Submitter : **Mr. Philip Davidson** **Date: 08/28/2007**

Organization : **Community rehab**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

In the past five years I have seen a significant change in referral patterns in the geographical area I serve. There are now 5 physician owned physical therapy pracices in this area. The physicians who own these practices have changed from a minor therapy user and now send most if not all of their therapy patients to the clinics they control. I have patients who have had to drive 40 miles out of their way becuase the physician has required they see the therapist that was employed in his facility. The quality of the service has gone down in these facilities and the frequency and duration of visits have increased. It has become more then a frustration in our geographical area. It has also become a concern for the patient's right to choose and to recieve quality care. It is difficult for an independent practice owned by a physical therapist to compete when the physician is able to refer their patient to the facility they control and profit from. Fair competition is fine, but if the patient is required to have the physician referral for therapy then it is a clear conflict of interest and a restraint of trade to limit the patient's choice to only the facility the physican controls.

Submitter : **Mr. Glen Cooper** **Date: 08/28/2007**

Organization : **Penn-Trafford 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 Glen Cooper and I am a Certified Athletic Trainer and Educator working in the secondary school setting. I am employed by the school district to meet the health care needs of our student athletes. I hold a national certification, a state liscense and state certificate.

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,

Glen L. Cooper, ATC

Submitter : **Dr. Carrie Steichen** **Date: 08/28/2007**

Organization : **Dr. Carrie Steichen**

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.

Carrie Steichen, D.O.

Submitter : **Mr. Bennett Smith** **Date: 08/28/2007**

Organization : **Mr. Bennett 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
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Thank you for your consideration of this serious matter.
Bennett Smith MD

Submitter : Dr. sanjeev verma **Date:** 08/28/2007

Organization : A.L.LEE MEMORIAL Hospital,fulton,ny 13069

Category : Physician

Issue Areas/Comments

Physician Scacity Areas

Physician Scacity Areas

i am working in rural physician scarcity area ,and looks like this increase in payment is long overdue ,At the present schedule it is very hard to staay in business for small groups or solo practitioners unless they are subsidized by the hospital and this was the first year that I had to go to the hospital to ask for my income to bc subsidized ,and also I have been moonlighting in the ED to keep my income at par with what it was in 1996-1997 (only 10 years ago looks like the cost of living has increased but medicare has not kept up with it)

sincerely
sanjeev k verma MD

Submitter : Mr. Andrew Osika **Date:** 08/28/2007

Organization : Mr. Andrew Osika

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 and very concerned that your pending legislation will have a negative effect on my profession. After obtaining my undergraduate degree in athletic training and becoming a Certified Athletic Trainer, I obtained my Masters Degree as well. Changes in legislation as you are proposing would be detrimental to my profession as well as the entire medical 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.

Sincerely,

Andrew K. Osika, MS, ATC, Licenesed

Submitter : Mr. Mark Wagner **Date:** 08/28/2007

Organization : Loudoun County Public Schools, VA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1385-P-10386-Attach-1.DOC

CMS-1385-P-10386-Attach-2.DOC

10386

Dear Sir or Madam:

Hello, my name is Mark Wagner, and I am the Certified Athletic Trainer at Stone Bridge High School of Loudoun County Schools in Virginia. I have bee a Certified Athletic Trainer since getting certified in 1988. I graduated from Slippery Rock University receiving both my BS and MS from this 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 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.

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Sincerely,

Mark Wagner, MS, ATC

Submitter : **Dr. John Lockenour** **Date: 08/28/2007**

Organization : **Dr. John Lockenour**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

Re: TECHNICAL CORRECTIONS

The proposed rule 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,

John D. Locknour DC

Submitter : Dr. Hanzhou Lian **Date:** 08/28/2007

Organization : Dr. Hanzhou Lian

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Submitter : Mr. Matthew Gerken **Date:** 08/28/2007

Organization : University of Southern Maine

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer of 29 years and have provided health care services to collegiate athletes all of those years. I have a Master's degree and am Board of Certification (BOC), Inc. Certified as an Athletic Trainer. I am very concerned about the proposed changes to CMS regulations that threatens the health and safety of US citizens. Certified Athletic Trainers are qualified and have a legal right to be providing rehabilitative health care in all venues to US Citizens. 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 seeking the unique and important services that Certified Athletic Trainers provide.

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 BOC, Inc certification 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 D. Gerken, MS, ATC

Submitter : **Dr. richard silver** **Date: 08/28/2007**

Organization : **unicom 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 : **Jennifer Nesseth** **Date: 08/28/2007**

Organization : **Portage Health Systems**

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. An Allied Healthcare Professional certified through a Board of Certification Organization of the National Athletic Trainers Association. I currently work for a hospital. My duties involve working as a physician extender in an orthopedic surgeon's clinic, working as an assistant for a physical therapist, and as a Certified Athletic Trainer for a local University. I received a four year Bachelor of Arts Degree in Athletic Training and recently finished my Masters of Science Degree in Health Science. I am involved with the National Athletic Trainers Association and the National Strength and Conditioning Association. My continuing education allows my to stay Certified nationally and state wide in the United States, also allowing my knowledge base to grow so I can be an assest to any patient I see.

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 Nesseth, M.S., ATC

Submitter : Dr. Jennifer Jeschke **Date:** 08/28/2007

Organization : Lake Mills Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To whom it may concern;
I am a physical therapist and owner of a physical therapy outpatient private practice. My area of specialization and business is primarily orthopedics. My concern with physician referral for profit is multifaceted:
Physicians that refer for profit have the tendency to refer not to a specialist but only one provider and that PT may not be the most appropriate to treat that patient, but because that physician doesn't care to build any professional relationships outside his profit opportunities.
As a business owner an physical therapist we provide patient care that is worthy of earning referrals. If a physical therapist is pressure to make profit and is "feed" referrals from their "boss", treatment tends to be excessive and possibly inappropriate.
Referral for profit is just unethical and should not be paid for by anyone.

Thanks you for your time.

