date: 08/29/2007**

Organization : **St. Cloud Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

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.

Tom Wright

Submitter : Mrs. Kari Gage **Date:** 08/29/2007

Organization : Central Washington University

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Kari Gage. I am the Assistant Athletic Trainer at Central Washington University. I am a certified athletic trainer with a BS is Sportsmedicine and Business. I also am currently working on my Master's in Exercise Science.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kari Gage, ATC

Submitter : J. Timothy Sensor **Date:** 08/29/2007

Organization : Kean University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I work at Kean University in Union, NJ. I am the Chief Athletic Trainer and the Chief Clinical Supervisor. I also teach in the Athletic Trainer Degree academic program.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients and will possibly affect the job opportunities for future graduates who are entering Athletic Training Profession.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

J. Timothy Sensor, ATC
Kean University
1000 Morris Avenue
Union, NJ 07083

Submitter : Mrs. Amy LaBelle **Date:** 08/29/2007

Organization : Prevea Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Amy LaBelle and I am a certified athletic trainer, licensed in the state of Wisconsin. I have a bachelor of science degree in athletic training and a master of science degree in exercise science. I work at a sports medicine clinic that has contracts with local high schools to provide medical coverage and services through the use of athletic trainers. Under the supervision of our physicians, I am the first qualified available resource for high school athletes who are in need of medical attention.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Amy LaBelle, MS, ATC, LAT

Submitter : **Dr. Travis Smith** **Date: 08/29/2007**

Organization : **Dr. Travis Smith**

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 : **Dr. David T Hafner** **Date: 08/29/2007**

Organization : **Univeristy of Arizona**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

David Todd Hafner MD
Director of Peri-Operative Services
University of Arizona

Submitter : **Mrs. Rebecca Choquette** **Date: 08/29/2007**

Organization : **University of Vermont**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I am a certified athletic trainer at the and although University of Vermont and I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for patients in Vermont.

As an athletic trainer's we are qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. Our education, clinical experience, and national certification exam ensure that patients receive quality health care. State law and hospital medical professionals have deemed certified athletic trainers qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Rebecca Choquette, ATC

Submitter : Dr. Max Gouron **Date:** 08/29/2007

Organization : Self

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

PLEASE SEE ATTACHMENT

CMS-1385-P-11016-Attach-1.DOC

#11016

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:

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

There is 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. It 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 support full implementation of the RUC's recommendation.

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

Thank you for your consideration of this serious matter.

Sincerely,
Max Gouron, M.D.

Submitter : **Ms. Lydia Cooper** **Date: 08/29/2007**

Organization : **Vanderbilt University**

Category : **Individual**

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 : **Dr. Timothy Bortz** **Date: 08/29/2007**

Organization : **South Orange Wellness and Injury Center**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Timothy Bortz

Submitter : **Mr. Daniel Piet** **Date: 08/29/2007**

Organization : **Saint Xavier University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am currently the Assistant athletic trainer at Saint Xavier University. I provide evaluation of injuries to determine their management and possible referral, documentation of injury reports and emergency contact information, preparation of athletes for practice or competition, including taping, bandaging and bracing assistance and implementation of treatment, rehabilitation, and conditioning protocols,interaction with physicians and other medical personnel regarding athlete status,communication with parents and athletes, as well as administration. I have an extensive educational background in human anatomy,physiology, rehabilitation, kinesiology, general medical conditions and disabilities. I have a undergraduate and masters degrees. I have been in the clinical setting as well as on the field management of a variety of athletes.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Daniel Piet MS,ATC,PES,

Submitter : Dr. David Nieto **Date:** 08/29/2007

Organization : University of Texas Medial Branc

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

David M. Nieto, M.D.

Submitter : **Dr. Stephen Breneman** **Date: 08/29/2007**

Organization : **Dr. Stephen Breneman**

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 : Mrs. Melissa VanGiesen **Date:** 08/29/2007

Organization : St. Mary's Good Samaritan Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Comment is attached, Please See Attachment

CMS-1385-P-11023-Attach-1.DOC

#11023

Dear Sir or Madam:

My name is Melissa VanGiesen. I am a certified athletic trainer that is currently working for St. Mary's Good Samaritan Hospital in Centralia, IL and I provide athletic training services to Centralia High School. I work part of my time at the hospital and our other outside clinics providing physical medicine and rehabilitation services to patients and the other parts of my time at the high school covering practices and games. I have both a Bachelor's degree and a Master's degree with a certification from the National Athletic Trainers Association Board of Certification.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Melissa VanGiesen, ATC, MS

Submitter : **Dr. Edward Furst** **Date: 08/29/2007**

Organization : **Capitol Anesthesiology Association**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Michael Fortanasce** **Date: 08/29/2007**

Organization : **Fortanasce**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear CMS Administrator

I'm writing to comment on the physician in office ancillary services which has created a loop-hole that has greatly resulted in the expansion in physician's owned arrangements that provide physical therapy services. I wish you had time to take a tour of physician owned offices in the San Gabriel Valley of So. California. The tour would demonstrate what the Florida Study showed in 1992, which was 32% more patients sent for physical therapy than was necessary and 43% more visits per patient. As the study demonstrated, the lowest level of care is still being performed at the physician owned offices.

Medicare was intelligent enough to continue to restrict physicians from selling medications, honing in on MRI's and durable medical goods, but why they allow physicians to self-refer, is beyond my comprehension. America was built on the free enterprise system, from 1993 to 2000 when physician self-referral was outlawed. Physical therapy clinics flourished when they provided excellent service & care at reasonable costs, while offices providing poor care and services went out of business. Physicians would refer their patients to the best physical therapy facilities, since they had no financial incentives to do otherwise. The last four presidents of the American Medical Associates had stated it is unethical to refer patients into entities which a physician has ownership, including physical therapy. However, the orthopedic surgeons, neurologists and neuron-surgeons have stated to my face It is legal, so we are going to do it. In this system there is no free enterprise, the patients are referred to the physician s physical therapy clinic. Even if that clinic provides the worst care in town and often even violates state law for physical therapy, but there is no one to question it!! I know for a fact that a local orthopedic group on Congress Street in Pasadena., the physical therapists see the patients for 15 minutes or less. I'm sure this is not evident or reflected in their billing.

I urge you to STOP SELF-REFERRAL of physical therapy to physician owned clinics. The Office of the Investigative General commented in 2000, about the excessive abuse of services when physicians have ownership.

I personally had a patient came to my office after being told by their doctor that they needed physical therapy daily for the next month. When the patient refused to receive treatment at the doctor s physical therapy clinic, This same patient was then given a prescription for my independent private practice office for only 2 times a week for 2 weeks. Self Referral is allowing the physicians to write themselves a blank check at Medicare s expense. They can provide sub-standard care to any patient that walks in the door and Medicare pays for it. If self-referral is outlawed and I provided sub-standard care I would receive no referrals and would justifiably go out of business.

I urge you once again, to stop physician self-referral of physical therapy services and re-establish the American free enterprise system in physical therapy. Allow the finest physical therapy clinics to receive referrals. As each of the orthopedic groups in our area opened their own physician owned physical therapy clinics they shut off the referrals to the independent physical therapy clinics. The independent owned physical therapy clinics continue to provide far superior care using only licensed physical therapists who spend much more time with the patients.

Thank you for your time and consideration.

Sincerely

Michael G. Fortanasce, PT, DPT

Submitter : **Dr. kent forss** **Date: 08/29/2007**

Organization : **american society of anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Leslie Norwalk,

Thank you for addressing the unfair disparity regarding medicare reimbursement for anesthesia services. As you know, the $16.19 per unit fee schedule did not even approach the cost for providing anesthesia care for our seniors. In fact, my telephone repairman is reimbursed at a higher rate than I am for performing anesthesia during a 3a.m. emergency surgery for a ruptured aortic aneuyrism (I am not exagerating!). I want to express my appreciation for your actions in finally rectifying this flagrant undervaluation of medical anesthesia services.

Thank you!

Submitter : **Mr. Joseph Carter** **Date: 08/29/2007**

Organization : **Mr. Joseph Carter**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Joseph D. Carter

Submitter : Mr. Matt Gage **Date:** 08/29/2007

Organization : Brigham Young University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11028-Attach-1.DOC

11028

Dear Sir or Madam:

My name is Matt Gage and I'm currently working on a PhD in Physical Medicine and Rehabilitation at Brigham Young University. I am a certified and licensed athletic trainer. My career has given me the opportunity to work at: a physical therapy clinic, high school, university. All of those opportunities have modeled me into the professional I am today.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

XXXXXX, ATC (and/or other credentials)

Submitter : **Dr. Thomas Butcher** **Date: 08/29/2007**

Organization : **SJAS**

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.

Thomas M Butcher MD

Submitter : **Ms. Diana Keith** **Date: 08/29/2007**

Organization : **Georgetown University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Diana Keith and I am a Certified Athletic Trainer working at Georgetown University. I have a Bachelor of Science degree in Athletic Training and a Master of Arts degree in Kinesiology and have been a Certified Athletic Trainer for 14 years.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Diana L Keith MA, ATC

Submitter : **Ms. Karin Krzal** **Date: 08/29/2007**

Organization : **Burke Mountain Academy**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

08/29/2007

Dear Sir or Madam:
My name is Karin Krzal for the past 5 year I had been employed by Burke Mountain Academy (BMA) in East Burke, Vermont as a certified and licensed athletic trainer. My education includes a B.S. in athletic training from Springfield College (MA.) and a M.S. in sport psychology from Purdue University (IN). My position included care and prevention of athletic injuries for 65 elite ski racers. Without the assistance of an athletic trainer BMA ski racers would have had great difficult recovering from injury and staying on the slopes.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Karin Krzal, M.S., ATC

Submitter : Mrs. Amy Ream **Date:** 08/29/2007

Organization : Munson Medical Center/ TC West JHS

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a graduate of Central Michigan University with a Bachelors degree in Sports Medicine and I am a Certified Athletic Trainer. I am currently employed by Munson Medical Center in Traverse City, Michigan. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospital and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the Hospital Conditions of Participation have not received the proper and usual vetting. I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As and Athletic Trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as Physical Therapy. My education, clinical experience and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and the proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans; especially these in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehab facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes to related hospital, rural clinics, and any Medicare Part A and B hospital or rehab facility.

Sincerely,
Amy Ream, ATC

Submitter : **Dr. Charles Dai** **Date: 08/29/2007**

Organization : **Dr. Charles Dai**

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 : **Mr. Christopher OBrien** **Date: 08/29/2007**

Organization : **Stony Brook University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Christopher W. O'Brien, MS, ATC. I am a Certified Athletic Trainer and a clinical assistant professor of athletic training at Stony Brook Univerity.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Christopher W. O'Brien, MS, ATC

Submitter : Mr. John Mcdougal **Date:** 08/29/2007

Organization : Munson Medical Center/TC West SH

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a graduate of Grand Valley State University and am currently employed by Munson Medical Center in Traverse City, Michigan. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospital and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the Hospital Conditions of Participation have not received the proper and usual vetting. I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As and Athletic Trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as Physical Therapy. My education, clinical experience and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and the proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans; especially these in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehab facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes to related hospital, rural clinics, and any Medicare Part A and B hospital or rehab facility.

Sincerely,
John Mcdougal, ATC

Submitter : **Mrs. Mary Robideaux** **Date: 08/29/2007**

Organization : **Mrs. Mary Robideaux**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Mary Robideaux

Submitter : **Mr. Aaron Galpert** **Date: 08/29/2007**

Organization : **Children's Hospital of Akron**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I have been a practicing athletic trainer for 26 years and am very concerned regarding the future of our athltic training profession.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Please help us with this fight to keep our jobs.

Sincerely,

Aaron Galpert ATC LAT
North East Ohio OATA Representative
Supervisor of athletic trainer services for Children's Hospital of Akron

Submitter : **Ms. Brenda Klein** **Date: 08/29/2007**

Organization : **Otterbein College**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer serving collegiate student-athletes at Otterbein College in Westerville, Ohio. After I completed my undergraduate education, I passed a national certification exam and earned my Master's degree. I provide immediate care and evaluation of injuries, rehabilitation services, and preventative measures to our athletes. When appropriate, I refer to a variety of health care specialists.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Brenda M. Klein, MEd, ATC

Submitter : **Mr. Bill Kovach** **Date: 08/29/2007**

Organization : **Advanced Health Rehabilitation**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007

Dear Sir or Madam:

My name is Bill Kovach and I am a nationally certified and Ohio Licensed Athletic Trainer. I have worked side by side with physical therapists and physical therapy assistants for over 17 years. I hold a Master s degree in Education and with our continuing education requirements to maintain my certification and licensure status; I have taken numerous courses to further strengthen my ability to help people.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Bill Kovach, M.Ed., LAT, ATC

Submitter : Ms. Angie Beisner **Date:** 08/29/2007

Organization : The Ohio State University

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am currenty a certified athletic trainer in the college seeting. I have been an ATC for the past ten years and hold a bachelor's degree from The Ohio State Univeristy and master's degree from Eastern Kentucky University.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Angie Beisner MA,ATC

Submitter : **Mr. John Norwig** **Date: 08/29/2007**

Organization : **Pittsburgh Steelers Football Club**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is John Norwig and I am the Head Athletic Trainer for the Pittsburgh Steelers. I have been certified by the National Athletic Trainers Association for the past twenty-five years.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

John Norwig, M.ED, ATC

Submitter : **Mrs. Athelene Carter** **Date: 08/29/2007**

Organization : **Mrs. Athelene Carter**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Athelene M. Carter

Submitter : **Date: 08/29/2007**

Organization :

Category : **Occupational Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am glad to see that you are considering removing the exemption for referral for profit for Occupational Therapy. I think that practices that are either owned by the physician or that provide a kick-back to the physician for referral lend themselves to fraud and abuse.
In my community we have 2 large orthopedic practices that have opened their own OT and PT practices for the sole purpose of increasing their profits. There are several hospital based practices and private therapist owned practices in the area that were providing those services for these physicians. When they opened these practices they offered these positions to therapists in the area that were already treating their patients so it wasn't an issue of quality of care.
In a neighboring community there were therapist owned practices that were told they would need to sell their practices to a physician group or they would not receive any referrals from the physicians.
We have had patients come to our practice that were initially treated at the physician owned practice. In one instance a patient had been fitted with a pre-fabricated splint. The patient c/o the splint not fitting. When she tried to return the splint to the practice she was told that since she had worn it they would not take in back and she would need to purchase another splint. Since the therapist should have fitted her with the splint I believe the patient should have beed provided with splint that correctly fit the paitent for no additional charge. Also, the patient informed me how much she was charged for the splint and it was significantly more expensive than the exact same splint at our facility.
Patients have informed us that they were not made aware that they could go to other facilities in the area for their treatments even though it could have been less costly for the patient.
We have received referrals for Medicare patients following the patient using up all of the visits they could use at the physician owned practice. This requires the patient to undergo another evaluation and it certainly isn't good for continuity of care. This occurs even when they know the patient will need more treatments than they can receive at the physician owned practice.
I recommend that the referral for profit exemption for Occupational Therapy be eliminated. I believe physician owned practices lend themselves to unethical practices and fraud and abuse.

Submitter : Ms. Kristine Terrio **Date:** 08/29/2007

Organization : Ms. Kristine Terrio

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

CMS is proposing to amend the regulations to change the plan of treatment recertification schedule. Currently, the referring physician must certify the initial plan of care and re-certify every 30 days thereafter.

CMS proposes to change the re-certification period to 90 days.

I strongly support the proposal to extend the 30 day re-certification requirement to 90 days.

The 30 day recertification is overly burdensome for physicians and physical therapists and is not an effective means of controlling utilization of therapy services.

CMS has adequate other requirements in place (referral, certification of the initial plan of care, specific medical necessity requirements, extensive documentation requirements, Local Coverage Determinations, Therapy Caps, CCI edits, etc.) and does not need the 30 day re-certification process in order to manage appropriateness of therapy care and utilization.

Submitter : **Ms. Dayna Carter** **Date: 08/29/2007**

Organization : **Ms. Dayna Carter**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Dayna Carter

Submitter : **Ms. Lizzie Robideaux** **Date: 08/29/2007**

Organization : **Ms. Lizzie Robideaux**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Lizzie Robideaux

Submitter : **Dr. Christian Eirich** **Date: 08/29/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Christian A. Eirich, MD
Anesthesiologist
American Society of Anesthesiology

Submitter : **Mr. Daryn Baker** **Date: 08/29/2007**

Organization : **Memorial Healthcare, Owosso, MI**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Certified Athletic Trainer who graduated in 1993 from Central Michigan University with a BS in Sports Medicine. After graduation I was very fortunate to work 2 seasons with a professional hockey team. Despite the rewards of working with professional athletes I wanted to help a wider patient population. Since 1996 I have been working in a clinical setting providing rehabilitation services to a wide array of patients ranging from housewives to commercial fishermen and everything in between. In conjunction to the clinic, I spend 20 hours per week caring for the student-athletes at a local high school. I have been very fortunate to have many positive letters from patients presented to my department manager citing the positive affects my interactions with them have had on their lives. This reflects very positively on the merits of quality care that is not dependent upon what degree one possesses be that a PT degree, ATC degree or PTA degree, but rather on the successful utilization of skills in a caring matter. A specific degree does not guarantee quality care.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification examination ensure that my patients receive quality healthcare. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known thorughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day healthcare needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Daryn J. Baker, ATC

Submitter : **Dr. Anuradha Perni** **Date: 08/29/2007**

Organization : **Dr. Anuradha Perni**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Anuradha Perni, M.D.