Jennifer Jeschke, DPT
Lake Mills WI 53551

Submitter : **kelly mellum** **Date: 08/28/2007**

Organization : **kelly mellum**

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.

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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: 08/28/2007**

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

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Thank you for your consideration of this serious matter.

Submitter : Dr. Jennie Mace **Date:** 08/28/2007

Organization : Anesthesiology Associates of North Florida

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/28/2007**

Organization : **Oasis MSO**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a recent graduate and have passed my BOC exam. I also now work in an orthopaedic clinic with patients of all ages, some with athletic backgrounds and some without.

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.

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Sincerely,

Jesse Abeler, ATC, CSCS

Submitter : Dr. Thomas Kohl **Date:** 08/28/2007

Organization : Comprehensive Athletic Treatment Center

Category : Physician

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

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

I am a family physician who practices sports medicine as well. My outpatient clinic employees certified and licensed athletic trainers to provide physical MEDICINE services to my patients under my direct supervision. Unfortunately my active medicare patients can no longer avail themselves of this convenient source of care directly connected to the office in which they receive their medical care.

CMS has offered no explanation as to why these significant changes to Hospital Conditions of Participation are neeessary. There has been no mention or documentation of poor care, lack of standards, or lack of cost effectiveness. These changes 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. Athletic trainers are qualified health care professionals. They undergo a more vigorous certification examination than my Board. They have more vigorous continuing education requirements than PTs and certainly PTAs who provide a lot of this care. I know that to be true because my wife is a PTA that has not practiced in 11 years, yet can maintain her license just by sending in the fee every two years to the state. I believe that physicians have the ultimate repsonsibility of care and should be the people making decisions about who is and is not qualified to ASSIST in the care of Medicare beneficiaries. Again there has not been any documentation that shows that this decision is based upon a problem with the current staffing. In fact with the aging population, we should not be restricting qualified practitioners; we should be welcoming them to the team. We should welcome others with expertise like the lymphedema specialists, the kinesiotherapists, and the vision therapists. The bottom line is good patient care, care access, and cost effectiveness. None of these things has been proven to be a problem necessitating change with the proposed revisions.

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 : **Date: 08/28/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Concerned regarding issue of physician self-referral and "in-office ancillary services" exception. Physician's and their attorneys are well aware of the loop-hole and are creating "self-referral profit centers" to enhance income. Self-referral POPTS clinics are expanding in this area and limiting access of patients to providers other than the facility owned by their referring physician. The profit motive also encourages increased referrals that might not be objectively appropriate. Greed is the name of the game in today's health care system. CMS only has to choose how much they desire to tolerate. Am asking that Physical Therapy services be removed from the "in-office ancillary services" exception to the federal physician self-referral laws. Thank You for the opportunity to share my comments.

Submitter : Mr. Michael Cash **Date:** 08/28/2007

Organization : PROActiave PT

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I do not understand what how physician owned practices benefit the consumers. If it is about the ease at which they monitor patients, I can say in my 10 years of practice, I have had maybe two doctors call me to find out how a patient was doing. In my opinion I belief self referral is ripe for over-utilization, only benefiting the bottom lines of the Physicians who own these practices. I would love to see the comparision of the average length of stay of the Physician owned practice vs a non- Physician owned practice. In a time when healthcare costs are coming under the magnifying glass, not allowing Physicians to own there own Physical Therapy practices would be a great way to decrease costs.

Submitter : **Dr. Leslie Borow** **Date: 08/28/2007**

Organization : **ASA**

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)

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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,

Leslie B. Borow, MD

Submitter : **Mr. Jorge Davila** **Date: 08/28/2007**

Organization : **Mr. Jorge Davila**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I an athletic trainer working in an orthopeadic clinic. Doctors at this clinic see the athletic trainer as an excellent person with the required background to keep their clinics and patients in order. They like our background of orthopeadics because we are able to understand the patients situation better than a trained person that as no specific or extensive orthopeadic knowledge. In this way we athletic trainers are part of the chain that provides the patient care the excels all their expectations. In the end contribuiting to the patients' treatment and henceforth their improve health.

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,
Jorge Davila, ATC

Submitter : **Dr. Ives Murray** **Date: 08/28/2007**

Organization : **Western Colorado 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:

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. Misty Colvey **Date:** 08/28/2007

Organization : Mrs. Misty Colvey

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

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Sincerely,

Misty Colvey, ATC/LAT

Submitter : **Dr. Patrick Slatev** **Date: 08/28/2007**

Organization : **Affiliated Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Patrick Slatev
Affiliated Anesthesiologists
Oklahoma City, Oklahoma

Submitter : **Dr. Richard Hayes** **Date: 08/28/2007**

Organization : **Dr. Richard Hayes**

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

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/28/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

Renfeng Liu D.O.

Submitter : **Mrs. Marni Beals** **Date: 08/28/2007**

Organization : **Athletico**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 28, 2007

Dear Sir or Madam:

I am a Nationally Certified and Licensed Athletic Trainer and Massage Therapist working in Illinois for the last 7 years. I have had the unique experience of working in a setting that is multidisciplinary, including Physical Therapists, Occupational Therapists, Athletic Trainers, and Massage Therapists. Each therapy takes an individual approach to the common goal of healing our population.

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.

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Sincerely,

Marni Beals, ATC, LMT

Submitter : **Dr. carolina isaacs** **Date: 08/28/2007**

Organization : **sheridan**

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)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Jeff Hartshorn **Date:** 08/28/2007

Organization : Baranof Chiropractic

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Chiropractors specialize in musculoskeletal disorders. By dealing with bones and muscles, it is important that we have access to examination procedures that allows us to properly diagnose bone disorders or pathologies, not to mention guard us and the patient from unsafe treatments. By forcing a patient go through their family practitioner in accrues more cost for the patient, decreased patient quality of care because less nessesary x-rays will be taken, and decreased chance of a proper diagnosis. It is just as important to know when not to treat due to bone pathologies or injuries as to know when to treat them.
Dr. Jeff Hartshorn

Submitter : **Dr. michael parimucha** **Date: 08/28/2007**

Organization : **Dr. michael parimucha**

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

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Thank you for your consideration of this serious matter.