Submitter : **Mr. Mark Kaufman** **Date: 08/29/2007**

Organization : **AthletiCo LTD**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer and Physical Therapist who graduated from the University of Iowa in 1986 with a BS in Athletic Training. In 1988, I earned my master s degree in Exercise and Sports Sciences from the University of Arizona. In 1989, I received a second bachelor s degree in Physical Therapy from Northwestern University Medical School in Chicago. I opened AthletiCo, LTD in 1991 and we are currently the largest employer of Athletic Trainers in Illinois.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Mark Kaufman, MS, ATC, PT

Submitter : **Mr. Daniel Kearney** **Date: 08/29/2007**

Organization : **McDonough Orthopaedic**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Certified Athletic Trainer working at a private orthopaedic clinic providing physician extender services in our clinic and outreach services to our local high schools.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Daniel J. Kearney, ATC, CSCS

Submitter : **Mr. Jason Trinidad** **Date: 08/29/2007**

Organization : **Bassett High School**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See Attachment

CMS-1385-P-11052-Attach-1.DOC

#11052

Dear Sir or Madam:

I have been a certified athletic trainer since 2003. Although 4 years is not a long time, I have worked with many different athletes from minor league baseball, university, community college, clinic outreach, and my current position, full time head athletic trainer for a high school in southern California.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

Now you might say that the CMS rule change has nothing to do with me, being that I work at a high school, and servicing hospital patients is a totally different matter. However, the fact of the matter is that many athletic trainers who work in outpatient hospital settings go out to local high schools a provide services under the hospital, or physicians practice. I am in charge of caring for approximately 350 athletes at my high school. Many of these athletes are from lower socioeconomic backgrounds, of whom have no health insurance coverage. The care, and access to medical coverage that an athletic trainer can give to these athletes is invaluable. Many of my students have no other access to medical care whatsoever other than the services I give. Changing the CMS rule would abolish why Medicare and Medicaid are funded, to help the people who need help the most.

It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jason Trinidad, MEd, ATC, CSCS
Head Athletic Trainer
Bassett High School

Submitter : **Dr. Shahla Heshmati** **Date: 08/29/2007**

Organization : **Self**

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:

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

There is 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 senior citizens. It 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. This 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 support full implementation of the RUC recommendation.

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

Thank you for your consideration of this serious matter.

Sincerely,
Shahla Heshmati, M.D.

Submitter : **Julie Legault** **Date: 08/29/2007**

Organization : **Lakeland Orthopedic Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Julie Legault, and I am a Certified Athletic Trainer employed in an Orthopedic Rehabilitation Facility in St. Joseph, Michigan. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience (over 17 years) and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Julie A. Legault, ATC

Submitter : Mr. Jerome Schimmenti **Date:** 08/29/2007

Organization : Linden Emergency Medical Services, Inc.

Category : Other Health Care Provider

Issue Areas/Comments

Beneficiary Signature

Beneficiary Signature

"Ambulance Scrivce" I believe that your change to the Beneficiary Signature for Ambulance Transport Services is fair and correct. The avenue given for compliance does not create a heavy burden on the serivce provider and can be accomplished in a timely manor. A signed contemporaneous statment used on a limited bases and tightly controlled so that it will not become a routine event should help increase compliance in this area. A clear and standardize format for this contemporance statment should be issued to allow for proper compliance to this new rule.

Submitter : **Dr. Dawn Hankins** **Date: 08/29/2007**

Organization : **McKendree University**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007
Dear Sir or Madam:
My name is Dawn Hankins; I am a Certified Athletic Trainer and Program Director at McKendree University. Our program is accredited by the Commission on Accreditation of Athletic Training Education (CAATE). I hold a PhD is Education and I am a full time tenured faculty member of the institution. As an Athletic Trainer I have 26 years of practice and I am currently licensed to practice in two states.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility. Let me further add that with more and more citizens not having access to medical insurance we are perpetuating a society of those that have and many more that have nothing, even the right to choose who provides their care!
Sincerely,
Dawn M. Hankins, PhD, ATC, LAT
Program Director of Athletic Training Education
Associate Professor of Athletic Training
McKendree University
701 College Road
Lebanon, Illinois 62254

Submitter : Dr. Darrell Randle **Date:** 08/29/2007

Organization : Medical Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Darrell Randle, MD

Submitter : **Mr. Kevin Brown** **Date: 08/29/2007**

Organization : **Elite Performance and Rehabilitation Center**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My Name is Kevin Brown ATC. I have been a Certified Member of the NATA since 1983 and co-own a facility where physical therapists and Athletic Trainers work together for the purpose of providing rehabilitation and athletic enhancement services to our community. It is our desire that Athletic Trainers be seen as a valued member of such organizations as ours and believe the changes proposed would lessen our existence to work and serve in our community.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Please don't allow powerful lobby groups such as the APTA to dictate the access to care and eliminate competition through monopolization of rehabiliation services.

Sincerely,

Kevin Brown, ATC

Submitter : Miss. Mary Rosinski **Date:** 08/29/2007

Organization : Central Michigan University Intern

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a soon-to-be graduate of Central Michigan University with a degree in Sports Medicine. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospital and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the Hospital Conditions of Participation have not received the proper and usual vetting. I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As and Athletic Trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as Physical Therapy. My education, clinical experience and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and the proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans; especially these in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehab facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes to related hospital, rural clinics, and any Medicare Part A and B hospital or rehab facility.

Sincerely,
Mary Rosinski, Athletic Training Intern

Submitter : Mr. Jason Nelson **Date:** 08/29/2007

Organization : Lakeside Ortopedics

Category : Other Health Care Professional

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Dear Sir or Madam,

I work for Lakeside Orthopedics in Omaha, Nebraska. I am a certified athletic trainer, who work in the clinical setting. My responsibilities as a DME Coordinator are to send a patient home with a rehabilitation program, along with fitting braces.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients. As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jason Nelson, MS, ATC

Submitter : **Dr. Thomas Rooney** **Date: 08/29/2007**

Organization : **University of Toledo Medical Center**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

See attachment.

CMS-1385-P-11061-Attach-1.DOC

#11061

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)
August 29, 2007

Dear Ms. Norwalk:

I support in the strongest possible terms the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. That the CMS has revisited this issue and recognized the gross undervaluation of anesthesia services is a step in the right direction to achieving a sustainable system for senior citizens dependent on Medicare for their health services.

The RBRVS greatly undervalued anesthesia services compared to other medical specialties. As an anesthesiologist in academic practice in Northwest Ohio at a smaller residency program, I can tell you that our continued viability rests on adequate funding so that we can train the anesthesiologists of the future to care for a rapidly aging population and keep abreast of the new technologies and procedures in our field. University of Toledo Medical Center (formerly the Medical College of Ohio) has trained most of the anesthesiologists in practice in NW Ohio, although our graduates have taken jobs across the country with great success. Restoring basic fairness to anesthesia payments is the right thing to do and it will keep our residency program viable into the future.

Our medical center (UTMC) is more dependent on your decision than the private hospitals in the Toledo, Ohio area, since we have a smaller proportion of privately insured patients than they. Please weigh your decision carefully, since the ramifications it will have will be considerable.

Thank you for considering my views on this serious matter.

Sincerely,

Thomas A. Rooney, M.D.
Diplomat of the American Board of Anesthesiology
Assistant Professor of Anesthesiology
University of Toledo Medical Center
Toledo, Ohio 43614
Thomas.rooney@utoledo.edu

Submitter : **Dr. Dean Ornish** **Date: 08/29/2007**

Organization : **Preventative Medicine Research Institute**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11062-Attach-1.DOC

[redacted]

CMS-1385-P-11085

Submitter : Dr. Reuben Sloan **Date:** 08/29/2007

Organization : Resurgens Orthopaedics

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I think the argument over whether physician-owned is ethical or fair comes down to a simple question; does the patient benefit or suffer? As a very busy musculoskeletal physician who sees hundreds of patients per week, the patients that do best (and therefore utilize far fewer medical services) are patients who are treated by the physical therapist in house (employed by my group). The reason is rather simple; communication. Not only to the physical therapists we employ have immediate access to the patients' electronic medical record, but, more importantly, they have immediate access to me, the prescibing physician. Therefore, these lucky patients get the best physician therapy care possible. Patients who cannot or choose not to utilize our physical therapist (because of insurance restrictions or geography) generally have poorer outcomes or require 2 to 3x the number of therapy visits, or both.

Submitter : **Tom Smith** **Date: 08/29/2007**

Organization : **Orlando Magic**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam,

Greetings from Orlando Florida. My name is Tom Smith and I am the Head Athletic Trainer for the Orlando Magic. I began working in professional sports in 1990 while completing my graduate degreein Sports Medicine. Since that time I have worked in minor league basketball & hockey, youth sports, with the USOC and at the high school and college level. After receiving my Masters degree in 1991 I have also added 3 additional certifications (NASM- PES & CES and NSCA - CSCS)

I am writing to you today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Comditions of Participation have not received the proper and usual vetting, I am more concerned that these propsed rules will create additional lack of access to quality health care for my athletes.

As an Athletic Trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. I have the wonderful opportunity of working with some of the best (and highest paid)athletes in the world. My education, experience and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treametn available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Tom Smith, MSS,ATC,PES,CES,CSCS
Orlando Magic Head Athletic Trainer

Submitter : Dr. Sally Shughart **Date:** 08/29/2007

Organization : Kansas University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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 : **Mr. Steve Blazier** **Date: 08/29/2007**

Organization : **Anesthesia Medical Consultants PC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Name & Credential

Address

City, State ZIP

Submitter : **Miss. Laura A. Schnettgoecke** **Date: 08/29/2007**

Organization : **Clemson University**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Laura A. Schnettgoecke. I have been a part of the National Athletic Trainers Association for seven years and been certified for two. I am currently a graduate assistant athletic trainer with the women s soccer team at Clemson University. At the university, my responsibility is to provide prevention, care and rehabilitation for all of my athletes.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules would create additional lack of access to quality health care for patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which is known not to be the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients and/or athletes receive quality health care. State law and hospital medical professionals have deemed us, as certified athletic trainers, qualified to perform these services. And these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, to further restrict their ability to receive those services. This is especially difficult for those in rural areas. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available. Which includes certified athletic trainers as a part of hospital staffs.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Laura A. Schnettgoecke, ATC

Submitter : **Dr. Brian Wagner** **Date: 08/29/2007**

Organization : **Dr. Brian Wagner**

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. As a young physician, this definitely affected my decision not to practice in a more rural setting.

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.

Brian Wagner M.D.
3722 Washoe St.
Davis, CA 95618

Submitter : **Dr. Robert Alpert** **Date: 08/29/2007**

Organization : **Southmetro Chiropractic Center, INC**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimore, Maryland 21244-8018

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Submitter : **Mrs. Lori Fuller** **Date: 08/29/2007**

Organization : **Mrs. Lori Fuller**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Lori Fuller

Submitter : **Dr. Patricia Youmans** **Date: 08/29/2007**

Organization : **Patricia A. Youmans, D.C.**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Attention: CMS-1385-P

The proposed rule dated July 12th called for an item in the technical corrections section,that a non-treating provider taking x-rays will not be reimbursed by Medicare if referred to by a Doctor of Chiropractic to determine subluxation. At this time, a non-treating provider of x-rays is reimbursed. If the reimbursement is eliminated, I am opposed to this proposal.

There are many Medicare patients on fixed incomes and will choose to forego treatment needed. Although subluxations do not need to be detected by x-ray, life threatening illnesses/osteopenia/"red flags"/fractures/degree of scoliosis/degeneration, etc., may go undetected without x-rays. Cost of patient care and treatment time due to extra referrals to M.D.'s(for x-rays)will increase, due to duplicative evaluation prior to a radiology/MRI referral. The patient will suffer if this proposal is passed.

I strongly urge you to table this proposal. These x-rays, if needed, are important to the overall treatment plan of Medicare patients.

Sincerely,

Patricia A. Youmans, D.C.

Submitter : **Mr. Ryan Harter** **Date: 08/29/2007**

Organization : **Niagara Falls Memorial Medical Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Ryan Harter and I am a Certified Athletic Trainer in Western NY/Niagara Falls Region of Upstate New York. I currently work for an hospital in Niagara Falls and my position details me working at a high school, in a physical therapy clinic as an assistant, as well as heading up the aquatic therapy program. I have been nationally certified for 4 years now after completing both undergraduate and graduate school.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Ryan Harter, MS, ATC

Submitter : **Ms. Tia Nowacki** **Date: 08/29/2007**

Organization : **Athletic Training Club MN State U-Mankato**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a senior in Minnesota State University-Mankato's athletic training program. This is a rigorous program including 20 hours a week of clinical experience as well as difficult coursework. In fact, my roommate, a nursing student, believes that the athletic training program is more difficult then the nursing one here.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Tia Nowacki, ATS

Submitter : **Dr. John Abran** **Date: 08/29/2007**

Organization : **Consultants in Pathology, S.C.**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 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 Anatomic and Clinical pathologist and a member of the College of American Pathologists and the American Society for Clinical Pathology. I practice in Chicago Heights, IL and Olympia Fields, IL as part of Pathology Consultants, Inc (Consultants in Pathology, S.C. in Illinois), a 20 pathologist group practice covering multiple hospitals in Illinois and Indiana. I am also the Vice-President of the Chicago Pathology Society, the second oldest local pathology society in the United States.

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 numerous 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,

John M. Abran, M.D.

Submitter : **Date: 08/29/2007**

Organization : **Arkansas State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Dustin Hartzer and I am currently working at Arkansas State University. I am a certified and licensed athletic trainer.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,

Dustin Hartzer, ATC, LAT
Athletic Trainer
Arkansas State University

Submitter : **Mrs. Susan Zajeski** **Date: 08/29/2007**

Organization : **Hines VA Hospital**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

RE: Docket #1385-P Therapy Standards and Requirements, Physician Self-Referral Provisions

To Whom It May Concern,

My name is Susan Zajeski. I have been working as a Registered Kinesiotherapist at Hines VA Hospital for 24 years. I have given excellent care to countless Veterans. They have made significant functional improvement in a safe, supervised enviornment. Our Veterans deserve quality healthcare as they have served for us.

I am writing today to voice my opposition to the proposed therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and other facilities proposed in Federal Register issue #1385-P. As a Kinesiotherapist, I would be excluded from providing physical medicine and rehabilitation services under these rules.

I am concerned that these proposed rules will create additional lack of access to quality health care for my patients. This is particularly important because my colleagues and I work with many wounded Veterans, an increasing number of whom are expected to receive services in the private market. These Medicare rules will have a detrimental effect on all commercial-pay patients because Medicare dictates much of health care business practices.

I believe these proposed changes to the Hospital Conditions of Participation have not received the proper and usual vetting. CMS has offered no reports as to why these changes are necessary. There have not been any reports that address the serious economic impact on Kinesiotherapists, projected increases in Medicare costs or patient quality, safety or access. What is driving these significant changes? Who is demanding these?

As a Kinesiotherapist, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, and Registered status insure that my patients receive quality health care. Hospital and other facility medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards and accepted practices.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the health care industry. It is irresponsible for CMS to further restrict PMR services and specialized professionals.

It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to reconsider these proposed rules. Leave medical judgments and staffing decisions to the professionals. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Susan Zajcski,RKT

Submitter : **Dr. Kathleen Sherwood** **Date: 08/29/2007**

Organization : **Sherwood Chiropractic Center, PC**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

"MEI"
Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimore, Maryland 21244-8018

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Thank you for your consideration!
Kathleen M. Sherwood

Submitter : **Mrs. kim conner** **Date: 08/29/2007**

Organization : **anesthesia medical consultants pc**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Date: 08/29/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a clinic business manger, I would like to state that although many physicians claim that their patients are in need of direct supervision when undergoing physical therapy and that is the reason they refer to their own clinics, indicating that communication is better. This is not true. As a clinic that gets referrals from many different groups, practices, and locations, we have no less trouble communicating on a regular basis and clearly and effectively regardless of business relationship.

Submitter : **Ms. Hayden Fuller** **Date: 08/29/2007**

Organization : **Ms. Hayden Fuller**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Hayden Fuller

Submitter : **Ms. Jaime May** **Date: 08/29/2007**

Organization : **St.Lukes Idaho Elks Rehabilitation Services**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I work at St.Lukes Idaho Elks Rehabilitation Services, which is an out patient facility associated with a hospital in Boise, Idaho. I have worked here for almost 3 years. I graduated from
Eastern Oregon University in 2002 and now I am a certified athletic trainer. I am licensed by the state of Idaho Board of Medicine and nationally certified by BOC. I am a certified personal trainer also.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

JAIME ANN MAY, ATC, ATL

Submitter : **Ms. Kathy Malone** **Date: 08/29/2007**

Organization : **Clarian Health, Inc**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer (ATC) in Indianapolis, IN. I have been practicing in my profession for over 17 years and I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kathy Malone, MA, ATC

Submitter : **Mr. Adam Peterson** **Date: 08/29/2007**

Organization : **Mayo Clinic**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer employed by the Mayo Clinic in Rochester, MN with main responsibilities including coverage to Rochester Mayo High School. I recently worked with the Washington Redskins as an intern athletic trainer. I have recently been married and secured this position for stability.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Adam B. Peterson, MS, ATC, ATR, EMT-B

Submitter : Dr. Craig senft **Date:** 08/29/2007

Organization : GA Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

Submitter : **Mr. jim nix** **Date: 08/29/2007**

Organization : **Anesthesia Medical Consultants PC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Dr. Thomas Jurrens** **Date: 08/29/2007**

Organization : **ASA**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Rakesh Vadhera** **Date: 08/29/2007**

Organization : **UTMB, Galveston, TX**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Rakesh Vadhera

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

8/29/2007eslie 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 : Mr. Larry Munger **Date:** 08/29/2007

Organization : Texas Tech University

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Larry Munger and I work at Texas Tech University as an Athletic Trainer. I am currently completing my doctoral studies (All But Dissertation) while working full time as an athletic trainer. I am a Certified Athletic Trainer through the Board of Certification, a Licensed Athletic Trainer in the state of Texas, and a Certified Strength and Conditioning Specialist through the National Strength and Conditioning Association Certification Commission. With these credentials and my responsibilities I am able to make a difference for many individuals especially the student athletes under my direct care. I also have experience working in many different settings and know my clinical skills have allowed me to design and implement rehabilitation programs the enhance the quality of life for individuals suffering from musculoskeltal dysfunction and injury.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Larry Munger, MS, ATC, CSCS

Submitter : **Ms. Barbara Duffy Stewart** **Date: 08/29/2007**

Organization : **Association of American Cancer Institutes**

Category : **Other Association**

Issue Areas/Comments

Drug Compendia

Drug Compendia

Please see attached letter from the Association of American Cancer Institutes.