Michael A. Parimucha MD

Submitter : **Dr. Grant Hayashi** **Date: 08/28/2007**

Organization : **Dr. Grant Hayashi**

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

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Submitter : **Dr. Donald Summers** **Date: 08/28/2007**

Organization : **Dr. Donald Summers**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing in response to the proposed deletion of code 93325 for the Doppler echocardiogram.
This study is a vital part of an echocardiographic study and is of particular significance when evaluating valvular heart disease. Indeed recent studies (Mayo Clinic Dr. Serranho) have shown that significant mitral regurgutation resulting from ischemic heart disease is often silent.

The fact that the Doppler study must be done for proper evaluation is not a reason not to pay for the procedure. Rather it is a reason to pay for the performance interpretation, preparation of records and to acknowledge the skills needed and the cost involved in providing excellence in cardiac care.

Donald N. Summers, M.D.

Submitter : **Mrs. Nicole Chisholm** **Date: 08/28/2007**

Organization : **Accelerated Rehabuilitation Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Hi, my name is Nicole Chisholm and I work for Accelerated Rehabilitation Centers as one of there certified 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.

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Sincerely,
Nicole Chisholm, ATC

Submitter : **Mr. Jose Martinez** **Date: 08/28/2007**

Organization : **Mr. Jose Martinez**

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Robert Wilson** **Date: 08/28/2007**

Organization : **Dr. Robert Wilson**

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

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Submitter : **Dr. Luba Voinov** **Date: 08/28/2007**

Organization : **NJSSA**

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
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Sincerely,
Dr. Luba Voinov
New Jersey

Submitter : **Mr. Greg Nauman** **Date: 08/28/2007**

Organization : **Mr. Greg Nauman**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Submitter : **Mr. Paul Kennedy** **Date: 08/28/2007**

Organization : **Select Physical Therapy**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Paul Kennedy and I am a Certified Athletic Trainer. I have been cetified since 2001 and I am employed with a community outreach program serving High School athletics in Las Vegas, NV.

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.

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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 Kennedy, LAT,ATC

Submitter : **Dr. James Rappaport** **Date: 08/28/2007**

Organization : **Dr. James Rappaport**

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. Israel Mitchell** **Date: 08/28/2007**

Organization : **Belen Jesuit Preparatory School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Israel Mitchell. I am the Head Athletic Trainer at Belen Jesuit Preparatory School. I am responsible for the care of approximately 600 High School and Middle School athletes. I graduated with a BS from the University of Florida and a MS from Florida International University. I have also taken the national Athletic Training exam and am liscensed by the state of 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.

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Sincerely,

Israel Mitchell, LAT, ATC

Submitter : **Dr. Frederick Torres** **Date: 08/28/2007**

Organization : **Anesthesia Associates of Naples**

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

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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. ELizabeth Hughes** **Date: 08/28/2007**

Organization : **Kalamazoo Wings**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Elizabeth Hughes and I am a certified athletic trainer. I am currently an athletic trainer for a professional hockey team and I am the sole provider of health care services to the team. I provide immediate care to the players as well as evaluate their injuries and help rehabilitate them back to their playing level. I also refer them to a physican when needed.

I graduated from the Univeristy of Cincinnati with a BA in Health Promotion and Education. I also attended Minnesota State where I recieved my MA in Sports Psychology. During my undergrad years I spent four years studing athletic training. I took a number of classes that related to immediate care, injury evaluation, rehabilitation, modilaties, several classes on documentation as well as a number of other classes to help develop athletic training skills. Besides our classroom learning we also participated in clinical settings where we got to practice our skills we learned in class in a real world setting under the direction of a certified athletic trainer. After graduation I had to take a certification test that consisted of 3 parts to evaulate my athletic training skills. The tests consisted of a multiple choice of a variety of health realted topices and written simulation of actual situtations. The third part consisted of a practical part where a varity of skills and tasks where performed. The combination of all three tests helped to evaluated all the dominas of athletic training. Once a person has passed all three parts then they become a Certified Athletic Trainer(ATC).

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.

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Sincerely,

Elizabeth Hughes, MA, ATC

Submitter : **Dr. Frank Stadler** **Date: 08/28/2007**

Organization : **Dr. Frank Stadler**

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)

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Marcia Lu** **Date: 08/28/2007**

Organization : **Dr. Marcia Lu**

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)

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

Thank you for your consideration of this serious matter.

Submitter : Ms. Alexandria Urgo **Date:** 08/28/2007

Organization : AthletiCo Ltd.

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Alexandria Urgo and I am an athletic trainer and massage therapist. I have worked for AthletiCo for a little over five years. I have been practicing since 2003 and work in a physical therapy setting as a full-time massage therapist and am an athletic trainer part-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 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,

Alexandria Urgo, ATC, LMT
Athletic Trainer/Massage Therapist

Submitter : **Miss. Kayla Shinew** **Date: 08/28/2007**

Organization : **Ohio University**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am relatively new to the profession of athletic training, receiving my bachelors degree from Lock Haven University of PA in 2006 and my masters of science degree from Austin Peay State University in 2007. I m currently working on my PhD at Ohio University and have the opportunity to be a graduate assistant athletic trainer with the ice hockey team.

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.

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Sincerely,

Kayla Shinew, MS, LAT

Submitter : Dr. James R Smith **Date:** 08/28/2007

Organization : MRHC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Ms Novak, I strongly support the proposed revision of anesthesia reimburesment. This is clearly a step in correcting the grossly undervalued reimbursement for anesthesia services.

Submitter : **Dr. William Wager** **Date: 08/28/2007**

Organization : **Dr. William Wager**

Category : **Other 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:

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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 Kirk** **Date: 08/28/2007**

Organization : **Womens Health Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Mary C. Kirk, M.D.

Submitter : **Miss. Ann Evans** **Date: 08/28/2007**

Organization : **NovaCare/Select Medical**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Ann Evans and I work for the outpatient division of Select Medical Rehabilitation. I am an athletic trainer with a master's in business and have been managing an office as well as treating patients for my organozation for the last 11 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.