CMS-1385-P-11113-Attach-1.PDF

#1113

Iroquois Building, Suite 308
200 Lothrop Street
Pittsburgh, PA 15213

Phone: 412•647•6111
Fax: 412•647•3659

Email: mail@aaci-cancer.org
Web: www.aaci-cancer.org

Association of American Cancer Institutes

August 29, 2007

Steve Phurrough, MD, MPA, CPE
Director, Coverage and Analysis Group
Office of Clinical Standards and Quality
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop: C1-09-06
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Phurrough,

The Association of American Cancer Institutes (AACI) supports the efforts of the Centers for Medicare and Medicaid Services (CMS) to provide access to effective cancer therapies and improve the quality of care for Medicare beneficiaries. As the association representing 89 of the nation's leading cancer centers, AACI recognizes the difficulty of establishing coverage policy based upon evaluation of safety and effectiveness, especially with regard to decisions regarding coverage for drugs and biologics. AACI welcomes the opportunity to reiterate its request that CMS recognize the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium (NCCN Compendium) as one of several mandated references for use by CMS and its intermediaries and carriers in setting coverage policies.

Cancer patients who rely on Medicare benefits for their treatment must have timely access to drugs and biologics. It is imperative that the compendia CMS relies on to make these coverage decisions be up-to-date and accurate, considering the rapid advances that are routinely made in the field of cancer research. NCCN's Clinical Practice Guidelines in Oncology, from which the NCCN Compendium is derived, are widely recognized as the standard for clinical policy in academic and community practice oncology settings. Recommendations in the Guidelines and Compendium are evidence-based, authoritative, and up-to-date. In fact, when CMS reviewed the NCCN Compendium, including asking the question, "how confident are you that compendia adhere to evidence-based criteria and processes in making recommendations?" the NCCN Compendium received a score of 4.5 (out of 5), compared to a score of 3.58 for the next-highest-scored compendium.

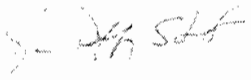
Given the critical role such compendia play in cancer treatment for Medicare participants, it is imperative that at least three compendia are available for reference in making coverage decisions. Currently, of the three compendia that were designated by CMS in 1993, one is no longer in existence and a second is changing its ownership, name, and format—it is unclear whether its new format will be of use to CMS in making coverage decisions. CMS has already favorably reviewed the NCCN Compendia.

On July 12, 2007, CMS issued a Proposed Rule (CMS Proposed Rule 1385-P) in the *Federal Register* that specifies criteria for compendia, and also identifies an implementation schedule for revising the current list of approved compendia. It appears that, based on this Proposed Rule, the earliest implementation of the revision of approved compendia is September 2008. However, CMS, under Medicare Part B, the Secretary of the Department of Health and Human Services already has the authority to revise the list of compendia.

We request that based on this authority, CMS immediately recognize the NCCN Compendia as an approved resource for coverage decisions for Medicare Part B and Part D. As more and more cancer medications are being taken orally, it is important that Congress act to ensure that modifications to the list of compendia used for Medicare Part B occur simultaneously for Medicare Part D.

On behalf of AACI's member centers and the patients they serve, we appreciate your consideration of this request.

Sincerely,



Barbara Duffy Stewart
Executive Director, AACI

Submitter : **Mrs. gwen stackhouse** **Date: 08/29/2007**

Organization : **Anesthesia Medical Consultants PC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Dr. Larry Davis** **Date: 08/29/2007**

Organization : **Dr. Larry Davis**

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 : **Dr. David Silver** **Date: 08/29/2007**

Organization : **Dr. David Silver**

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.

David A Silver MD

Submitter : **Ms. Marni Fuller** **Date: 08/29/2007**

Organization : **Ms. Marni Fuller**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Marni Fuller

Submitter : **Dr. Kkyle Morrissey** **Date: 08/29/2007**

Organization : **Indiana University Hospital**

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 : **Dr. Mary Allen Watson** **Date: 08/29/2007**

Organization : **Westfield State College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007
Dear Folk:
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
I am a college professor in sports medicine and athletic training with more that 28 years of experience. I currently teach at Westfield State College in Westfield, Massachusetts. I am a certified athletic trainer who teaches and mentors future athletic trainers, physical therapists, occupational therapists and physician assistants.
While I am concerned that the proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for patients.
Nationally certified athletic trainers (ATC) are qualified to perform physical medicine and rehabilitation services, which you know are not the same as physical therapy. The education, clinical experience, and national certification exam ensure that athletic trainiers patients receive quality health care. State law and hospital medical professionals have deemed the ATC qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Mary Allen Watson, Ed.D., ATC, LATC

Submitter : Mr. Terry Truex **Date:** 08/29/2007

Organization : Orthopedic Institute

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certfied athletic trainer that works for a physcian based orthopedic practice in Sioux Falls, SD. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Terry Truex, ATC

Submitter : **Mr. Ronald Ritchie** **Date: 08/29/2007**

Organization : **Mr. Ronald Ritchie**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would strongly urge that Physical Therapy services be added to the list of prohibited services that physicians may not be able to refer to businesses in which they have a financial interest.

This trend hurts the consumer of physical therapy services by requiring them to sometimes travel a greater distance to return to a physician's location instead of using a local P.T. clinic. It hurts the profession of Physical Therapy, by making the therapist another paid employee of the physician, instead of the independent liscensed health care practioners that they are educated to be. And finally, there is the potential to hurt consumers and third party payers financially, by over-utilizing services.

I would highly recommend placing restrictions on the physician's ability to refer patients to P.T. in which they have a financial interest. Thank you.

Submitter : **Mr. Thomas Reid** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

August 29, 2007

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

Dear Administrator:

RE: CMS-1385-P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

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

This increase in Medicare payment is important for the following reasons:

1) Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. MedPAC and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but only reimburses for anesthesia services at approximately 40% of private market rates.

2) This proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers' services had been reviewed and adjusted in previous years, effective January 2007. This proposed rule is the first adjustment to address the value of anesthesia work.

3) CMS' proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services that have long slipped behind inflationary adjustments.

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

In the US, 36,000 CRNAs provide 27 million anesthetics annually and in every setting requiring anesthesia services. CRNAs are the predominant anesthesia providers to rural and medically underserved areas. Medicare patients and healthcare delivery in the US depend on these services. The availability of anesthesia services depends in part on fair Medicare payment. I support the agency's acknowledgment that anesthesia payments have been undervalued. I support the proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Thomas Reid, CRNA
82 Westhaven Drive
Asheville, NC 28804-3737

Submitter : **Mr. Mark Donelson** **Date: 08/29/2007**

Organization : **SAint Francis Medical Center**

Category : **Other Technician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dcar Sir or Madam:
I am writing today to voicc my opposition to thc thcrapy standards and rcquirements in rcgards to the staffing provisions for rchabilitation in hospitals and facilitics proposcd in 1385-P.

Whilc I am concerned that thcsc proposcd changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am morc concerned that thcse proposcd rules will createc additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical cxperience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to pcrform thcse scrvices and these proposed regulations attempt to circumvent those standards.

Thc lack of acccss and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concernecd with thc health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and othcr rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage thc CMS to consider the recommcndations of thosc professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw thc proposcd changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Mark Donelson ATC
Assistant Manager OP Rehab
Saint Francis Medical Center
mdonelson@sfmc.net

Submitter : **Ms. Dace Zemzars** **Date: 08/29/2007**

Organization : **Cleveland Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a Clinical Athletic Trainer at the Cleveland Clinic. I have been treating orthopedic patients in the physical therapy clinic for the last eight years. My education includes a bachelor's degree along with a master's degree in athletic training. I am certified by our national organization and am licensed in the state of Ohio. My education has prepared me to treat active individuals in the clinical setting who are recovering from an injury and/or surgery. I feel that my patients benefit from the care that I provide them.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Dace Zemzars MS,ATC

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007

Mr. Kerry N Weems
Administrator Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

RE: Physician Self Referral Issues: Medicare Program Proposed Revisions to Payment Policies Under Physician Fee Schedule and Other Part B Payment Policies for CY 2008 Proposed Rule

Dear Mr. Weems,

I am a physical therapist with 29 years of experience and practice. I have practiced in multiple states and now practice in Massachusetts in one of Boston s most prestigious teaching hospitals. The comments I present in this letter are my own personal comments relative to the proposed July 12 physician fee schedule rule regarding physician self referral and the in-office ancillary services exception. I seek your support, and the support of others who can influence CMS policy in removing Physical Therapy services from being allowed under the in-office ancillary exception.

I believe a high potential for fraud and abuse exist anytime a practitioner is able to refer a patient, in this case Medicare beneficiaries, to entities in which they have a financial interest. This is the case with physician owned physical therapy services. I have personally witnessed this happen in every state in which I have practices. Anytime a practitioner has an inherent financial interest or incentive to utilize services for which they gain profit the potential for over-utilization may result. The potential exists throughout health care and is not confined to the private practice setting. From experience I can say that the same temptation exists even in the hospital setting if a physician, or the department in which they practice, believe that they will derive financial gain or be given credit from the control of the billing and revenue from an ancillary service to which they refer.

I believe that there is ample evidence that allowing Physical Therapy services to be furnished under the in-office ancillary services exception has resulted in programmatic abuse and over-utilization. I urge CMS to eliminate Physical Therapy as a designated health service (DHS) under the in-office ancillary exceptions program.

Direct physician supervision is not necessary to administer physical therapy service. Physical therapists are qualified practitioners with the knowledge, skill and training to render care to the patient independent of the physician. Allowing in-office, incident to billing of Physical Therapy services not only creates a financial incentive for abuse but also for the use on non-qualified practitioners to deliver physical therapy services.

While I would prefer to attach my name and address to this letter I am reluctant to and am only placing my zip code on this email letter. This is because of my concern regarding potential adverse reactions from physicians who refer patients to me. I believe that this also speaks to the sensitivity of this issue an another reason why referral to physical therapists from physicians should not be required.

I strongly urge you remove Physical Therapy Services from being allowed under the in-office ancillary exemption.

Thank you for your consideration of my request.

Sincerely,
Name Withheld at Discretion of Sender
Zip: 02492

Submitter : **Miss. Mita Patel** **Date: 08/29/2007**

Organization : **Clemson University**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Mita Patel and I am currently working for Clemson University Sports Medicine as an Athletic Training Intern. I graduated from the College of Charleston Athletic Training program in May 2007.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services.
The flexible current standards of staffing in hospitals and other
rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and
any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Mita A. Patel, AT

Submitter : **Dr. Susan Goelzer** **Date: 08/29/2007**

Organization : **University of Wisconsin**

Category : **Individual**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I appreciate recognition of the previous inequitable valuation of anesthesia services, and that CMS is taking steps to address this complicated issue.

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

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

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

Thank you for your consideration of this serious matter.

Sincerely

Susan L. Goelzer MD

Professor of Anesthesiology, Internal Medicine and Population Health Sciences

Submitter : **Ms. Teresa Maupin** **Date: 08/29/2007**

Organization : **Ms. Teresa Maupin**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Teresa Maupin

Submitter : **Mrs. Stephanie Erlandson** **Date: 08/29/2007**

Organization : **Sports Medicine Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer with a bachelor of science degree who works in an outpatient injury clinic with two orthopedic surgeons and several certified athletic trainers. The clinic I work in also contracts certified athletic trainers with approximately 14 local high schools.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Stephanie B. Erlandson, ATC

Submitter : **Mrs. Corrie Wagner** **Date: 08/29/2007**

Organization : **Mrs. Corrie Wagner**

Category : **Individual**

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 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.

Thank you,

Corrie Wagner

Submitter : Dr. Brad Russell **Date:** 08/29/2007

Organization : Hug Chiropractic Clinic

Category : Chiropractor

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

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

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

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

Submitter : **Dr. Sami Lababidi** **Date: 08/29/2007**

Organization : **Colorado permanente medical group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Sami Lababidi, DO
Anesthesiology

Submitter : Ms. Joan Purrington **Date:** 08/29/2007

Organization : MN Chp American Physical Therapy Association

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The following comments are on behalf of the Minnesota Chapter of the American Physical Therapy Association (MN APTA). I serve as President of MN APTA. I have been practicing Physical Therapy for 37 years and I currently practice in a school-based setting.

As an Association, we wish to comment on the July 12 proposed 2008 physician fee schedule rule, and in particular the issue surrounding physician self-referral and the in-office ancillary services exception. We support the removal of physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws.

We believe that a conflict of interest exists whenever physicians are permitted to refer to, and profit from physical therapy services in which they have a financial interest. In these arrangements physicians seek income beyond the fee for their own services and enter into arrangements that amount to voluntary, or avoidable, conflicts of interest. These types of arrangements are being marketed to physicians as passive revenue streams and courses are being offered to teach physicians how to start such practices and how to effectively maximize their billing practices..

Since Stark II the number of physician-owned and chiropractic-owned physical therapy practices has rapidly increased in this state. Physical therapist-owned practices have suffered measurable and significant losses in the number of patients who are referred to them, specifically from those physicians who employ their own physical therapists. In a survey of our members done early in 2005, 30% of respondents indicated that their clinics had been adversely affected by physician self-referral. Since then, the number has increased, although we cannot accurately report the severity of the impact.

As a professional association MN APTA opposes allowing one profession to control the marketplace of another profession. We do not believe that patients are well-served when avoidable conflicts of interest exist. Our concern is that physician self-referral is a cost-driver in healthcare and that it can lead to over utilization in the forms of unnecessary referrals, excessive durations or frequencies of treatment, and unnecessary procedures and equipment. We are also concerned about under utilization in the forms of denial or restriction of physical therapy. This has been reported to occur when the therapy might eliminate the need for other high cost services, such as imaging or surgery, from which the physician profits. Finally, MN APTA has concerns over the limited choice that the Medicare beneficiary might have in physical therapists. Beneficiaries have reported that they feel pressured to discontinue the relationships they have with their own physical therapist in order to receive the physical therapy that they need.

Physician self-referral is being defended as allowing physicians a greater role in the physical therapy services provided to patients. However the trend in Minnesota has been for physician-owned physical therapy clinics to take advantage of the reassignment of benefits laws to collect payment in order to circumvent the incident to requirements. Either way, the physician is controlling demand and access to services and at the same time is profiting from that control.

MN APTA strongly supports any efforts to eliminate abusive financing arrangements under the Stark law that are contrary to the best interest of the Medicare beneficiary. MN APTA strongly urges the CMS to remove physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws.

On behalf of MN APTA, thank you for your consideration of our comments.

Joan C. Purrington, PT, MA
President
MN APTA

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I do not feel that physical therapy should be included in the ancillary services exception that allows PT to be performed in a physicians office. This is opening the door for unregulated service abuse and potential fraudulent activity. Some physicians are using this as a "loophole" in the Stark laws and are practicing self-referral for profit. Patient care is being directly affected. I have had many patients inform me that their physician strongly encouraged and suggested that the patient attend PT in the physicians clinic rather than being offered a choice as to which facility the patient would prefer to use. Just in the last week, a patient was told by their doctor that he wanted them to have physical therapy. The doctor then set the patient an appointment in his own clinic. The patient requested to be sent to another PT clinic that was much closer to their home, more convenient for the patient, and the patient had attended PT at the requested clinic in the past with quality sevice and a very successful outcome. Upon hearing this request, the doctor told the patient just to perform some exercises at home, instead of allowing the patient to attend the PT clinic of their choice. This is clearly just one of many incidences where physician self-referral for physical therapy services is detrimental for patients. I believe the Stark law "loophole" should be amended to protect the public and avoid unregulated patient services.

Submitter : **Dr. Ethan Caughey** **Date: 08/29/2007**

Organization : **Chiropractic USA**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Todd Caughey DC

Submitter : **Dr. David Stark** **Date: 08/29/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
David M. Stark M.D.

Submitter : Mr. Kyle Havercroft **Date:** 08/29/2007

Organization : Rockwood Clinic P.S.

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Submitter : **Mr. Jeff Kreuser** **Date: 08/29/2007**

Organization : **Mr. Jeff Kreuser**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jeff Kreuser. I am a Certified Athletic Trainer who works at the Student Health Center on the campus of Kansas State University. I have been certified and assisting injured people since 1992. I feel the care I provide is an excellent service for my patients.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jeff Kreuser MS, ATC, CSCS

Jeff Kreuser MS, ATC, CSCS
Athletic Trainer
Lafene Health Center
Kansas State University
PH: (785) 532-5242

Submitter : Mariell Archer **Date:** 08/29/2007

Organization : DermSurgery Associates, P.A.