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Sincerely,

Ann Catherine Evans ATC, MBA
Center Manager NovaCare Rehabilitation
Head Trainer USA Wonmen's Rugby

Submitter : Steve Blades **Date:** 08/28/2007

Organization : Cardiovascular Outpatient Center Alliance

Category : Health Care Provider/Association

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

See attachment

CMS-1385-P-10459-Attach-1.DOC

#10459

COCA
CARDIOVASCULAR OUTPATIENT CENTER ALLIANCE

206 WELLSPRING COURT, BRENTWOOD, TN 37027
PHONE: 615-776-1810
www.cocaheart.org

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 Physician Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Mr. Kuhn:

On behalf of the members of the Cardiovascular Outpatient Center Alliance (COCA), we appreciate the opportunity to submit these 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 proposed 2008-2010 PE RVU's established for non-facility outpatient cardiac catheterization procedure codes and the significant negative impact on the practices and patients of our members that would result if these RVU changes are implemented.

COCA is a national non-profit organization representing over 60 medical cardiology practices and organizations and more than 1,000 cardiologists that own and operate non-hospital outpatient cardiac catheterization facilities. As will be described below, the impact of the CMS proposed PE RVU changes would be devastating to cardiovascular outpatient cardiac catheterization centers, with the potential to force these facilities to exit the market. As a result, Medicare beneficiaries would be denied access to high quality, convenient cardiovascular services at a reasonable cost and the overall cost to the Medicare program for these services would increase dramatically.

Background
Cardiac catheterizations are an important and sophisticated tool for diagnosing heart disease that were traditionally performed in hospitals until the 1980's. Since then an increasing number of catheterizations are now performed in non-facility (i.e. non-hospital) cardiovascular outpatient centers because they offer patients greater convenience, higher

quality, and lower costs – factors that have led payers, including CMS, to encourage their development. Non-facility cardiovascular outpatient catheterization labs can be organized as part of a cardiology group practice or an independent diagnostic testing facility (IDTF). The cardiology group practice can bill a global fee for both the professional and technical components, while the IDTF bills only the technical component. Medicare's payments for the technical component, either as part of the global payment billed by the cardiology group or the separate technical component billed by an IDTF, are intended to reimburse solely for the technological and other support services that enable physicians to perform catheterizations. Medicare calculates payments for the technical component through the same fee schedule methodology used to pay physicians. This methodology seeks to identify a "relative value" that reflects the resources needed to provide each service. Because Medicare has been unable to capture complete cost information for the technical services associated with certain non-facility services such as cardiac catheterizations, the program for several years used a special estimation method to calculate values for the practice expenses associated with these technical services, which involved the use of the non-physician work pool (NPWP) in a "top-down" methodology.

In the June 29, 2006 Proposed Notice regarding *Proposed Changes to the Practice Expense Methodology*, CMS stated its intent to replace the "top-down" methodology with a "bottom-up" approach that would result in payment levels that it believed would more accurately reflect the relative costs of certain services. The Proposed Notice described two changes to the PE RVU methodology. The first change was to replace the "top-down" methodology with a "bottom-up" methodology for developing resource-based RVU's for the practice expenses associated with discrete physician services. The second change was the elimination of the NPWP. These changes were implemented for most CPT codes in the 2007 Physician Fee Schedule; however, most outpatient cardiac catheterization procedure codes were not included in this change. COCA and other cardiology advocacy organizations submitted formal written comments, and after discussions with COCA representatives, CMS acknowledged in their December 1, 2006 Final Rule that *"We currently do not have direct cost input data for the non-facility setting for these services. Until we are able to obtain such data, we will carrier-price the cardiac catheterization codes."* (Federal Register/Vol. 71, No. 231/ page 69642). CMS went on to state in the same section that *"We urge interested parties to continue to work with the RUC to develop direct cost inputs for these services in the future."*

Based on this CMS request, COCA members proactively engaged Medicare carriers throughout the country to present direct and indirect cost data. We understand that carriers also received informal guidance from CMS regarding this issue. The result was that Medicare reimbursement to non-facility outpatient cardiac catheterization centers in 2007 was equal with 2006 reimbursement (with some minor adjustments resulting from the Five Year RVU review).

AMA RUC/PERC Participation

In addition to their comments in the December 1, 2006 Final Rule, CMS representatives verbally requested that COCA participate with the American College of Cardiology (ACC) in providing direct cost data for non-facility outpatient cardiac catheterization centers to the RUC to establish appropriate PE RVU's. COCA readily agreed and conducted a detailed

study of these direct costs. The preliminary results were presented to CMS in COCA's formal comments to the August 22, 2006 Proposed Rule for the 2007 Physician Fee Schedule. The final report was presented to you on May 3, 2007 at a meeting organized by representatives from the Florida Congressional delegation.

COCA Direct Cost Study

The COCA direct cost study was managed by staff from Epstein Becker and Green, P.C. and the cost information was based on the median value reported for the clinical time in the pre-, intra-, and post- procedure phases of the procedure. The Bureau of Labor Statistics hourly compensation was used to calculate the clinical labor cost associated with each phase of activity. Similarly, the clinical supplies and equipment costs reflect the median values. With regard to equipment, the cost estimate is based on the same assumptions regarding useful life, utilization rate and financing that CMS used in the June 29' 2006 Notice.

The study reveals that the major problem associated with the 2006 RUC estimate of direct costs for non-facility outpatient cardiac catheterization was that the list of direct patient care activities was inadequate and that the total estimates of clinical time were so low as to lack credibility. COCA learned that some under-reporting of time was due to an assumption that clinical staff performs services related to patients who are undergoing other procedures. This allocation of time to other procedures is inappropriate because non-facility cardiovascular outpatient catheterization centers focus on diagnostic catheterizations and all of the clinical labor activities and time should be allocated to these procedures alone.

Participation in 2007 RUC Process

In direct response to CMS' requests, COCA members and physicians committed extensive time and resources from September 2006 through April 2007 in a good-faith effort to provide accurate direct and indirect cost data to the Practice Expense Review Committee (PERC) of the AMA's RUC. Unfortunately, this process did not allow a significant portion of COCA's data to be considered and resulted in PE RVU recommendations to CMS that severely undervalued the direct and indirect costs of providing these procedures to its members' patients. There are many reasons for this failure, but they primarily involve two areas:

1) arbitrary definitions established by the RUC/PERC that unfairly penalize highly specialized procedures performed by physicians that require equipment and supplies for patient safety, and

2) the underlying politicizing of the RUC process that pits medical specialties against each other and forces them to consider the political implications of each request as opposed to simply presenting the complete data set for discussion.

Two examples of our experience will help explain why the final RUC recommendations to CMS severely underestimated the costs associated with non-facility outpatient cardiac catheterization procedures:

1) Arbitrary definitions
The RUC has established a definition that automatically disallows direct costs that are essential to patient safety in a cardiac catheterization lab. Specifically, the RUC will only count staffing, equipment, and supplies that are used in a "typical" case and they arbitrarily define "typical" as a case where these items are used at least 51% of the time. This definition disallows patient safety devices and equipment that are infrequently used, but are essential to quality patient care (e.g., "crash carts" with defibrillators and essential pharmaceuticals, and expensive wound closure devices).

2) Politicized process
COCA was fortunate to work collaboratively with the American College of Cardiology, allowing COCA physician members to present non-facility cardiac catheterization cost data to the PERC as part of the ACC/COCA team. However, the presentation data only included a portion of COCA's actual direct cost data instead of the full report. This is because the nature of the current RUC process forces the medical specialty societies to balance their various constituents' requests instead of simply presenting data to be evaluated on their own merits. There is a strong perception that if the gap is too wide between the preexisting RUC data base and the new data being presented for clinical time, equipment or supplies, the new data is often considered suspect and rejected. In this specific case, the preexisting RUC data base for cardiac catheterization clinical staff time primarily reflected hospital data with little relationship to actual direct cost data for dedicated outpatient cardiac catheterization facilities, resulting in tremendous disparity.

Comment [MC1]: Needs another sentence explaining why the RUC processes prejudices the RUC decision.

Proposed Rule PE RVU Impact
It appears from the July 2, 2007 Proposed Rule that CMS has accepted the 2007 PERC/RUC direct cost recommendations for outpatient cardiac catheterization codes without considering the more accurate direct cost information that COCA provided to CMS in May 2007. As a direct result, the July 2, 2007 Proposed Rule would result in draconian cuts in reimbursement for cardiac catheterizations performed in medical cardiology practices and IDTF locations. If the 2007 conversion factor is applied to the technical components of the primary three CPT codes for a Left Heart Catheterization (93510TC, 93555TC, and 93556TC) the reimbursement in 2008 would be reduced from the 2007 rate by 32.18%, and when fully implemented in 2010 the total reimbursement reduction would be 49.0%. These severe cuts would undoubtedly result in the closing of the majority of non-facility outpatient cardiac catheterization labs in the country forcing Medicare patients who now benefit from improved access and lower costs into more acute and expensive hospital settings.

The inappropriateness of the current rate setting process becomes self-evident when the proposed negative changes for outpatient diagnostic cardiac catheterization codes listed in the 2008 Physician Fee Schedule are compared with the proposed 2008 APC rate increase of 11.18% for APC 0080 "Diagnostic Cardiac Catheterization" published in the August 2, 2007 Federal Register (CMS-1392-P). It is clear that the RUC recommendations concerning the cost of performing these procedures are dramatically at odds with those that CMS determined for the same procedures performed in facility-based

outpatient cardiac catheterization centers. This comparison is set out in the following chart:

Comparison of Payment Rates by Site of Service for Family of Diagnostic Catheterization Codes (PFS 93510 TC, 93555 TC, 93556 TC and APC 0080)

	Actual 2007	Proposed 2008	Proposed 2010	% Change	2008 PFS as % of 2008 APC	2010 PFS as % of 2008 APC
APC Rate	$2,283.55	$2,539.00		11.19%		
PFS Rate	$2,138.56	$1,450.34		-32.18%	57.12%	
PFS Rate	$2,138.56		$1,090.69	-49.00%		42.96%

COCA's Request

COCA requests that CMS review the additional cost data provided by COCA and revise the current proposed PE RVU's for outpatient cardiac catheterization procedures to values that more reasonably reflect the direct and indirect costs of providing these services. An additional solution would be to recognize the difficulty in determining direct and indirect costs for non-facility outpatient cardiac catheterization centers utilizing RUC criteria and tie reimbursement for these procedures to a reasonable percentage of the hospital APC rate for the same family of procedure codes.

As COCA stated both in our 2006 written comments and during our August 12, 2006 meeting with you and your senior staff, the costs of performing these services in facility and non-facility locations are remarkably similar based on actual experience from COCA members who administer both facility and non-facility cardiac catheterization centers. We view APC payment levels as a reasonable benchmark when accurately evaluating the Medicare Physician Fee Schedule payment methodology for outpatient cardiac catheterization procedures where the technical component can be billed separately.

Conclusion

We believe that you have no interest in supporting a flawed process that would drive non-facility cardiac catheterization centers out of business. We base this belief not only on our face-face discussions, but also on the statement CMS made in the July 2 Proposed Rule when expressing concern with service furnished under arrangement with a hospital because it *"not only costs the Medicare program more, but also costs Medicare beneficiaries more in the form of higher deductibles and coinsurance"* (CMS-1385-P, pages 349-50). This concern about increased Medicare program and beneficiary costs must also apply to other services...which is exactly the point we have expressed about

non-facility outpatient cardiac catheterization centers from our first formal written comments about the proposed reimbursement cuts in 2006.

We thank you for the opportunity to describe our concerns about the proposed rule, specifically as it relates to payment for cardiac catheterization-related procedures and the development of standards for centers that perform these procedures on an outpatient basis.

We look forward to meeting with you and your staff after the comment period is over and before CMS finalizes the 2008 Physician fee Schedule. If you have any questions, please do not hesitate to contact me at (615) 776-1810.