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

It is inappropriate to subject 17311 and 17313 to the multiple procedure reduction rule for repairs performed on the same day as the Mohs procedure or for multiple Mohs lesion excisions performed on the same day. Following are some concerns regarding the proposed changes to the Medicare 2008 Fee Schedule:

? This proposal will negatively impact Medicare beneficiaries access to timely and quality care and application of the Multiple Procedure Reduction Rule will not likely generate significant cost savings and may paradoxically increase the cost of providing care to these patients.

? By removing the exempt status of the Mohs codes, Medicare beneficiaries access to timely and quality care will be effected. Application of the proposed rule to a second tumor treated on the same day will mean that reimbursement for the second procedure does not cover the cost of providing the service. This will affect Medicare beneficiaries disproportionately, since the incidence of skin cancers peaks in Medicare-age patients, who are most likely to have multiple tumors.

? Patients who are immuno-suppressed from organ transplantation, cancer chemotherapy, infection or other diseases are at significantly higher risk for skin cancers and often have multiple tumors. Many of these patients are also Medicare beneficiaries. These immuno-suppressed patients are not only at higher risk for cancers but also at higher risk for potential metastases and possibly death from skin cancers, especially squamous cell carcinoma.

? When Mohs procedures are performed with higher-valued repairs such as flaps or grafts, application of the MPRR to the Mohs codes will result in reduced reimbursement for Mohs that doesn t cover the cost of the procedure. Likewise, for lower-valued repairs such as intermediate and complex layered closures, which are the most commonly performed repairs, reduced reimbursement will not cover the cost of the repair.

? Because of the dual components of surgery and pathology associated with each Mohs surgery procedure, there is no gain in efficiencies when multiple, separate procedures are performed on the same date, making application of the reduction inappropriate.

Submitter : Dr. jon minter **Date:** 08/29/2007

Organization : Dr. jon minter

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please exclude physical therapy from the in-office ancillary services exception from the self referral laws.
Physical therapy is an adjunct to the services we provide our patients and removing this from the domain of the Doctor impacts how we deliver our quality care. I do a number of very difficult surgeries and being able to have direct communicatiion and input with our therapy team insures the best outcome for my patients.

Submitter : **Dr. Yewande Johnson** **Date: 08/29/2007**

Organization : **Dr. Yewande Johnson**

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. Jan Holder** **Date: 08/29/2007**

Organization : **Ms. Jan Holder**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Jan Holder

Submitter : Mr. Clay Jamieson **Date:** 08/29/2007

Organization : University of Oregon

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Clay Jamieson, and I am a Certified Athletic Trainer with the University of Oregon Athletic Department in Eugene, OR. I have been involved in the Athletic Training profession for 17 years,the past 13 years spent in NCAA Division I Intercollegiate Athletics. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As a Certified Athletic Trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Clay Jamieson, MS, ATC/R, PES, CES
Assistant Athletic Trainer
University of Oregon
2727 Leo Harris Pkwy
Eugene, OR 97401

Submitter : **Dr. James Gill** **Date: 08/29/2007**

Organization : **Medical Anesthesia Consultants**

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.

James H. Gill, MD

Submitter : **Ms. Kerry Waple** **Date: 08/29/2007**

Organization : **Children's Sports Medicine**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I am the Senior Athletic Trainer and Columbus Children s Sports Medicine in Columbus, Ohio. I have a bachelors degree in Athletic Training from Canisius College in New York and a Masters Degree in Education from the University of Virginia. I have been a practicing athletic trainer for the past 20 years and I am very concerned about some upcoming legislation.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Kerry E. Waple, MEd, ATC, CSCS
Senior Athletic Trainer
Childrens Sports Medicine
584 County Line Rd. West
Westerville, OH 43082

Submitter : Mr. Steven Hitt **Date:** 08/29/2007

Organization : Blue Ridge Health Care

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

This is to express support for changes to the Medicare rules to prohibit making referrals to an entity for the furnishing of designated health services if the physician or immediate family member has a financial relationship with the entity. Allowing the rules to continue as presently structured in this area does two things: (1) it encourages physicians to create physical and occupational therapy practices when in many cases there are adequate services in a geographic locale, thus raising healthcare costs; and (2) enables physicians to order and subsequently perform ancillary services instead of making a referral to a specialist such as an occupational therapist.

The very nature of "in office ancillary services" and inherent financial relationships with referring physicians encourages overuse, negates choice and competition, because patients being treated by physicians almost always seek ancillary services at the location recommended by the doctor. This in effect negates choice and in a "built-in" conflict of interest.

I encouage CMS to consider eliminating physician owned practices for these reasons. Thank you.

Submitter : **Mr. Voyle Holder** **Date: 08/29/2007**

Organization : **Mr. Voyle Holder**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Voyle Holder

Submitter : Mrs. Justine Stelter **Date:** 08/29/2007

Organization : Hinsdale Orthopaedic Therapy Center

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a licensed athletic trainer currently working at Hinsdale Orthopaedic Therapy Center in Hinsdale,IL. I recieved my bachelors from Elmhurst College located in Elmhurst,IL. in the year 2000.Since that time, I have worked for both clinical and outreach high school settings. At Hinsdale Orthopaedics, I work with a combined team of occupational therapists, physical therapists, athletic trainers, and physicians.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Justine Stelter, ATC

Submitter : Dr. Alex Homaechevarria **Date:** 08/29/2007

Organization : Inter Mountain Orthopaedics

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

August 29, 2007
Dear Sir or Madam:
I am a Board certified Primary Care Sports Medicine physician n Boise Idaho who works very closely with certifired Athletic Trainers on a daily basis.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
I believe athletic trainers, are qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. Their education, clinical experience, and national certification exam ensure that my patients and athletes receive quality health care. State law and hospital medical professionals have deemed them qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of patients and athletes. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Alex A. Homaechevarria M.D., CAQSM

Submitter : **Miss. kathleen whitehead** **Date: 08/29/2007**

Organization : **Miss. kathleen whitehead**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kathleen Whitehead ATC/L, CSCS

Submitter : Ms. Alice Willard **Date:** 08/29/2007

Organization : Ms. Alice Willard

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter

Sincerely,

Alice Willard.

Submitter : Dr. Michael Ford **Date:** 08/29/2007

Organization : CA Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11153-Attach-1.DOC

#11153

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Craig Palmer** **Date: 08/29/2007**

Organization : **Dr. Craig Palmer**

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. Susan Rotsky** **Date: 08/29/2007**

Organization : **Ullucci Sports Medicine and Physical Therapy**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Susan Rotsky I graduated from Russell Sage College in 2007 with a Bachelor of Science degree in Athletic Training and my Emergency Medical Technician certification. I currently hold licensure in Massachusetts and Rhode Island as a Certified Athletic Trainer. I work in the Physical Therapy Clinical setting and I am contracted out to a High School throughout the school year.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Susan Rotsky, ATC,LAT, EMT

Submitter : **Mrs. Judy Maupin** **Date: 08/29/2007**

Organization : **Mrs. Judy Maupin**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Judy Maupin

Submitter : Dr. Tom Dougherty **Date:** 08/29/2007

Organization : Emory Sports Medicine Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

29 August 2007

CMS-1385-P-11157-Attach-1.DOC

#11157

Dear Sir or Madam:

My name is Tom Dougherty MD, FAAFP, CAQSM, board certified by the American Board of Family Practice. I have athletic trainers in my practice and am amazed how useful they are to the premiere care of my patients, here at Emory Sports Medicine.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

I truly believe in the words of an athletic trainer who says: As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Tom Dougherty MD, FAAFP, CAQSM

Emory Sports Medicine

59 Executive Park Atlanta GA 30329

Submitter : **Mr. Jamie Schupbach** **Date: 08/29/2007**

Organization : **Cleveland Clinic**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I have been a certified Athletic Trainer for thirteen years. The majority of my career has been spent working in outpatient physical therapy.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Thomas J Schupbach, ATC, CSCS

Submitter : Mr. John Reuter **Date:** 08/29/2007

Organization : Mr. John Reuter

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a practicing physical therapist, I have seen many Pts who went to therapy in an MD's office who did not know they had a choice of where they went for treatment. Self referral can lead to abuse for profit, actually decrease the quality of care, and increase the cost of care for everyone. As costs go up, more people become uninsured and their quality of care decreases. The people who have insurance just see their own costs for care go up. For these reasons, I feel MD self referral for PT/OT is wrong and should not be included in the "in-office ancillary services"

Submitter : **Date: 08/29/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am currently an Athletic Trainer at the United States Military Academy.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jennifer Huff MA ATC

Submitter : **Dr. Mark Susman** **Date: 08/29/2007**

Organization : **Dr. Mark Susman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Ann Marie Mallat** **Date: 08/29/2007**

Organization : **Group Anesthesia Services**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Sincerely,
Ann Marie Mallat, MD
14808 Sutton Dr.
San Jose, CA 95124
amgas@nextel.blackberry.net

Submitter : **Ms. Callie Maupin** **Date: 08/29/2007**

Organization : **Ms. Callie Maupin**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Callie Maupin

Submitter : Mrs. Alyson Pearson **Date:** 08/29/2007

Organization : Jordan Valley Medical Center-CORE

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a Certified Athletic Trainer working for Jordan Valley Medical Center, but more especially for Dr. Jim Macintyre and The Center of Orthopedic and Rehabilitation Excellence in Salt Lake City, Utah. I work as a Physician Extender for Dr. Macintyre. My job is to assist the doctor in the daily care of his patients, by providing injury evaluation skills as well as therapeutic exercise instruction to his patients. Many of our patients can heal without formal physical therapy and I am able to instruct them on exercises that they can do at home which will aid in that healing. This helps keep the cost down for his patients, as well as insurance companies, who do not need to be sent to physical therapy to obtain the necessary exercises and information to help them recover from their injuries. I also act a liaison between the Physician and his patients, as well as between the physical therapist.

I have worked for Dr. Macintyre for 6 and a half years. I graduated with a Bachelors of Science in Biology and Athletic Training and then went on to receive my Masters in Public Health. Both of these degrees have aided in my ability to counsel patients on proper nutrition, exercise prescription and over all general medical health. I love my job and the chance that I have to play a role in assisting injured patients to get better. I am currently in good standing with the National Athletic Trainers Association. We are required to attend 75 hours of continuing education over a three year period to keep up with our certification. We are constantly learning the new and latest medical information based on our skill sets. I am also currently licensed by the state of Utah to practice as an Athletic Trainer.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Alyson C. Pearson, MPH, ATC-L
The Center of Orthopedic and Rehabilitation Excellence
Jordan Valley Medical Center
3584 W. 9000 S. Suite 204
West Jordan, Utah 84088

Submitter : **Mr. Paul Ullucci, Jr.** **Date: 08/29/2007**

Organization : **Ullucci Sports Medicine**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Paul A. Ullucci, Jr. and I am the owner of Ullucci Sports Medicine & Physical Therapy, Inc. I am also a physical therapist, certified athletic trainer, sports clinical specialist and certified strength and conditioning specialist. Additionally, I am currently working on two Doctorate degrees in the area of sports medicine and As both a physical therapist and certified athletic trainer I have a unique perspective of the impact this change will have on the quality of healthcare provided my patients and I am writing to you to express my deep concern regarding this change.

Specifically, I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Paul A. Ullucci, Jr., PT, ATC, LAT, SCS, CSCS
President
Ullucci Sports Medicine & Physical Therapy, Inc.
Ullucci Sports Medicine Scholarship Fund, Inc.
1235 Wampanoag Trail
East Providence, RI 02915

Submitter : **Dr. virginia greenwood** **Date: 08/29/2007**

Organization : **providence anesthesiologists, inc.**

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 : Linda Winger **Date:** 08/29/2007

Organization : CyberKnife Coalition

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11169-Attach-1.PDF

#11169

CYBERKNIFE®

CKC

COALITION

August 15, 2007

Submitted electronically via attachment to http://www.cms.hhs.gov/eRulemaking

Kerry N. Weems
Administrator Designee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: Comments to Proposed Rule [File Code: CMS-1385-P]

Dear Administrator Weems:

The CyberKnife® Coalition is a non-profit association of thirty-seven (37) institutions across the United States committed to improving patient access to radiosurgery throughout the body. As such, we appreciate the opportunity to comment to the Centers for Medicare and Medicaid Services (CMS) on CMS-1385-P RIN 0938-AO65 Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule (PFS), and Other Part B Payment Policies for CY 2008.

<u>Background</u>

Medical linear accelerators (LINACs) were developed in the 1960's and allowed physicians to deliver isocentric radiation treatments of tumors over several weeks to spare normal tissue. Advancements in computer and linear accelerator technology in the 1980's led to 3-dimensional conformal radiation (3D-CRT) and image-guided radiation therapy (IGRT) which combined CT imaging with LINAC technology to register the location of a lesion before and after a treatment session. In the 1990's, intensity modulated radiation therapy (IMRT) further customized the shape of the radiation field to better conform to the lesion.

In the 1960's, frame-based stereotactic radiosurgery (SRS), was developed to deliver radiation with a high degree of accuracy to the brain and skull base. This intracranial treatment relies on placement and adjustment of an external head frame and manual adjustment of the patient. The accuracy afforded by this technology allows delivery of large, single, ablative doses of radiation. Then, in the late 1990's, image guided robotic stereotactic radiosurgery (r-SRS) proved significantly different from traditional radiosurgery in two ways: 1) no head or body

[illegible] Wurzbach, Suite [illegible] | San Antonio, TX 78229 | [illegible] | fax [illegible] | info@ckcoalition.org

frames are required, and 2) the flexibility of non-isocentric treatments allows for highly conformal treatments throughout the body together with significant decrease in normal tissue radiation.

Addendum B: 2008 Relative Value Units and Related Information Used in Determining Medicare Payments for 2008

In the CY 2007 PFS Final Rule, CMS revised the status indicator of level II HCPCS codes for image guided robotic linear accelerator-based stereotactic radiosurgery (G0339 and G0340) to indicate that they would be Carrier priced. We support CMS in maintaining these HCPCS codes for CY 2008 with the current status indicator so that Medicare beneficiaries may continue to have access to this treatment in the freestanding center setting, and providers may continue to bill for services using the most appropriate codes.

Conclusion

In summary, we appreciate the opportunity to comment, and thank the agency for its decision to continue the use of Carrier-priced level II HCPCS codes for image guided robotic stereotactic radiosurgery in CY 2008.

Sincerely,

Linda F. Winger
President, CyberKnife® Coalition

Submitter : **Ms. Katie Maupin** **Date: 08/29/2007**

Organization : **Ms. Katie Maupin**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Katie Maupin

Submitter : Mr. Timothy Tourville **Date:** 08/29/2007

Organization : University of Vermont Dept. of Orthopaedics

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Vermont State licensed, nationally certified Athletic Trainer working as a clinical research coordinator with the University of Vermont Department of Orthopaedics and Rehabilitation. My primary research involvement is in clinical research of the onset and progression of osteoarthritis, as well as the identification of risk factors for various musculoskeletal injuries which occur in active, healthy individuals of all ages. I also work clinically, and provide skilled orthopaedic rehabilitation for patients with these injuries.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

In addition to the aforementioned items, I am also concerned that the resulting removal of certified athletic trainers from the hospital setting would greatly hinder our research efforts, which are geared toward the prevention of musculoskeletal injuries in secondary school and collegiate aged men and women. Our research is highly dependent upon athletic trainers working at these institutions, many of whom are formally employed by a hospital or outpatient orthopaedic rehabilitation clinic. If these individuals were unable to obtain or maintain employment through their respective hospitals, they would not be able to provide outreach medical coverage in many high school or collegiate settings, and our interaction with these athletic trainers would cease. The consequences of this would be an abrupt stop to a large portion of our NIH-funded research which is geared toward the identification of injury risk factors or prevention of injuries and decreasing health care costs. As you can see, the 'ripple-effect' of the proposed change would have far-reaching and abhorrent consequences, many of which I am sure where not considered when these rule changes were proposed.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Timothy W. Tourville, MEd, ATC, CSCS

Submitter : **Dr. Pamela Bryan** **Date: 08/29/2007**

Organization : **Anesthesia Consultants of Indianapolis**

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.

Pamela S. Bryan MD
Anesthesia Consultants of Indianapolis

Submitter : **Dr. Paul Jeffords** **Date: 08/29/2007**

Organization : **Resurgens Orthopaedics**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician-owned PT facilities significantly increase the efficiency and efficacy of patient care. With in-office PT, therapists have instant access to patient medical records and imaging which improves patient care. If a patient is having a problem, the therapist can immediately consult with the physician who can then evaluate the patient. Patients can complete their office visit with the physician and have their post-operative therapy without having to travel to a separate facility. This increases patient compliance with the therapy protocols and allows the physician to follow their progress.

Submitter : **Mr. Mark Melton** **Date: 08/29/2007**

Organization : **Melton Physical Therapy, Inc**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing to encourage the removal of physical therapy from the in-office ancillary services exception to the federal self-referral laws. In this proposal for 2008 physician fee schedule the Stark Law is obviously being misconstrued and will allow an environment in which fraud can abound.

Currently I am aware of one office in my small town in which a physician shared space with his son who is a chiropractor and the chiropractor was billing for chiropractic manipulation as well as 97140 manual treatment in which he claimed manual traction 15 min under a medical billing code. The patient who received the treatment and the bill reported that she had less than 5 minutes of treatment.

I also know of a chiropractic in our town who owns a whole health clinic in which a doctor is employed or is a partner. The were seeing patients for chiropractic and the physician was writing prescription for all patients to receive physical therapy in their office in which they were having therapy performed by aides under the physicians supervision.

Please remove physical therapy from the in-office ancillary services exception. It will save the system money in getting good services to the people who need it and by saving investigation and prosecuting costs.

CMS-1385-P-11174-Attach-1.DOC

11174

I am writing to encourage the removal of physical therapy from the "in-office ancillary services" exception to the federal self-referral laws. In this proposal for 2008 physician fee schedule the Stark Law is obviously being misconstrued and will allow an environment in which fraud can abound.

Currently I am aware of one office in my small town in which a physician shared space with his son who is a chiropractor and the chiropractor was billing for chiropractic manipulation as well as 97140 manual treatment in which he claimed manual traction 15 min under a medical billing code. The patient who received the treatment and the bill reported that she had less than 5 minutes of treatment.

I also know of a chiropractic in our town who owns a "whole health clinic" in which a doctor is employed or is a partner. The were seeing patients for chiropractic and the physician was writing prescription for all patients to receive physical therapy in their office in which they were having therapy performed by "aides" under the physicians supervision.

Please remove physical therapy from the in-office ancillary services exception. It will save the system money in getting good services to the people who need it and by saving investigation and prosecuting costs.

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.

Thank you,

Forrest Quiggle, MD
Department of Anesthesiology
University of Miami-Jackson Memorial Hospital

Submitter : **Christopher Ritter** **Date: 08/29/2007**

Organization : **Cal Poly State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are being affected.

Thank you for your time and consideration,

Sincerely,

Christopher M. Ritter, M.Ed., A.T.C.
Assistant Athletic Trainer, Cal Poly University

Submitter : Mr. Jeffrey Job **Date:** 08/29/2007

Organization : Regional Orthopaedic Associates

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a physical therapist working collaboratively with three orthopaedic surgeons in office, I appreciate the opportunity to review some of CMS' decision making processes as it contemplates changes to the "Stark" self-referral regulations. While CMS does not make specific proposals with regard to some of the self-referral provisions, I would like to submit comments and clarifications.

The advantages of physican owned physical therapy practices to physicians, therapists and, most importantly, patients are obvious. These practices give patients more places to choose from to get physical therapy services. In some cases, it may also be more convenient for patients to obtain therapy at their physicians' offices. In addition, some patients may feel more comfortable knowing that their therapists and physicians are working together at the same location.

CMS refers to "letters from therapists that the in-office ancillary services exception encourages physicians to created therapy practices." CMS does not elaborate any further on the propriety or harm of this activity. I strongly challenge some of the characterizations articulated in this section of the proposed rule and request that the CMS elaborate on its concerns in this area, acknowledging that the number of letters received on a subject is not always indicative of the gravity of the issue or need for correction. And also request that the CMS engage in discussions with stakeholders on this issue given the obvious importance of physican and therapist expertise, patient needs, clinical quality, and the appropriate use of Medicare resources in the area of physical therapy.

Sincerely,
Jeffrey J. Job, M.S., P.T.

Submitter : **Dr. Brian Ribak** **Date: 08/29/2007**

Organization : **Dr. Brian Ribak**

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.

Brian Ribak, M.D.

Submitter : **Ms. Sara Maupin** **Date: 08/29/2007**

Organization : **Ms. Sara Maupin**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Sara Maupin

Submitter : Ms. Renee Scroggins **Date:** 08/29/2007

Organization : Institute for Athletic Medicine

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I am writing to oppose the changes to the therapy standards and requirements proposed in 1385-P. They will further tax a health care industry that is already experiencing a workforce shortage. Certified Athletic Trainers are qualified health care providers who have the educational and real world experience as well as nationally standardized testing to ensure we are qualified.

Thank you, Renee Scroggins

Submitter : **Date: 08/29/2007**

Organization : **Institute for Athletic Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer working in a clinical setting and provide athletic training services to a local high school. I have my bachelor's of science degree in athletic training and passed the Board of Certification exam in 2005. I work closely with physical therapists, who feel I am capable to see medicare/medicaid patients, and also see me as a an extension of themselves.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Emily Haywood, ATC

Submitter : **Dr. Chad Larsen** **Date: 08/29/2007**

Organization : **Private Practice Chiropractor**

Category : **Chiropractor**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Please reconsider this change of x-ray benefits. This will end up costing medicare patients more money. I have long appreciated the fact that they can have a medical x-ray exam without an additional office visit expense. The existing policy has been working well and a change will not produce any improvements in benefits, but it will increase costs to those who can least afford it.

Please reconsider this change.

Thank You,

M. Chad Larsen, D.C.

Submitter : **Dr. Laura Foster** **Date: 08/29/2007**

Organization : **Dr. Laura Foster**

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 : Dr. Hugo Torres **Date:** 08/29/2007

Organization : Carroll Hospital Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11184-Attach-1.DOC

#11184

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

Re: CMS-1385-P

Dear Mr. Weems:

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

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

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

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

RESOURCE-BASED PE RVUs

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

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

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

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

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

CPT Code	Anesthesiologists - 05	Interventional Pain Management Physicians

	(Non-Facility)	- 09 (Non-Facility)
64483 (Inj foramen epidural l/s)	59%	18%
64520 (N block, lumbar/thoracic)	68%	15%
64479 (Inj foramen epidural c/t)	58%	21%
62311 (Inject spine l/s (cd))	78%	8%

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

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

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

II. CMS Should Develop a National Policy on Compounded Medications Used in Spinal Drug Delivery Systems

We urge CMS to take immediate steps to develop a national policy as we fear that many physicians who are facing financial hardship will stop accepting new Medicare beneficiaries who need complex, compounded medications to alleviate their acute and chronic pain. Compounded drugs used by interventional pain physicians are substantially different from compounded inhalation drugs. Interventional pain physicians frequently use compounded medications to manage acute and chronic pain when a prescription for a customized compounded medication is required for a particular patient or when the prescription requires a medication in a form that is not commercially available. Physicians who use compounded medications order the medication from a compounding pharmacy. These medications typically require one or more drugs to be mixed or reconstituted by a compounding pharmacist outside of the physician office in concentrations that are not commercially available (*e.g.*, concentrations that are higher than what is commercially available or multi-drug therapy that is not commercially available).

The compounding pharmacy bills the physician a charge for the compounded fee and the physician is responsible for paying the pharmacy. The pharmacy charge includes the acquisition cost for the drug ingredients, compounding fees, and shipping and handling costs for delivery to the physician office. A significant cost to the physician is the compounding fees, not the cost of drug ingredient. The pharmacy compounding fees cover re-packaging costs, overhead costs associated with compliance with stringent statutes and regulations, and wages and salaries for specially trained and licensed compounding pharmacists bourn by the compounding pharmacies. The physician administers the compounded medication to the patient during an office visit and seeks payment for the compounded medication from his/her carrier. In many instances, the payment does not even cover the total out of pocket expenses incurred by the physician (*e.g.*, the pharmacy fee charged to the physician).

There is no uniform national payment policy for compounded drugs. Rather, carriers have discretion on how to pay for compounded drugs. This has lead to a variety of payment methodologies and inconsistent payment for the same combination of medications administered in different states. A physician located in Texas who provides a compounded medication consisting of 20 mg of Morphine, 6 of mg Bupivacaine and 4 of mg Baclofen may receive a payment of $200 while a physician located in Washington may be paid a fraction of that amount for the exact same compounded medication. In many instances, the payment to the physician fails to adequately cover the cost of the drug, such as the pharmacy compounded fees and shipping and handling. Furthermore, the claim submission and coding requirements vary significantly across the country and many physician experience long delays in payment.

We urge CMS to adopt a national compounded drug policy for drugs used in spinal delivery systems by interventional pain physicians. Medicare has the authority to develop a separate payment methodology for compounded drugs. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA") mandated CMS to pay providers 106% of the manufacturer's Average Sales Price ("ASP") for those drugs that are separately payable under Part B. The language makes clear that this pricing methodology applies only to the sale prices of manufacturers. Pharmacies that compound drugs are not manufacturers, and Congress never contemplated the application of ASP to specific drug compounds created by pharmacies. Accordingly, CMS has the discretion to develop a national payment policy.

We believe that an appropriate national payment policy must take into account all the pharmacy costs for which the physicians are charged: the cost of the drug ingredient, the compounding fee costs, and the shipping and handling costs. We stand ready to meet with CMS and its staff to discuss implementing a national payment policy.

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

I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge

CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

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

The sustainable growth rate ("SGR") formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

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

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

***

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

Sincerely,

Hugo A. Torres, M.D.
Advanced Pain Management Center
Carroll Hospital Center
291 Stoner Avenue
Westminster, MD 21157

Submitter : **Ms. Abby Maupin** **Date: 08/29/2007**

Organization : **Ms. Abby Maupin**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Abby Maupin

Submitter : **Dr. Russell L. Brock** **Date: 08/29/2007**

Organization : **Dr. Russell L. Brock**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Russell Brock MD, JD
Richmond, VA

Submitter : **Dr. Kevin Dennehy** **Date: 08/29/2007**

Organization : **MGPO - Partners**

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.

Yours sincerely
Dr. Kevin Dennehy

Submitter : Mrs. Tyra Harrell **Date:** 08/29/2007

Organization : Spring Branch Independent School District

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a licensed athletic trainer working in the secondary school setting, I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Tyra Harrell, LAT

Submitter : **Dr. Beth Elliott** **Date: 08/29/2007**

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

I am writing to support the proposed increase in anesthesia payments under the 2008 Physician Fee Schedule. It is greatly appreciated that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

With the adoption of RBRVS a significant undervaluation of anesthesia work compared to other physician services resulted. Now, 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 increasingly unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations. This will ultimately result in substandard care for our elderly population.

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Beth A. Elliott, M.D.
Rochester, MN 55902

Submitter : **Dr. Paul Bicket** **Date: 08/29/2007**

Organization : **Dr. Paul Bicket**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Paul Bicket

Submitter : **Mr. Donald Brady** **Date: 08/29/2007**

Organization : **Akron General Sports and PT**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Donald C. Brady. I am currently employed as a nationally certified and state licensed athletic trainer in the state of Ohio. Currently I work in an outpatient physical therapy clinic.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. I encourage you to research the curriculum needed to attain a degree, become certified,and become licensed in athletic training. You will see that it qualifies us to practice and reimburse for our services in orthopaedic rehabilitation. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Donald C.Brady, ATC/L

#11193

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

Re: "TECHNICAL CORRECTIONS"

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

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

By limiting a Doctor of Chiropractic from referring an X-ray the cost to the Medicare patient will go up significantly 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,

Carl M. Brofman, D.C.
1101 West Bluff St.
Woodville, TX 75979

Submitter : **Mrs. Colleen Bicket** **Date: 08/29/2007**

Organization : **Mrs. Colleen Bicket**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter

Sincerely,

Colleen Bicket

Submitter : **Ms. Jonathan Friedman** **Date: 08/29/2007**

Organization : **Long Branch Public Schools**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Jonathan Friedman, and I am a Certified Athletic Trainer and Nationally Registered Emergency Medical Technician. I hold a degree from a nationally accredited university. As a Certified Athletic Trainer, I am licensed by the State of New Jersey, Department of Law and Public Safety - Board of Medical Examiners to provide athletic training services in this state. Only those licensed by the Board of Medical Examiners are allowed to provide services under the law. I am further regulated by the State Department of Education as a Secondary School Athletic Trainer. As a Certified Athletic Trainer, I am nationally credentialed by an independent board accredited by the National Commission for Certifying Agencies. Part of this ongoing process requires me to obtain 80 hours of medically relevant continuing education every three years. Additionally, the U.S. Department of Heath and Human Services, Centers for Medicare and Medicaid Services has deemed it appropriate to award me with a National Provider Identification number as a covered health care provider under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for all patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Jonathan Friedman, ATC, NREMT-B.

Submitter : Dr. John Gleason **Date:** 08/29/2007

Organization : resurgens orthopedics

Category : Physician

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

As a group that provides PT as an in office service, I am constsantly reminded by my patients their satisfasction with our product. N ot only do we provide the HIGHEST quality PT service but have better outcome for our area. Patiens also like the convience of doing PT and seeing the doctor on the same day with out traveling. THe ban of in office PT as a self referal is a lose and hardship to the patient.

Submitter : Mr. Steven Ashby **Date: 08/29/2007**

Organization : Cabarrus County Schools

Category : Other Health Care Professional

Issue Areas/Comments

TRHCA– Section 201: Therapy CapS

TRHCA-- Section 201: Therapy CapS

I am an athletic trainer working in the North Carolina Public School System. If you are unfamiliar with whom athletic Trainers are here is a brief description: Certified athletic trainers are health care professionals who specialize in preventing, recognizing, managing and rehabilitating injuries that result from physical activity. As part of a complete health care team, the certified athletic trainer works under the direction of a licensed physician and in cooperation with other health care professionals, athletics administrators, coaches and parents.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Therapy Standards and Requirements

Therapy Standards and Requirements

I am an athletic trainer working in the North Carolina Public School System. If you are unfamiliar with whom athletic Trainers are here is a brief description: Certified athletic trainers are health care professionals who specialize in preventing, recognizing, managing and rehabilitating injuries that result from physical activity. As part of a complete health care team, the certified athletic trainer works under the direction of a licensed physician and in cooperation with other health care professionals, athletics administrators, coaches and parents.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Submitter : **Mr. Avery Ford** **Date: 08/29/2007**

Organization : **Mr. Avery Ford**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Avery Ford

CMS-1385-P-11199

Submitter : Mrs. Gabriela Geise **Date:** 08/29/2007

Organization : American Medical Directors Association

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11199-Attach-1.DOC

11199

amda
American Medical Directors Association

#11199

A national organization of long term care physicians committed to quality care

American Medical Directors Association

10480 Little Patuxent Parkway
Suite 760
Columbia, MD 21044
(410) 740-9743

Washington, DC
(301) 598-5774

Toll Free
(800) 876-AMDA

FAX
(410) 740-4572

www.amda.com

August 29, 2007

Herb Kuhn
Acting Director
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05
7500 Secutiry Blvd.
Baltimore, MD 21244-1850

Submitted electronically: http://www.cms.hhs.gov/eRulemaking

Subject: CMS-1385-P Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008

Dear Mr. Kuhn,

The American Medical Directors Association (AMDA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Notice on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2008, published in the July 12, 2007 *Federal Register*.

In May 2007, the RUC submitted recommendations for new physician work values for the Nursing Facility Care family of codes (99304–99318) as part of the 2005 Five-Year Review. The proposed values were developed through the established multi-specialty RUC process and reflect the views of organized medicine.

AMDA feels that the proposed values are consistent with the increased work associated with nursing facility care. We thank CMS for accepting the RUC's recommendations for the Nursing Facility Care (99304-99318) family of codes.

We commend CMS staff for their flexibility and assistance in accommodating the atypical time frame under which the codes were developed and reviewed by the RUC.

Sincerely,

Lorraine S. Tarnove
Executive Director

Submitter : **Dr. Stuart lane** **Date: 08/29/2007**

Organization : **greenville anesthesiology**

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.

CMS-1385-P-11201

Submitter : Dr. Joseph Bailes **Date:** 08/29/2007

Organization : American Society of Clinical Oncology

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1385-P-11201-Attach-1.PDF

11201

ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY

2008 Annual Meeting
May 30–June 3, 2008
Chicago, Illinois

For more information about ASCO Meetings
Phone: (703) 631-6200
Fax: (703) 818-6425
Website: www.asco.org

August 29, 2007

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

Re: Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and other Part B Payment Policies for 2008 (CMS-1985-P)

Dear Mr. Kuhn:

These comments are submitted by the American Society of Clinical Oncology (ASCO) in response to the proposed changes to payment policies under the Medicare physician fee schedule and other Part B policies, which were published in the Federal Register on July 12, 2007. ASCO is the national organization representing physicians who specialize in the treatment of cancer, and we are very interested in issues raised by the proposal.

PROPOSED REDUCTION IN THE CONVERSION FACTOR

Unless Congress acts, the sustainable growth rate (SGR) methodology will result in an estimated 9.9% reduction in the fee schedule conversion factor in 2008. Further cuts of almost 40% are projected in the absence of a permanent fix to the Medicare payment formula for physicians. This reduction is entirely unwarranted in light of the increased practice costs faced by physicians and the small increases in recent years that have failed to keep up with inflation. CMS should take administrative steps that would lessen the reduction, such as removing drugs retroactively from the definition of physician services subject to the SGR methodology. We also urge CMS to work with Congress to avert scheduled cuts in 2008 and, in the longer term, repeal the SGR and replace it with a system that keeps pace with increases in medical practice costs.

PHYSICIAN QUALITY REPORTING INITIATIVE

ASCO generally supports the proposed continuation of the PQRI program into 2008. ASCO has actively participated in the AMA Physician Consortium for Performance Improvement process to develop new cancer-related quality measures that could be adopted in 2008 and with the goal of replacing 2007 PQRI measures 71, 72, 73, and 74.

Moving forward, we encourage CMS to continually reassess and evaluate methodologies to assess the quality of care provided to people with cancer. We

have been concerned during this initial year of PQRI that measure specifications and the implementation methodology may have an adverse affect on participation as well as the quality of data collected through the program. One of the challenges for oncology has been reconciling reporting requirements with the realities of clinical practice. For example, it is common for patients to visit the physician office for chemotherapy without having a physician evaluation and management encounter on the same day. However, several current cancer-related measures cannot be reported unless chemotherapy is administered on the same day as an evaluation and management visit.

We also encourage CMS to explore alternative strategies for quality reporting under the value based purchasing program. For example, as part of the 2006 Oncology Demonstration Project, CMS collected data from oncologists on cancer disease status. As we have stated before, if reporting on disease status were continued in lieu of other PQRI reporting requirements, the Medicare program would have a rich repository of claims data that could be analyzed for specific cancer quality measures. ASCO remains interested in working with CMS to discuss the details of alternate methodologies.