Sincerely yours,

Steve Blades
President

Submitter : Dr. Robin Harms **Date:** 08/28/2007

Organization : Western Oaks Anesthesia Assoc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my support for the proposal to increase anesthesia payments under the 2008 physician fee schedule. (RVUs)

Resource-Based PE RVUs

Resource-Based PE RVUs

I am writing to express my strong support for the proposal to increase anesthesia reimbursement under the 2008 physician fee schedule.

Submitter : Dr. Timothy Lindsay **Date:** 08/28/2007

Organization : Twin Cities 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.

Timothy Lindsay, MD

Submitter : **Mr. Jeremy Tiermini** **Date: 08/28/2007**

Organization : **Finger Lakes Community College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name iS Jeremy Tiermini and I am a certified athletic trainer and an athletic training educator at Finger Lakes Community College. I have been an ATC for over 13 years and I consider myself a health-care professional who is concerned for every aspect of his students' health and wellness.

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 any 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 all 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,

Jeremy Tiermini, ATC

Submitter : **Dr. Wade Sewell** **Date: 08/28/2007**

Organization : **Dr. Wade Sewell**

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)

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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.

Wade Sewell,DO

Submitter : **Mr. Chris Mathewson** **Date: 08/28/2007**

Organization : **Mr. Chris Mathewson**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Chris Mathewson, I am the head athletic trainer at Ponderosa High School in Parker, Colorado. I have held this position for 13 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,
Chris Mathewson, MSS, ATC, CSCS

Submitter : **Dr. David Burgin** **Date: 08/28/2007**

Organization : **Anesthesia Specialists of Acadiana**

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Daniela Rusu** **Date: 08/28/2007**

Organization : **Mississippi Valley Surgery 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)

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Sameh Saad** **Date: 08/28/2007**

Organization : **ASA**

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Jeff Lindsay **Date:** 08/28/2007

Organization : Oklahoma society of anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am in strong support of the proposed increase for Medicare payment for anesthesiologists. This is absolutely necessary to assure continued care for the Medicare patient. I am very appreciative of the proposed increase and I see this as progress in the right direction.

Submitter : Dr. Eric Schwartz **Date:** 08/28/2007

Organization : Anne Arundel Urology

Category : Health Care Provider/Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Imagine being told you have cancer, but in actuality not. This happened on multiple occasions when i was forced to send pathology specimens to the major labs with nameless pathologists. Since we contracted with a pathologist of our choosing, one with impecable credentials, this situation has not happened. I get quick opinions I trust. I have the ability to discuss the pathology with the pathologist in my own office. Changing the Stark "in-office" ancillary exemption would hurt my patients and the care i provide to them. My patients trust me. I must trust the opinion of my pathologist. With Labcorp and Quest, I never could. With my current "in-office" pathologist, trained directly by the best prostate cancer pathologist in the country, i can. Diagnosis changes do not occur anymore. Changing the "in-office" Stark exception would hurt my ability to provide the right diagnosis and treatment.

Submitter : **Miss. Lori Kurszewski** **Date: 08/28/2007**

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 Lori Kurszewski, and I practice as an athletic trainer in the state of Minnesota. I provide on-site care for employees at major Twin Cities metro companies. I am able provide these employees with injury prevention tools, heath/wellness information, injury assessment and rehabilitation, along with triage to further medical attention as needed. I help to keep them healthy and on the job, and also provide these workers tools to be able to enjoy their time away from work. I attended the University of Wisconsin-Stevens Point and earned a Bachelor s of Science degree in Athletic Training and Biology, and then a Mater s of Arts degree from the University of Minnesota-Minneapolis in Kinesiology with a Human Factors/Ergonomics emphasis.

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.

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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 S. Kurszewski, ATC, MA

Submitter : Mr. Van Coble **Date:** 08/28/2007

Organization : Medicap Pharmacy

Category : Pharmacist

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

I believe that by eliminating use of computer generated faxed, we are being taken back several years in technology. I am not sure why this is a problem and if one exists then it should be explained so a solution can be found. Use of computers to send faxes back and forth from physicians, to hospitals, and to retail pharmacies is a huge time saving practice. Since the advent of Medicare Part D and in the increase of "hoops" that pharmacies and physicians must "jump through" for the patients time is of the essence. On the health care provider end, if we spend time achieving meaningless tasks then we have less time to spend with our patients, thus less care is provided for these patients. Due to the health care crisis that this country is experiencing, we must do see more patients, fill more prescriptions, for less return than we ever have in the 30 years I have been involved in the health care arena. Until the Federal Government realizes that providers must make a living, while treating and serving their patients, the continued downward spiral of the system will continue. This, in the greatest nation on earth. CMS is at the head of a system created for the citizens of the United States. This system is for the benefit of taxpayers, not politicians. Partisinship must be put away under lock and key. Only after this happens will health care return to US citizens. Finding savings in the CMS payment system is not hard for providers. I can find real time savings on a daily basis and still pay providers a legitimate profit.

Submitter : JESSE NEUBARTH **Date:** 08/28/2007

Organization : JESSE NEUBARTH

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

Sincerely,

Jesse Neubarth, MD

Submitter : **Dr. Robert Bossard** **Date: 08/28/2007**

Organization : **Pinnacle Anesthesia, Dallas, Texas**

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:

The proposal to increase anesthesia payments under the 2008 Physician Fee Schedule is vitally important and I support it strongly. CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue. Importantly, it will serve to maintain quality of care.

RBRVS was instituted created a huge payment disparity for anesthesia care due to significant undervaluation of anesthesia work compared to other physician services. Today, a decade after the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. Because 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. Without addressing this issue, seniors will continue to be progressively more underserved.

To attempt 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.

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Paul Kulick** **Date: 08/28/2007**

Organization : **Forest City Physical Therapy**

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 in Rockford Illinois with nearly 20 years experience in treating the unfortunate injuried people both in a clinical setting and on the sports 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.

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Sincerely,

Paul J Kulick ATC

Submitter : **Ms. Christina McCabe** **Date: 08/28/2007**

Organization : **Harrisburg Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Christina McCabe and I am a certified athletic trainer employeed at Harrisburg Medical Center as an outreach athletic trainer to the local high school and junior college as well as an athletic trainer that treats outpatient orthopedic patients. I have not only obtained a bachlor's degree in Athletic Training but I also received a Master's degree in 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 usual vetting, I am concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

Christina McCabe, MS, ATC

Submitter : Mr. Robert Stacey **Date:** 08/28/2007

Organization : Athletico

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am currently employed by Athletico, a company specializing in patient care for those have been injured. While I work in the clinical setting, I am also part of the outreach program to local high schools in the area. While in the high school setting I am responsible for the prevention, recognition, and treatment of injuries to the athletes at the school. I also perform the taping duties and all of the necessary rehabilitaion for the athletes that is needed for a specific injury. I feel very well qualified to perform these duties based on the wonderful education I have received both in the classroom as well as during my observation hours. I had the oppotunity to attend Xavier University for four years where I graduated with a Bachelors Degree in Athletic Training. Following this experience, I continued my education at Western Michigan University where I completed my Masters of Art Degree in Physical Education with an emphasis on Athletic Training. In the time in between schools, I became certified by the National Athletic Trainers Association, to practice as an Athletic Trainer. Also following my return to the state of Illinois I became licensed to practice in the state. Through all of these experiences I believe my wealth of knowledge has expanded greatly, and I look forward to the opportunity to continue the learning process in order to provide the best care I possibly can to those I treat.

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.

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Sincerely,

Robert R. Stacey, ATC, MA

Submitter : **Steven Pusker** **Date: 08/28/2007**

Organization : **Steven Pusker**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Dear Ms. Norwalk:

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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 : Steve Blades **Date:** 08/28/2007

Organization : Cardiovascular Outpatient Center Alliance

Category : Health Care Provider/Association

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

See Attachment

CMS-1385-P-10478-Attach-1.DOC

#1C478

CARDIOVASCULAR OUTPATIENT CENTER ALLIANCE
206 WELLSPRING COURT, BRENTWOOD, TN 37027
PHONE: 615-776-1810
www.cocaheart.org

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 Physician Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Mr. Kuhn:

On behalf of the members of the Cardiovascular Outpatient Center Alliance (COCA), we appreciate the opportunity to submit these 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 proposed 2008-2010 PE RVU's established for non-facility outpatient cardiac catheterization procedure codes and the significant negative impact on the practices and patients of our members that would result if these RVU changes are implemented.

COCA is a national non-profit organization representing over 60 medical cardiology practices and organizations and more than 1,000 cardiologists that own and operate non-hospital outpatient cardiac catheterization facilities. As will be described below, the impact of the CMS proposed PE RVU changes would be devastating to cardiovascular outpatient cardiac catheterization centers, with the potential to force these facilities to exit the market. As a result, Medicare beneficiaries would be denied access to high quality, convenient cardiovascular services at a reasonable cost and the overall cost to the Medicare program for these services would increase dramatically.

Background

Cardiac catheterizations are an important and sophisticated tool for diagnosing heart disease that were traditionally performed in hospitals until the 1980's. Since then an increasing number of catheterizations are now performed in non-facility (i.e. non-hospital) cardiovascular outpatient centers because they offer patients greater convenience, higher

quality, and lower costs – factors that have led payers, including CMS, to encourage their development. Non-facility cardiovascular outpatient catheterization labs can be organized as part of a cardiology group practice or an independent diagnostic testing facility (IDTF). The cardiology group practice can bill a global fee for both the professional and technical components, while the IDTF bills only the technical component. Medicare's payments for the technical component, either as part of the global payment billed by the cardiology group or the separate technical component billed by an IDTF, are intended to reimburse solely for the technological and other support services that enable physicians to perform catheterizations. Medicare calculates payments for the technical component through the same fee schedule methodology used to pay physicians. This methodology seeks to identify a "relative value" that reflects the resources needed to provide each service. Because Medicare has been unable to capture complete cost information for the technical services associated with certain non-facility services such as cardiac catheterizations, the program for several years used a special estimation method to calculate values for the practice expenses associated with these technical services, which involved the use of the non-physician work pool (NPWP) in a "top-down" methodology.

In the June 29, 2006 Proposed Notice regarding *Proposed Changes to the Practice Expense Methodology*, CMS stated its intent to replace the "top-down" methodology with a "bottom-up" approach that would result in payment levels that it believed would more accurately reflect the relative costs of certain services. The Proposed Notice described two changes to the PE RVU methodology. The first change was to replace the "top-down" methodology with a "bottom-up" methodology for developing resource-based RVU's for the practice expenses associated with discrete physician services. The second change was the elimination of the NPWP. These changes were implemented for most CPT codes in the 2007 Physician Fee Schedule; however, most outpatient cardiac catheterization procedure codes were not included in this change. COCA and other cardiology advocacy organizations submitted formal written comments, and after discussions with COCA representatives, CMS acknowledged in their December 1, 2006 Final Rule that *"We currently do not have direct cost input data for the non-facility setting for these services. Until we are able to obtain such data, we will carrier-price the cardiac catheterization codes."* (Federal Register/Vol. 71, No. 231/ page 69642). CMS went on to state in the same section that *"We urge interested parties to continue to work with the RUC to develop direct cost inputs for these services in the future."*

Based on this CMS request, COCA members proactively engaged Medicare carriers throughout the country to present direct and indirect cost data. We understand that carriers also received informal guidance from CMS regarding this issue. The result was that Medicare reimbursement to non-facility outpatient cardiac catheterization centers in 2007 was equal with 2006 reimbursement (with some minor adjustments resulting from the Five Year RVU review).