CMS has noted separately in the proposed rule that the recent law requiring reporting on anemia quality indicators will be implemented on January 1, 2008. The statute requires that "Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include...information on the hemoglobin or hematocrit levels for the individual." CMS states in the proposed rule its intent to use the anemia indicators to "facilitate assessment of the quality of care for this condition" and "help determine the prevalence of anemia associated with cancer therapy, the clinical and hematologic responses to the institution of anti-anemia therapy, and the outcomes associated with various doses of anti-anemia therapy." Given CMS' intent to use this requirement to evaluate quality, we would strongly urge that for those physicians who elect to participate in PQRI, reporting on anemia be considered equivalent to reporting on any other PQRI measure, and therefore tied to PQRI data reporting and bonus. While we understand that reporting on anemia is mandatory and participation in PQRI is voluntary, we believe that extending this opportunity is an important signal that CMS views anemia quality indicator reporting to be on par with the other measures. The implementation requirements for both types of measures could remain unchanged; that is, the anemia reporting occurring on every claim including a bill for the treatment of anemia and the PQRI measures reported for a minimum of 80% of applicable cases. ASCO would help educate our members accordingly.

COMPENDIA FOR DETERMINING MEDICALLY ACCEPTED OFF-LABEL USES

Section 1861(t)(2) of the Social Security Act (in conjunction with sections 1832 and 1861(s)(2)) requires Medicare to cover "medically accepted" uses of drugs and biologicals used in cancer chemotherapy regimens if the uses are supported by citations that are included, or approved for inclusion, in specified compendia. The compendia specified in the statute are AMERICAN HOSPITAL FORMULARY SERVICE – DRUG INFORMATION, AMERICAN MEDICAL ASSOCIATION DRUG EVALUATIONS (which is no longer published), and UNITED STATES PHARMACOPOEIA –

DRUG INFORMATION. The statute provides that CMS "may revise the list of compendia . . . as is appropriate for identifying medically accepted indications for drugs."

The Proposed Changes

CMS has proposed to establish a process for adding or deleting compendia from the list of authoritative compendia. Under the proposal, CMS would annually issue a notice inviting requests to revise the list. The notice would establish a 30-day window for accepting requests, which would start 45 days (or later) after publication of the annual notice. Requests would be required to include a copy of the compendium at issue and would need to include detailed, specific documentation showing that the compendium does or does not meet CMS's standards for compendia. CMS would publish a list of the complete requests received, and the public would have 30 days to comment on them. CMS would reach a final decision within 120 days after the close of the comment period. CMS proposes to execute the various steps in the process through notices posted on its website, although other "reasonable means" could also be used. In addition to the annual notice, CMS would reserve the right to act on its own initiative at any time.

The standards that CMS is proposing to apply in evaluating the compendia appear to fall into three categories. First, CMS is defining a compendium as having the following characteristics:

- It is a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, such as a compendium of anticancer treatment.
- It includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases.
- It is indexed by drug or biological (and not by disease).

Second, CMS would "consider a compendium's attainment" of the "desirable characteristics" recommended by the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) at its March 2006 meeting. As listed in the July 12 notice, the Committee identified the following desirable characteristics:

- Extensive breadth of listings.
- Quick throughput from application for inclusion to listing.
- Detailed description of the evidence reviewed for every individual listing.
- Use of pre-specified published criteria for weighing evidence.
- Use of prescribed published process for making recommendations.
- Publicly transparent process for evaluating therapies.
- Explicit "Not recommended" listing when validated evidence is appropriate.

- Explicit listing and recommendations regarding therapies, including sequential use or in combination in relation to other therapies.
- Explicit "Equivocal" listing when validated evidence is equivocal.
- Process for public identification and notification of potential conflicts of interest of the compendia's parent and sibling organizations, reviewers, and committee members, with an established procedure to manage recognized conflicts.

Third, CMS is proposing additional criteria:

- Unspecified "reasonable factors" such as, for example, factors "that are likely to impact the compendium's suitability for this use, such as a change in ownership or affiliation [,] the standards applicable to the evidence considered by the compendium, and any relevant conflicts of interest. We may also consider that broad accessibility by the general public to the information contained in the compendium may assist beneficiaries, their treating physicians or both in choosing among treatment options."
- The compendium's grading of evidence and the process by which the compendium grades the evidence.

Comments on the Proposed Process

We agree with CMS's conclusion that there should be a formal process to consider revisions to the list of authoritative compendia. We do not, however, support the proposed process as outlined in the July 12 Federal Register.

Initially, we question the need for an annual process. The universe of compendia is small – only six compendia were identified for consideration by the MedCAC in 2006, and new compendia are rarely introduced. An annual process to consider and reconsider these same six compendia, and possibly one or two additional compendia in future years, seems highly disproportionate to the scope of the potential work involved.

In addition, the informal process proposed by CMS would be inconsistent with statutory requirements. Section 1871 of the Social Security Act provides that any "rule, requirement, or statement of policy . . . that establishes or changes a substantive legal standard governing the scope of benefits" must be promulgated as a regulation after a 60-day period for public comment. The identity of the compendia deemed authoritative under section 1861(t)(2) directly affects the drug uses covered under the Medicare Part B benefit, and therefore any changes in the list of authoritative compendia may be adopted only through the issuance of regulations after notice and opportunity for public comment. The proposed process of using notices posted on the CMS website and a 30-day public comment period does not conform to the requirements of section 1871.

ASCO suggests that CMS announce a procedure in which it is continually open to receiving requests to add or delete compendia from the list authorized by section 1861(t)(2). If a request is

supported by adequate information, CMS could propose a regulation for public comment in the same manner as for other changes in the regulations.

Comments on the Proposed Criteria

We have serious concerns about the criteria that CMS is proposing to use in deciding which compendia should be deemed authoritative. Our initial concern is that the proposal gives no indication as to how CMS will apply the criteria. The proposed factors do not appear to be definitive standards that must be met but instead are apparently only a list of characteristics that CMS will apply, or not apply, in particular cases in some unspecified manner. Any criteria used to evaluate compendia should be recast as specific standards that must be met or should otherwise provide clear rules defining what qualifies as an authoritative compendium.
Moreover, we question the substance of the proposed criteria. The July 12 notice states that "MedCAC concluded that none of the compendia fully display the desirable characteristics." By proposing to adopt the MedCAC criteria, which the statutorily authorized compendia apparently do not meet, CMS seems to be preparing a case for revoking the authoritative status of the currently designated compendia. ASCO strongly opposes dismantling the coverage requirements set in statute, including invalidation of the originally named compendia. Instead, we believe that it would be more consistent with the statute to identify the characteristics of the compendia that Congress deemed satisfactory, and apply those criteria to other compendia that are not currently recognized.

In addition, the proposed criteria are not closely tied to the statutory standard for revisions to the list. Section 1861(t)(2) permits CMS to revise the list "as is appropriate for identifying medically accepted indications for drugs." Under this statutory language, the test for a satisfactory compendium should be whether the compendium identifies the medically accepted uses of drugs with sufficient accuracy. By contrast, many of the proposed criteria, such as those requiring descriptions of the evidence, use of a published and transparent process, dealing with conflicts of evidence, and grading the evidence, do not directly bear on the statutory standard. ASCO recommends that CMS adopt the standard that a compendium should identify medically accepted uses of drugs with sufficient accuracy as the key determinant for authoritative status.

The proposed criteria should also be consistent with the statutory standard for using the compendia to determine Medicare coverage. Section 1861(t)(2) requires Medicare coverage when the "use is supported by one or more citations" in the compendia. For a compendium to be useful for purposes of section 1861(t)(2), its format should make clear whether its citation does or does not support the particular use of the drug. In that connection, we note that the proposed criteria would consider whether the compendium grades the evidence used in making its recommendation. Although grades of evidence may be valuable from a medical standpoint, they are a confusing factor in determining whether the compendium citation "supports" a particular drug use. To implement section 1862(t)(2), we believe that it would be desirable for a compendium to make clear whether it regards each drug use as medically accepted or not, thus avoiding the need for interpretation of its conclusions.

ASCO Recommendation

Section 1861(t)(2) makes the compendia authoritative only with respect to drugs used in cancer chemotherapy regimens. Although Medicare contractors are free to rely on the compendia in determining coverage for other types of drugs, we believe that CMS's focus on evaluating compendia should be on their statutory function, which relates to cancer treatment.

As discussed above, the key determinant under the statute should be whether a compendium identifies the medically accepted uses of drugs used in cancer therapy with sufficient accuracy. We suggest that, as a practical matter, the most efficient way to assess this characteristic is to seek the opinions of oncologists. A group of qualified oncologists could be added to the MedCAC for the purpose of evaluating a compendium and could recommend to CMS whether the compendium is sufficiently accurate in identifying medically accepted uses of drugs used cancer chemotherapy regimens. We encourage CMS to consult with ASCO in forming an expert panel for this purpose.

United States Pharmacopoeia – Drug Information

We understand that the publisher of UNITED STATES PHARMACOPOEIA – DRUG INFORMATION is no longer updating the compendium under that name and that the successor publication is called DRUGPOINTS. We urge CMS to advise its contractors that DRUGPOINTS is an authoritative compendium under section 1861(t)(2) and to provide the contractors with any instructions necessary for the contractors to begin using the successor publication immediately.

INTRAVENOUS IMMUNE GLOBULIN

There is currently a payment amount based on 1.97 relative value units for pre-administration related services for intravenous infusion of IVIG. CMS is proposing to continue this payment amount through 2008.

ASCO supports this proposal. There continue to be significant problems in obtaining IVIG for less than the Medicare payment amount, and this additional payment amount helps to mitigate the adverse financial impact that many physicians experience in obtaining IVIG for their patients.

WAMP AND AMP THRESHOLD

The statute authorizes CMS to establish a payment amount for a drug based on its widely available market price (WAMP) or average manufacturer price (AMP) if the ASP exceeds the WAMP or AMP by a specified threshold percentage. For 2005, the statute set the threshold at 5%, and CMS has administratively continued the threshold at the same percentage in subsequent years. CMS is proposing to maintain the threshold at 5% in 2008 as well.

ASCO supports continuing the threshold at 5%. The ASP-based payment system does not ensure that physicians are able to purchase drugs for less than the Medicare payment amount,

and in many cases they are not able to do so. The surveys of WAMP and the calculations of AMP should not be used to reduce the Medicare payment amounts.

COMPETITIVE ACQUISITION PROGRAM

There are serious problems with the competitive acquisition program (CAP) that make it unattractive to most physicians. While we recognize CMS' attempt in this proposal to improve aspects of the CAP, we believe that the CAP has fundamental defects that the proposals do not resolve.

CMS is proposing to broaden the definition of "exigent circumstances" in which a physician can cancel the CAP election agreement before the end of the calendar year. Because of the problems posed by the CAP, which physicians may not recognize when they enroll in the program, ASCO supports these changes.

The notice asks for comment on the current rule requiring drugs to be shipped to the site at which they are administered. As ASCO has previously commented, this restriction is an obstacle to CAP enrollment by oncologists who use satellite offices that are not continually staffed. Physicians who administer drugs are well-qualified to maintain their integrity when transporting them to an alternative site of administration, and there should be no restrictions on their doing so. We do not understand the basis for CMS's concerns that the CAP vendor needs to maintain control over the drugs and that this control is somehow jeopardized if a physician transports drugs from one practice site to another. Once the CAP vendor ships drugs, it is relying on the receiving physician to properly handle and account for them, and we do not see how the CAP vendor's interests are threatened if the physician is permitted to transport the drugs to another practice site.

CMS also asks for comments on the current requirement that the physician enter the CAP's prescription order number on the claim form that the physician submits to Medicare for the related drug administration services. CMS recognizes that this administrative requirement is burdensome and asks for comment on alternative mechanisms. We suggest that the Medicare contractors simply match claims from the CAP vendor to claims from physicians. Generally, it should be possible to match the claims successfully, and if there are substantial discrepancies, the contractor could make inquiries or conduct an audit. This change would eliminate a significant current administrative burden on physicians who participate in the CAP.

REPORTING OF ANEMIA QUALITY INDICATORS

The proposal implements the recent statutory amendment requiring that claims for drugs administered for the treatment of anemia in connection with the treatment of cancer must be accompanied by information on the patient's hemoglobin or hematocrit level. The proposed regulation provides that the claim must indicate the patient's "most recent" hemoglobin or hematocrit level.

ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY

ASCO supports the proposal to require the "most recent" hemoglobin or hematocrit level to be reported. This formulation makes clear that patients are not required to undergo a medically unnecessary blood test solely for the purpose of the Medicare claims process.

* * * * *

Thank you for the opportunity to comment on the proposal.

Sincerely,

Joseph S. Bailes

Joseph S. Bailes, MD
Chair, Government Relations Council

CMS-1385-P-11202

Submitter : Wendy Wifler **Date:** 08/29/2007

Organization : Accuray

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11202-Attach-1.PDF

11202

ACCURAY

August 27, 2007

Submitted electronically via attachment to
http://www.cms.hhs.gov/eRulemaking

Kerry N. Weems
Administrator Designee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: Comments to Proposed Rule [File Code: CMS-1385-P]

Dear Administrator Weems:

Accuray Incorporated is a producer of image-guided robotic stereotactic radiosurgery (r-SRS) equipment used around the world to treat malignant and benign tumors and other select disorders with high dose, precisely targeted radiation. On behalf of Accuray, I thank you for the opportunity to comment on the Notice of Proposed Rulemaking regarding the Medicare Physician Fee Schedule for Calendar Year 2008 published in the Federal Register on July 12, 2007 ("NPRM"). These comments focus on several of the significant proposed changes to the regulations promulgated under the Ethics in Patient Referrals Act (frequently referred to as the "Stark Law") – Section II.M. of the NPRM.

I. Background

For over 30 years, traditional radiosurgery systems have been used primarily to destroy brain tumors. Accuray developed the CyberKnife® Robotic Radiosurgery System, which represents the next generation of radiosurgery systems, to extend the benefits of radiosurgery to the treatment of tumors anywhere in the body. The CyberKnife System combines continuous image-guidance technology with a compact linear accelerator that has the ability to move in three dimensions according to the treatment plan. Using this image-guidance technology and computer controlled robotic mobility, the CyberKnife System automatically tracks, detects and corrects for tumor and patient movement in real-time throughout the treatment. This enables the CyberKnife System to deliver precise, high-dose radiation, minimizing damage to surrounding healthy tissue and eliminating the need for invasive head or body stabilization frames.

The CyberKnife procedure requires no anesthesia and allows for the treatment of patients that otherwise would not have been treated with radiation or who may not have been good

candidates for surgery. The procedure avoids many of the potential risks and complications associated with other treatment options, including surgical risks.

The CyberKnife System received U.S. Food and Drug Administration 510(k) clearance in July 1999 to provide treatment planning and image-guided robotic radiosurgery for tumors in the head and neck. In August 2001, the CyberKnife System received 510(k) clearance to treat tumors anywhere in the body where radiation treatment is indicated. Unlike frame-based radiosurgery systems, which are generally limited to treating brain tumors, the CyberKnife System is being used for the treatment of primary and metastatic tumors outside the brain, including tumors on or near the spine and in the lung, liver, prostate and pancreas. Experience from 2001 to 2006 has demonstrated both safety and efficacy. Reports of clinical efficacy of CyberKnife treatment for intra- and extracranial tumors, and quality of life in patients so treated, have been published extensively in peer reviewed journals and presented at major medical conferences worldwide, such as ASTRO, ASCO, AANS, AATS, Chest, ESTRO, STS and the AUA.

Healthcare providers choosing to utilize image-guided r-SRS include for-profit and not-for-profit hospitals, physician group practices, and small closely-held limited liability companies that often include physician members. These physician members are specialists trained in one of several medical specialty areas that treat cancer and who want CyberKnife treatments to be among the options available to treat their patients. The multi-disciplinary team involved in treating patients with the CyberKnife System generally includes neurosurgeons and/or other surgical specialists, radiation oncologists, medical physicists and radiation therapists, depending on needs of each individual patient. This technology requires a significant capital investment and treats, as compared with other technologies, a relatively small number of patients, considering many patients who are candidates for r-SRS are surgically or medically inoperable.

II. Physician Self-Referral Provisions

A perceived correlation between physicians' financial ties to the delivery of certain medical and health care services and measurable increases in utilization and price was the impetus for Congress to enact the Ethics in Patient Referrals Act eighteen years ago. Since that time, the Stark Law has been expanded to further restrict and/or eliminate certain physician business arrangements, often common in the industry, that Medicare has become increasingly convinced could be abusive to the Medicare program and beneficiaries.

Physician investment in services for which they recommend also has benefits. Often physician-driven investments involve the acquisition and early adoption of the newest technology or the development of alternative, more efficient sites of services (i.e., establishment of ambulatory surgery centers). Thus, these arrangements contribute to quicker and broader access to state-of-the-art services than if the system relied solely on facilities, such as hospitals, that have competing interests for scarce funds.

CMS has acknowledged this benefit to some extent in its ongoing attempts to carve out certain regulatory exceptions from the all-encompassing grasp of the Stark Law. But, the latest proposed changes to Stark Law seem to dismiss this balancing of the potential positives of physicians' financial relationships with entities that provide health care services they order without any definitive data cited in the preamble that these changes are necessary. Nor does the preamble contain any explicit discussion regarding the types of services about which CMS has the most concern. Rather, the proposed changes, if finalized, would institute sweeping

prohibitions against arrangements that are perfectly legitimate under current regulation and in existence across the country.

The ability for physicians to participate in many of these arrangements is a primary reason certain services are available in particular areas. Without the physician financial involvement these services may not have been available to Medicare beneficiaries. As such, we are very concerned about the potential unintended consequences these proposed changes to the Stark Law may have on patient access to important therapeutic treatments. This is particularly true for procedures like robotic stereotactic radiosurgery that require the use of expensive, complex technology that is used for a relatively small number of patients.

A. Services Furnished as "Under Arrangements"

CMS proposes to expand the definition of an "entity" to include both the entity that performs a designated health service ("DHS") as well as the entity that bills Medicare for the DHS.[1] CMS explains that this proposal is intended to reduce the number of "under arrangement" ventures, *e.g.*, where a physician-owned entity provides certain services that were previously provided by a hospital directly. According to CMS, the net effect of these arrangements is to allow physicians to make money on referrals for separately payable services that could continue to be furnished directly by the hospital.

While CMS discusses anecdotal reports related to under arrangement ventures that presumably are abusive, there is no suggestion that these concerns are equally applicable to all types of services. Yet, the proposed change would eliminate completely this significant option utilized by hospitals, particularly those without significant financial resources, to bring certain services (like new technology) to their community. Before CMS implements any changes to the Stark regulations that will restrict or eliminate under arrangement ventures with entities that are owned in whole or in part by physician referral sources, it is imperative that CMS assess the potentially significant impact such a change will have on the quality and scope of care offered by many institutions.

Most hospitals have a finite pool of dollars to spend on technology every fiscal year. Like any business, these purchasers must understand their potential return on investment before agreeing to any outlay for new capital equipment. The natural outcome of this process is that hospitals simply decide not to offer certain services. The losing technologies often are those with the highest price tag and/or the smallest financial return. This outcome may be offset by the seriousness of the medical condition that a technology is designed to treat or the political clout of the physician pushing the hospital to purchase certain equipment. Nevertheless, some technologies simply will not be made available to patients if the only option a hospital has is to purchase certain equipment.

Under arrangement contracts, therefore, give hospitals an important means to offer treatment options, particularly those that are expensive and used for smaller patient populations, without tying up scarce capital dollars. Physician investment in technologies offered through under arrangement ventures is a vital source of funding to improve access to new services. Moreover, because physicians are more likely to invest in services they trust and believe will be beneficial in the management of their patients, there is an inherent bias for physicians to invest in technologies supported by solid clinical evidence.

---

[1] 42 CFR § 411.351 as proposed in the Proposed Rule.

We believe such an all-encompassing change is a critical mistake, and should not be finalized. If, however, CMS feels that these under arrangements must be limited we urge the agency to provide some exceptions that would permit physician-investors in a DHS entity to refer patients to a hospital for medical care in certain situations. First, CMS should permit all arrangements existing at the time the proposed rule was published to stand without change, even if the agreement between the parties calls for annual renewal. There simply would be no way for some hospitals to fund the direct purchase of the technologies they currently offer through under arrangement deals. Consequently, the services related to these technologies would become extinct, and patients would be faced with a critical access problem. Moreover, parties to these lawful deals have invested significant resources into obtaining technology, negotiating relationships, and implementing the related services. It would be unfair to apply the changes retroactively.

Second, CMS should craft an exception that does not prohibit physician referrals for under arrangement services at issue when the DHS involves a technology that requires a considerable capital investment and where the risk of over utilization is minimal because the number of patients to be treated with the technology is small (as compared, for example, to technology such as imaging equipment). The exception could be further narrowed by requiring the technology or service be used in the treatment of a serious or life-threatening illness or injury.

B. Unit-of-service (Per-Click) Payments in Space and Equipment Leases

CMS is proposing to prohibit unit-of-service (per click) payments to a physician-lessor for services provided by a designated health services ("DHS") entity lessee to patients who were referred by the physician lessor.[2] If finalized, the proposal would require that "per click" fees paid to the physician-lessor exclude amounts associated with the use of the equipment for patients referred by the physician. According to CMS, it is concerned that a physician-lessor has a financial incentive to refer a higher volume of patients to the lessee when the physician receives a per-click payment.

The agency's proposal will affect all space and equipment leases where a physician lessor currently receives a "per click or "per use" rental payment from a DHS entity. We assume that a physician lessor could receive another type of payment for space/equipment used in connection with patients that the physician refers, but we ask CMS to clarify this point. For example, we ask CMS to make clear that time-based rental payments, such as "block time" leases (*e.g.*, $1,000 per month), would be acceptable.

Accuray urges CMS to reconsider its decision to eliminate all unit of service based arrangements. As with "under arrangement" ventures, unit of service leases give hospitals and other entities, which might not otherwise have the financial resources to purchase equipment outright or lease it for extended periods, the opportunity to make technology dependent services available to the community.

We find it difficult to comprehend that there is a systemic problem with physicians ordering unnecessary surgical procedures or invasive tests simply to generate lease fees. We have to believe that the vast majority of physicians take seriously their ethical responsibilities for patients and would not risk the possibility of ethics violations, malpractice claims or fraud allegations to garner a few extra dollars from a lease arrangement. Thus, so long as a per click lease fee is fair market value for the use of the equipment then we believe the potential benefits

[2] 42 CFR § 411.357(a)(5) and § 411.357(b)(4) as proposed in the Proposed Rule.

of assuring technology is available outweighs the concern that all physicians will act inappropriately. If there is a prevalence of over utilization in a particular area, such as diagnostic testing, then the changes should be aimed at addressing real rather than theoretical concerns.

Consequently, we appeal to CMS to withdraw its proposal to eliminate per click fees.

C. In-Office Ancillary Services Exception

CMS requested input regarding whether the in-office ancillary services (IOAS) exception should be modified to limit the types of services that qualify for the exception or restrict the circumstances to which the exception would apply. While CMS has not put forth any particular proposed changes it appears from the preamble that CMS is in favor of narrowing the IOAS exception in order to limit physician ability to profit from referral for ancillary services that are not closely connected to the physician/group. CMS also clearly suspects that the exception also has contributed to the (presumably undesirable) migration of sophisticated and expensive equipment to the physician office.

While we can understand the agency's desire to ensure that IOAS offered to patients are services closely related to the physicians practice and expertise, there appears – either by design or unintended consequence - to be a common theme running through many of the Stark proposals that concerns us as a developer and manufacturer of state-of-the art technology. This theme is the discouragement of making health care services available in a variety of sites of service. Together the proposed changes eliminate most sound business opportunities that would make a physician's decision to invest in new technology a rational choice. Consequently, it leaves all patients, including Medicare beneficiaries, at the whim of hospitals and other third-party entities to invest in new technology. Such an outcome is inconsistent with the push to move care out into the community, to build efficiency in health care delivery through the development of large multi-specialty full-service groups, and to create a level playing field across sites of service. The Stark changes are antithetical to these goals rather than supportive of them. Therefore, we ask the agency to reconsider such broad sweeping prohibitions. Instead, we suggest a clearer articulation of the types of arrangements and services that lead CMS to believe these proposals are necessary, and changes made to the regulations to address these specific problem areas.

III. Addendum B: 2008 Relative Value Units and Related Information Used in Determining Medicare Payments for 2008

In the CY 2007 PFS final rule, CMS revised the status indicator of HCPCS Level II codes for image-guided robotic linear accelerator-based stereotactic radiosurgery (G0339 and G0340) to indicate that they would be carrier priced. We support CMS in maintaining these HCPCS codes with the current status indicator in CY 2008 so that Medicare beneficiaries may continue to have access to this treatment in the freestanding center setting, and providers may continue to bill for services using the most appropriate codes.

IV. Conclusion

We commend the agency's efforts to maintain the delicate balance between preserving trust funds and ensuring patient access to necessary medical care. We thank you for the opportunity

to convey our support for the continued use of Carrier-priced level II HCPCS codes for image-guided robotic stereotactic radiosurgery. Furthermore, we appreciate the consideration of our comments and hope that you find value in the recommendations articulated herein. We ask CMS to reconsider the broad sweeping prohibitions proposed in the Medicare Physician Fee Schedule for CY 2008. Instead, there should be a clearer articulation of the types of arrangements and related services that are leading CMS to believe these proposals are necessary and design changes to the regulations to address these specific problem areas. Physician investment in technology is an important aspect to the deployment of state-of-the-art health care. The ability for physicians to participate in many of these arrangements is a primary reason certain services are available to patients in particular areas. Without the physician financial involvement these services may not have been available to Medicare beneficiaries. As such, we are very concerned about the potential unintended consequences these proposed changes to the Stark Law may have on patient access to important therapeutic treatment services. This is particularly true for procedures like robotic stereotactic radiosurgery that require the use of expensive, complex technology that is used for a relatively small number of patients. If we shut down all incentives for physicians to make these investments, we fear that our healthcare system will suffer immeasurably from decreased access and diminished quality of care.

Sincerely,

Wendy Wifler
Sr. Director, Health Policy and Payment

Submitter : **Mr. William Eickhoff** **Date: 08/29/2007**

Organization : **Mr. William Eickhoff**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.
William Eickhoff

CMS-1385-P-11204

Submitter : Dr. James Merrell **Date:** 08/29/2007

Organization : Cardiovascular Anesthesiologist

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see atttachment

CMS-1385-P-11204-Attach-1.PDF

11204

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Mrs. Leigh Smith** **Date: 08/29/2007**

Organization : **Mrs. Leigh Smith**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely.
Leigh Ann Smith

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Administrator,

Thank-you for the opportunity to comment on the physician self-referral provision. As a long time practicing physical therapist I have seen payment policy shift referral patterns dramatically in physical therapy. Before it became highly touted and marketed for physicians to supplement their medical income by opening ancillary services, physical therapy was delivered by clinics/practices who achieved a desired outcome, cost effectively. Patients were referred to clinics that could see them in a timely fashion, were staffed by therapists that had obtained specialty certifications and produced successful outcomes. Once physicians became the owners of these practices, patients were subjected to "waiting lists" to get into therapy and often drove many miles from their home or work to attend therapy at the physician s office rather than a closer facility. In our town, the experienced physical therapists with specialty certifications were not the preferred employees of the physicians, rather inexperienced new graduates who would work for less money and add to the profit margin of the physician owned practice were the employees of choice. As a former practice owner in the market place, I found that very ironic as I previously had to staff with experienced personnel to attract the physician's business. Suddenly experience and outcome did not matter.

Thankfully, the physical therapists in South Carolina were able to revive a statute that prohibited physical therapists from working in these abusive arrangements. The physicians however aggressively fought this statute enforcement. The South Carolina Attorney General clarified that indeed physical therapists could not work in an employment setting owned by physicians and that this restriction was not a restriction on the practice of medicine. The statue was upheld in circuit court and eventually in the South Carolina State Supreme Court. Following their failure in the courts and with no options but to change the statue, physicians lobbied heavily in the legislature to overturn this statute the following year. Testimony from impacted patients, physical therapists that had suffered loss in the business arena and facilities that had become the dumping grounds for the low pay or nonpaying physical therapy patients gave the SC Legislature a clear picture of physician intent, that of profit and greed. The SC Legislature upheld the prohibition of physical therapists working in an employment arrangement with a referring physician. The "warnings" to the legislature of huge numbers of unemployed physical therapists and underserved patients did not come true. In the two years since the clarification of the statute, all physical therapists remain employed in a setting independent of the referral source and patients have had greater access to care, as they no longer have to wait or drive long distances to obtain care.

The physical therapy care Medicare recipients receive in South Carolina is finally based on whether or not the physical therapists can deliver a good functional outcome. No longer are patients blindly and aggressively referred to physical therapy as a revenue stream. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS will insure that ALL Medicare patients can be treated with this same quality based outcome cost effectively.

Thank-you again for the opportunity to comment

Submitter : Mr. Mack Rubley **Date:** 08/29/2007

Organization : University of Nevada Las Vegas

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I have been in the Athletic Training profession as a clinician and educator for 15 years. In that time I have worked with a variety of physicians, therapists and surgeons in clinical and athletic settings. Since beginning my study of athletic training and medicine I have earned several certifications, a masters and doctoral degree. Currently, I serve as the director of an athletic training education program and I am a licensed athletic trainer in the state of Nevada. Nevada is primarily a rural area and many of those in need of health care particularly in the school districts will first be evaluated by a Licensed and Certified Athletic Trainer.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Mack D. Rubley, PhD, LAT, ATC, CSCS

Submitter : Mrs. Amy Eickhoff **Date:** 08/29/2007

Organization : Mrs. Amy Eickhoff

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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.
Amy Eickhoff

Submitter : **Ms. Melanie Pennington** **Date: 08/29/2007**

Organization : **St. Francis Hospitals**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified Athletic Trainer with a Master's Degree in Athletic Training and a License to practice athletic training in the state of Indiana. I have worked at St. Francis Hospital's Department of Physical Therapy and Sports Medicine for 14 years, providing cost effective and high quality care to patients.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Melanie Pennington, ATC, LAT

Submitter : Mr. Christian Hakim **Date:** 08/29/2007

Organization : Mr. Christian Hakim

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Athletic Trainers are qualified allied heath professionals that specialize in therapuetic exercise, modalities, and acute/chronic care of inuries. Our professional does not differ from that of a physical therpaist. However, we are highly selective about who enters our program so our profession requires only a bachelor's degree and passing a national and state licensure. Athletic trainers have a better understanding of how to rehabilitate someone is less time, which helps insurance companies save money. This also helps patients return to work faster so less time is spent away from work.

Submitter : **Mrs. june heberling** **Date: 08/29/2007**

Organization : **passavant area hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

RE: CMS 1385 P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

Name & Credential
__june heberling crna_____
Address
__202 east lincoln _____
City, State ZIP
whitehall,il. 62092

Submitter : **Mr. Riki Smith** **Date: 08/29/2007**

Organization : **Mr. Riki Smith**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Riki R. Smith

Submitter : **Dr. Alan Espelien** **Date: 08/29/2007**

Organization : **Dr. Alan Espelien**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.
Alan Espelien

Submitter : Dr. Tim McComas **Date:** 08/29/2007

Organization : Mesilla Valley Anesthesiology PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please increase payment to anesthesia providers for Medicare in 2008. This would correct the undervaluation that has persisted for some time. Here in New Mexico, our large Medicare population makes it difficult to recruit and retain quality anesthesia providers.

Submitter : Ms. Lisa Wilder **Date:** 08/29/2007

Organization : clarian arnett rehab

Category : Other Health Care Provider

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Lisa Wilder and I have been an athletic trainer for 15 years. I have worked in the clinical/ high school setting during that time. I have also been an off site ACI for the past 4 years with Purdue university AT students working again in the clinic and high school with them. At the clinic we work closely with our medical doctors in the sports medicine program, if this bill goes though we will no longer have this program and the area high school athletes will suffer because of it. I graduated from southern Illionis univ in 1992 with a BS in atheletic training which required 1200 clinical hours to graduate. I feel that I have the knowledge and ablity to servc the patients and athleties that I deal with on a daily basis.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Lisa A Wilder, ATC

Submitter : **Dr. William Rice** **Date: 08/29/2007**

Organization : **Dr. William Rice**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.
Bill Rice

Submitter : **Mr. Robert Smith** **Date: 08/29/2007**

Organization : **Mr. Robert Smith**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Robert A. Smith

Submitter : Dr. Ann Borseth **Date:** 08/29/2007

Organization : Ann R. Borseth, P.C.

Category : Chiropractor

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

The proposed elimination of payment of x-rays when referred by a Chiropractic physician is discrimanatory. It will diminish the quality of care some medicare patients receive. Although it is possible to detect subluxation without x-rays, there are at times complicating factors that determine the extent or type of care that is rendered. Changing this policy will cost beneficiaries and essentially CMS more money as the patient will need to utilize 2 physicians for office calls when 1 referring doctor should be enough.

Submitter : Dr. Kristie Fong **Date:** 08/29/2007

Organization : Dr. Kristie Fong

Category : Chiropractor

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Eliminating the reimbursement for patients having their x-rays taken by radiologists for chiropractic use would hurt patients and make it more difficult for some to afford and receive the care they need and deserve.

Submitter : **Mr. Mert Eckes** **Date: 08/29/2007**

Organization : **Mr. Mert Eckes**

Category : **Physician Assistant**

Issue Areas/Comments

GENERAL

GENERAL

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.
Mert Eckes

Submitter : **Dr. Andrea Parde** **Date: 08/29/2007**

Organization : **Lincoln Anesthesiology Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Andrea KZ Parde, M.D.

Submitter : Lani Luers **Date:** 08/29/2007

Organization : Bethune Cookman University

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Hello, my name is Lani Luers. I'm an assistant athletic trainer at Bethune Cookman University. Along with being a certified and licensed athletic trainer in the state of Florida, I am also a certified strength and conditioning specialist. I work with the university's sports teams as a medical liason between the coaches, student athlete's and the university. I graduated from Stetson University with a bachelor of science degree in 2001.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Lani Luers, ATC/L, CSCS

Submitter : Lisa Neubert **Date:** 08/29/2007

Organization : Minnesota State University Athletic Training

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Lisa Neubert and I am a senior athletic training student at Minnesota State University in Mankato, Mn.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Lisa Neubert ATS

Submitter : **Ms. Jane Partaine** **Date: 08/29/2007**

Organization : **Ms. Jane Partaine**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Jane Partaine

Submitter : Dr. Eric Finley **Date:** 08/29/2007

Organization : Eric M. Finley, MD LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The Multiple Surgery reduction for Mohs' Micrographic Surgery will produce catastrophic results for Medicare patients if adopted. I am a Moh's Micrographic surgeon in New Orleans and currently Medicare reimbursement rates are below cost for the treatment of these patients. Labor costs are high in this post Katrina city, reagents are increasing in price and the medical equipment used for Mohs Surgery is increasing in price as well. If reimbursement is unfairly reduced as currently proposed, patients may be unable to have their repairs on the same day as the removal of the tumor and they may be unable to have more than one tumor removed on any given day. I have even heard some of my colleagues discussing the feasibility of refusing to see Medicare patients altogether. I may ponder this option as well in the future. Imagine if you will, that your mother or grandmother had two skin cancers simultaneously, would you want her to have to make two trips simply because reimbursement had dropped? Would you want her to have to live with an open wound on her nose for 24 hours before her repair could be accomplished? These are the types of marketplace changes you will force if this proposal is adopted. Please reconsider your position and continue to keep Mohs' Surgery exempt from the multiple surgery reduction rule.

Submitter : **Mrs. Dawn Ciuk** **Date: 08/29/2007**

Organization : **University of Michigan - MedSport**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Dawn Ciuk and I am a certified athletic trainer. I currently work at MedSport, a sports medicine clinic that is a part of the University of Michigan Health System. My job not only allows me to work in the outreach setting, but in the clincal setting as well. Athletic Traiers are a vital part of our clinic and help us to be successful in our mission.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Dawn Ciuk, MS, ATC

Submitter : **Date: 08/29/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

We need to stop all fraud and abuse in healthcare and this is another example. The answer is obvious and should be that physical therapy services be excluded from the in-office ancillary services exception!

Submitter : **Mrs. Jane McGinnis** **Date: 08/29/2007**

Organization : **Mrs. Jane McGinnis**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Jane McGinnis

Submitter : Mr. Dean Cole **Date:** 08/29/2007

Organization : Mr. Dean Cole

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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.
Dean Cole

Submitter : **Ms. Carolyn Emmett** **Date: 08/29/2007**

Organization : **Ms. Carolyn Emmett**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Carolyn Emmett

Submitter : Dr. Ervin Malcheff **Date:** 08/29/2007

Organization : MAC

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Chiropractic physicians need to refer patients to outside x-ray providers when M.R.I. and C.T. scans are indicated.Otherwise, D.C.'s would have to refer the patients to an M.D. to send the patient for M.R.I. or C.T. which would add the cost of an unnecessary referal.

Submitter : **Ms. Darlene Carter** **Date: 08/29/2007**

Organization : **Ms. Darlene Carter**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Carolyn Emmett

Submitter : **Dr. David K. Emerson** **Date: 08/29/2007**

Organization : **Anesthesia Associates of Ann Arbor**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
David K. Emerson, M.D.

Submitter : **Dr. William Johnson** **Date: 08/29/2007**

Organization : **Reading Anesthesia Associates**

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 : **Mr. Larry Carter** **Date: 08/29/2007**

Organization : **Mr. Larry Carter**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Larry Carter

Submitter : **Ms. Kelsey McGinnis** **Date: 08/29/2007**

Organization : **Ms. Kelsey McGinnis**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter

Sincerely,

Kelsey McGinnis.

Submitter : **Mr. Larry Carter** **Date: 08/29/2007**

Organization : **Mr. Larry Carter**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Fred Carter

Submitter : Mrs. Angela Garcia **Date:** 08/29/2007

Organization : ASA

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
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 faetor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Angela Garcia

Submitter : **Mr. Charles Carter** **Date: 08/29/2007**

Organization : **Mr. Charles Carter**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Charles Carter

Submitter : **Stuart Lane** **Date: 08/29/2007**

Organization : **Greenville Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Stuart Lane, M.D.

Submitter : **Mr. Bob Orme** **Date: 08/29/2007**

Organization : **Mr. Bob Orme**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Bob Orme

Submitter : **Date: 08/29/2007**

Organization : **Jackson Purchase Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am a Certified Athletic Trainer (ATC) working in a hospital outpatient physical therapy clinic.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Lance Harper, MESS, ATC

Submitter : Dr. Karrie Markland **Date:** 08/29/2007

Organization : Markland Chiropractic

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I am writing in to strongly oppose this proposal.
While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any 'red Flags,' or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.
By limiting a Doctor of Chiropractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.
I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,

Dr. Karrie Markland, D.C.

Submitter : Dr. Mary Watkins **Date:** 08/29/2007

Organization : Watkins Chiropractic

Category : Physician

Issue Areas/Comments

Technical Corrections

Technical Corrections

MEI - File Code CMS-1385-P - Technical Corrections - The proposed rule dated July 12th contained an item under the Technical Corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicaree for an X-Ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I AM WRITING IN STRONG OPPOSITION TO THIS PROPOSAL. I strongly urge you to bale this proposal. These X-rays, if needed, are intragral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation. 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.

I strong again urge you to table this proposal.

Submitter : Dr. George Maihafer **Date:** 08/29/2007

Organization : Virginia Board of Physical Therapy

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11246-Attach-1.DOC

CMS-1385-P-11246-Attach-2.DOC

CMS-1385-P-11246-Attach-3.DOC

11246

#11246 (attachment #1)

August 28, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-1850

Re: CMS-1385-P
THERAPY STANDARDS AND REQUIREMENTS

Dear Sir or Madam:

The Virginia State Board of Physical Therapy submits the following comments on the proposed rules changing the definition of "physical therapist" in Section 484, Title 42 of the Code of Federal Regulations. The proposed rules are part of the 2008 Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 2008, found in Volume 72 of the Federal Register, published on July 12, 2007.

Under subsection (i)(B) and (ii)(B) of the proposed definition of "physical therapist" an applicant would need to have "[p]assed the National Examination approved by the American Physical Therapy Association." We strongly suggest that CMS rely on state licensure and that the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist" be deleted from the final rule. At the very least, the Centers for Medicare and Medicaid Services ("CMS") should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We, along with all other state boards of physical therapy, have already adopted a national qualifying exam for physical therapists, the National Physical Therapy Examination ("NPTE"). The Federation of State Boards of Physical Therapy ("FSBPT") develops and administers the NPTE in close collaboration with the state boards. Working together, we have developed a national passing score. The FSBPT has done an outstanding job of meeting our needs. Likewise, the NPTE has been a valuable tool in screening physical therapist applicants. Through the NPTE, we have been able to successfully filter applicants. In turn, we, as a policing body, have been able to protect the public by ensuring that only qualified therapists are licensed care for our citizens.

CMS should not usurp the states' function of licensing physical therapists and other professionals. Health care professional credentialing and licensing is a classically state function. Licensing and credentialing are the domain of the states. CMS' proposal would inappropriately transform a state function into a federal function. There is no justification for this action, and CMS should prevent it by removing the proposed rule.

CMS respects states' rights and state licensure for other health care professions, and it should continue to do so with respect to physical therapists. For example, CMS' regulations define a

physician as a "doctor of medicine ... legally authorized to practice medicine and surgery by the State in which such function or action is performed." 42 C.F.R. § 484.4 (2006). Likewise, a registered nurse is defined as "[a] graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing." 42 C.F.R. § 484.4. Establishing requirements that are different than what the states require for licensing PTs would be inconsistent with not only the rights of the states, but also CMS' own standards.

Moreover, the federal government should not impose an additional burden on the states, particularly since its stated desire for a national examination already satisfied and its other stated goals would not be better met by the burden it proposes to impose. The proposed unfunded mandate could result in the development of a second exam, which would create confusion and more work for the states, without benefit. Our resources are already limited and stretched.

In the preamble to the proposed regulations, CMS says that it is seeking uniformity. The fact of the matter is that uniformity and consistency across the nation and across provider settings already exists. State licensing requirements apply to physical therapists without regard to where they practice. All states accept CAPTE accreditation. All states accept the NPTE and have adopted the same passing score. No federal regulation is required.

In fact, the proposed regulations would likely defeat CMS' own goal of uniformity. If, for example, the APTA were to approve a different exam than the NPTE, which the regulations would permit it to do, physical therapists, patients, including Medicare and Medicaid beneficiaries and recipients, and others could face substantial confusion and interruption of service. As a state board of physical therapy examiners, we would continue to have authority to select an exam of our choice for licensing purposes. However, under the proposed rule, a physical therapist would have to pass a second exam approved by the APTA to qualify for Medicare reimbursement. Thus, patients might be forced to change physical therapists as they become Medicare or Medicaid eligible, and the current uniformity and continuity of standards across the country would be lost. Thus, the proposed rules undermine CMS' ambition for uniformity of standards.

CMS and the federal government should not empower an advocacy group, like the APTA, to establish an examination or any qualifications for professionals to provide healthcare services to patients. The APTA's mission is to advocate and promote the profession. As a licensing body, our mission is to ensure that physical therapists are qualified to provide physical therapy services and are authorized to do the work for which they are trained. The FSBPT, the organization to which we look for the national licensing exam, was created to eliminate, protect against and prevent the inherent conflict of interest that the APTA would have if it were to have authority over the examination and credentialing processes. Even the APTA recognized this conflict of interest problem two decades ago when it created the Federation of State Boards of Physical Therapy. CMS must not allow this conflict of interest to become a rule.

The Virginia State Board of Physical Therapy Examiners strongly urges CMS to require only state licensure. Most importantly, CMS should remove the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist." At a minimum , CMS should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We appreciate the opportunity to comment on the proposed rules regarding physical therapist and physical therapy assistant qualification requirements.

Respectfully yours,

George Maihafer, PT, President
Virginia State Board of Physical Therapy

#11246-Attachment #2

August 28, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-1850

Re: CMS-1385-P
THERAPY STANDARDS AND REQUIREMENTS

Dear Sir or Madam:

The Virginia State Board of Physical Therapy submits the following comments on the proposed rules changing the definition of "physical therapist" in Section 484, Title 42 of the Code of Federal Regulations. The proposed rules are part of the 2008 Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 2008, found in Volume 72 of the Federal Register, published on July 12, 2007.

Under subsection (i)(B) and (ii)(B) of the proposed definition of "physical therapist" an applicant would need to have "[p]assed the National Examination approved by the American Physical Therapy Association." We strongly suggest that CMS rely on state licensure and that the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist" be deleted from the final rule. At the very least, the Centers for Medicare and Medicaid Services ("CMS") should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We, along with all other state boards of physical therapy, have already adopted a national qualifying exam for physical therapists, the National Physical Therapy Examination ("NPTE"). The Federation of State Boards of Physical Therapy ("FSBPT") develops and administers the NPTE in close collaboration with the state boards. Working together, we have developed a national passing score. The FSBPT has done an outstanding job of meeting our needs. Likewise, the NPTE has been a valuable tool in screening physical therapist applicants. Through the NPTE, we have been able to successfully filter applicants. In turn, we, as a policing body, have been able to protect the public by ensuring that only qualified therapists are licensed care for our citizens.

CMS should not usurp the states' function of licensing physical therapists and other professionals. Health care professional credentialing and licensing is a classically state function. Licensing and credentialing are the domain of the states. CMS' proposal would inappropriately transform a state function into a federal function. There is no justification for this action, and CMS should prevent it by removing the proposed rule.

CMS respects states' rights and state licensure for other health care professions, and it should continue to do so with respect to physical therapists. For example, CMS' regulations define a

physician as a "doctor of medicine ... legally authorized to practice medicine and surgery by the State in which such function or action is performed." 42 C.F.R. § 484.4 (2006). Likewise, a registered nurse is defined as "[a] graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing." 42 C.F.R. § 484.4. Establishing requirements that are different than what the states require for licensing PTs would be inconsistent with not only the rights of the states, but also CMS' own standards.

Moreover, the federal government should not impose an additional burden on the states, particularly since its stated desire for a national examination already satisfied and its other stated goals would not be better met by the burden it proposes to impose. The proposed unfunded mandate could result in the development of a second exam, which would create confusion and more work for the states, without benefit. Our resources are already limited and stretched.

In the preamble to the proposed regulations, CMS says that it is seeking uniformity. The fact of the matter is that uniformity and consistency across the nation and across provider settings already exists. State licensing requirements apply to physical therapists without regard to where they practice. All states accept CAPTE accreditation. All states accept the NPTE and have adopted the same passing score. No federal regulation is required.

In fact, the proposed regulations would likely defeat CMS' own goal of uniformity. If, for example, the APTA were to approve a different exam than the NPTE, which the regulations would permit it to do, physical therapists, patients, including Medicare and Medicaid beneficiaries and recipients, and others could face substantial confusion and interruption of service. As a state board of physical therapy examiners, we would continue to have authority to select an exam of our choice for licensing purposes. However, under the proposed rule, a physical therapist would have to pass a second exam approved by the APTA to qualify for Medicare reimbursement. Thus, patients might be forced to change physical therapists as they become Medicare or Medicaid eligible, and the current uniformity and continuity of standards across the country would be lost. Thus, the proposed rules undermine CMS' ambition for uniformity of standards.

CMS and the federal government should not empower an advocacy group, like the APTA, to establish an examination or any qualifications for professionals to provide healthcare services to patients. The APTA's mission is to advocate and promote the profession. As a licensing body, our mission is to ensure that physical therapists are qualified to provide physical therapy services and are authorized to do the work for which they are trained. The FSBPT, the organization to which we look for the national licensing exam, was created to eliminate, protect against and prevent the inherent conflict of interest that the APTA would have if it were to have authority over the examination and credentialing processes. Even the APTA recognized this conflict of interest problem two decades ago when it created the Federation of State Boards of Physical Therapy. CMS must not allow this conflict of interest to become a rule.

The Virginia State Board of Physical Therapy Examiners strongly urges CMS to require only state licensure. Most importantly, CMS should remove the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist." At a minimum , CMS should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We appreciate the opportunity to comment on the proposed rules regarding physical therapist and physical therapy assistant qualification requirements.

Respectfully yours,

George Maihafer, PT, President
Virginia State Board of Physical Therapy

#11246-Attachment #3

August 28, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-1850

Re: CMS-1385-P
THERAPY STANDARDS AND REQUIREMENTS

Dear Sir or Madam:

The Virginia State Board of Physical Therapy submits the following comments on the proposed rules changing the definition of "physical therapist" in Section 484, Title 42 of the Code of Federal Regulations. The proposed rules are part of the 2008 Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 2008, found in Volume 72 of the Federal Register, published on July 12, 2007.

Under subsection (i)(B) and (ii)(B) of the proposed definition of "physical therapist" an applicant would need to have "[p]assed the National Examination approved by the American Physical Therapy Association." We strongly suggest that CMS rely on state licensure and that the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist" be deleted from the final rule. At the very least, the Centers for Medicare and Medicaid Services ("CMS") should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We, along with all other state boards of physical therapy, have already adopted a national qualifying exam for physical therapists, the National Physical Therapy Examination ("NPTE"). The Federation of State Boards of Physical Therapy ("FSBPT") develops and administers the NPTE in close collaboration with the state boards. Working together, we have developed a national passing score. The FSBPT has done an outstanding job of meeting our needs. Likewise, the NPTE has been a valuable tool in screening physical therapist applicants. Through the NPTE, we have been able to successfully filter applicants. In turn, we, as a policing body, have been able to protect the public by ensuring that only qualified therapists are licensed care for our citizens.

CMS should not usurp the states' function of licensing physical therapists and other professionals. Health care professional credentialing and licensing is a classically state function. Licensing and credentialing are the domain of the states. CMS' proposal would inappropriately transform a state function into a federal function. There is no justification for this action, and CMS should prevent it by removing the proposed rule.

CMS respects states' rights and state licensure for other health care professions, and it should

continue to do so with respect to physical therapists. For example, CMS' regulations define a physician as a "doctor of medicine ... legally authorized to practice medicine and surgery by the State in which such function or action is performed." 42 C.F.R. § 484.4 (2006). Likewise, a registered nurse is defined as "[a] graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing." 42 C.F.R. § 484.4. Establishing requirements that are different than what the states require for licensing PTs would be inconsistent with not only the rights of the states, but also CMS' own standards.

Moreover, the federal government should not impose an additional burden on the states, particularly since its stated desire for a national examination already satisfied and its other stated goals would not be better met by the burden it proposes to impose. The proposed unfunded mandate could result in the development of a second exam, which would create confusion and more work for the states, without benefit. Our resources are already limited and stretched.

In the preamble to the proposed regulations, CMS says that it is seeking uniformity. The fact of the matter is that uniformity and consistency across the nation and across provider settings already exists. State licensing requirements apply to physical therapists without regard to where they practice. All states accept CAPTE accreditation. All states accept the NPTE and have adopted the same passing score. No federal regulation is required.

In fact, the proposed regulations would likely defeat CMS' own goal of uniformity. If, for example, the APTA were to approve a different exam than the NPTE, which the regulations would permit it to do, physical therapists, patients, including Medicare and Medicaid beneficiaries and recipients, and others could face substantial confusion and interruption of service. As a state board of physical therapy examiners, we would continue to have authority to select an exam of our choice for licensing purposes. However, under the proposed rule, a physical therapist would have to pass a second exam approved by the APTA to qualify for Medicare reimbursement. Thus, patients might be forced to change physical therapists as they become Medicare or Medicaid eligible, and the current uniformity and continuity of standards across the country would be lost. Thus, the proposed rules undermine CMS' ambition for uniformity of standards.

CMS and the federal government should not empower an advocacy group, like the APTA, to establish an examination or any qualifications for professionals to provide healthcare services to patients. The APTA's mission is to advocate and promote the profession. As a licensing body, our mission is to ensure that physical therapists are qualified to provide physical therapy services and are authorized to do the work for which they are trained. The FSBPT, the organization to which we look for the national licensing exam, was created to eliminate, protect against and prevent the inherent conflict of interest that the APTA would have if it were to have authority over the examination and credentialing processes. Even the APTA recognized this conflict of interest problem two decades ago when it created the Federation of State Boards of Physical Therapy. CMS must not allow this conflict of interest to become a rule.

The Virginia State Board of Physical Therapy Examiners strongly urges CMS to require only state licensure. Most importantly, CMS should remove the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist." At a minimum , CMS should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We appreciate the opportunity to comment on the proposed rules regarding physical therapist and

physical therapy assistant qualification requirements.

Respectfully yours,

George Maihafer, PT, President
Virginia State Board of Physical Therapy