AMA RUC/PERC Participation

In addition to their comments in the December 1, 2006 Final Rule, CMS representatives verbally requested that COCA participate with the American College of Cardiology (ACC) in providing direct cost data for non-facility outpatient cardiac catheterization centers to the RUC to establish appropriate PE RVU's. COCA readily agreed and conducted a detailed

study of these direct costs. The preliminary results were presented to CMS in COCA's formal comments to the August 22, 2006 Proposed Rule for the 2007 Physician Fee Schedule. The final report was presented to you on May 3, 2007 at a meeting organized by representatives from the Florida Congressional delegation.

COCA Direct Cost Study

The COCA direct cost study was managed by staff from Epstein Becker and Green, P.C. and the cost information was based on the median value reported for the clinical time in the pre-, intra-, and post- procedure phases of the procedure. The Bureau of Labor Statistics hourly compensation was used to calculate the clinical labor cost associated with each phase of activity. Similarly, the clinical supplies and equipment costs reflect the median values. With regard to equipment, the cost estimate is based on the same assumptions regarding useful life, utilization rate and financing that CMS used in the June 29 2006 Notice.

The study reveals that the major problem associated with the 2006 RUC estimate of direct costs for non-facility outpatient cardiac catheterization was that the list of direct patient care activities was inadequate and that the total estimates of clinical time were so low as to lack credibility. COCA learned that some under-reporting of time was due to an assumption that clinical staff performs services related to patients who are undergoing other procedures. This allocation of time to other procedures is inappropriate because non-facility cardiovascular outpatient catheterization centers focus on diagnostic catheterizations and all of the clinical labor activities and time should be allocated to these procedures alone.

Participation in 2007 RUC Process

In direct response to CMS' requests, COCA members and physicians committed extensive time and resources from September 2006 through April 2007 in a good-faith effort to provide accurate direct and indirect cost data to the Practice Expense Review Committee (PERC) of the AMA's RUC. Unfortunately, this process did not allow a significant portion of COCA's data to be considered and resulted in PE RVU recommendations to CMS that severely undervalued the direct and indirect costs of providing these procedures to its members' patients. There are many reasons for this failure, but they primarily involve two areas:

1) arbitrary definitions established by the RUC/PERC that unfairly penalize highly specialized procedures performed by physicians that require equipment and supplies for patient safety, and

2) the underlying politicizing of the RUC process that pits medical specialties against each other and forces them to consider the political implications of each request as opposed to simply presenting the complete data set for discussion.

Two examples of our experience will help explain why the final RUC recommendations to CMS severely underestimated the costs associated with non-facility outpatient cardiac catheterization procedures:

1) Arbitrary definitions
The RUC has established a definition that automatically disallows direct costs that are essential to patient safety in a cardiac catheterization lab. Specifically, the RUC will only count staffing, equipment, and supplies that are used in a "typical" case and they arbitrarily define "typical" as a case where these items are used at least 51% of the time. This definition disallows patient safety devices and equipment that are infrequently used, but are essential to quality patient care (e.g., "crash carts" with defibrillators and essential pharmaceuticals, and expensive wound closure devices).

2) Politicized process
COCA was fortunate to work collaboratively with the American College of Cardiology, allowing COCA physician members to present non-facility cardiac catheterization cost data to the PERC as part of the ACC/COCA team. However, the presentation data only included a portion of COCA's actual direct cost data instead of the full report. This is because the nature of the current RUC process forces the medical specialty societies to balance their various constituents' requests instead of simply presenting data to be evaluated on their own merits. There is a strong perception that if the gap is too wide between the preexisting RUC data base and the new data being presented for clinical time, equipment or supplies, the new data is often considered suspect and rejected. In this specific case, the preexisting RUC data base for cardiac catheterization clinical staff time primarily reflected hospital data with little relationship to actual direct cost data for dedicated outpatient cardiac catheterization facilities, resulting in tremendous disparity.

Proposed Rule PE RVU Impact
It appears from the July 2, 2007 Proposed Rule that CMS has accepted the 2007 PERC/RUC direct cost recommendations for outpatient cardiac catheterization codes without considering the more accurate direct cost information that COCA provided to CMS in May 2007. As a direct result, the July 2, 2007 Proposed Rule would result in draconian cuts in reimbursement for cardiac catheterizations performed in medical cardiology practices and IDTF locations. If the 2007 conversion factor is applied to the technical components of the primary three CPT codes for a Left Heart Catheterization (93510TC, 93555TC, and 93556TC) the reimbursement in 2008 would be reduced from the 2007 rate by 32.18%, and when fully implemented in 2010 the total reimbursement reduction would be 49.0%. These severe cuts would undoubtedly result in the closing of the majority of non-facility outpatient cardiac catheterization labs in the country forcing Medicare patients who now benefit from improved access and lower costs into more acute and expensive hospital settings.

The inappropriateness of the current rate setting process becomes self-evident when the proposed negative changes for outpatient diagnostic cardiac catheterization codes listed in the 2008 Physician Fee Schedule are compared with the proposed 2008 APC rate increase of 11.18% for APC 0080 "Diagnostic Cardiac Catheterization" published in the August 2, 2007 Federal Register (CMS-1392-P). It is clear that the RUC recommendations concerning the cost of performing these procedures are dramatically at odds with those that CMS determined for the same procedures performed in facility-based

outpatient cardiac catheterization centers. This comparison is set out in the following chart:

Comparison of Payment Rates by Site of Service for Family of Diagnostic Catheterization Codes (PFS 93510 TC, 93555 TC, 93556 TC and APC 0080)

	Actual 2007	Proposed 2008	Proposed 2010	% Change	2008 PFS as % of 2008 APC	2010 PFS as % of 2008 APC
APC Rate	$2,283.55	$2,539.00		11.19%		
PFS Rate	$2,138.56	$1,450.34		-32.18%	57.12%	
PFS Rate	$2,138.56		$1,090.69	-49.00%		42.96%

COCA's Request

COCA requests that CMS review the additional cost data provided by COCA and revise the current proposed PE RVU's for outpatient cardiac catheterization procedures to values that more reasonably reflect the direct and indirect costs of providing these services. An additional solution would be to recognize the difficulty in determining direct and indirect costs for non-facility outpatient cardiac catheterization centers utilizing RUC criteria and tie reimbursement for these procedures to a reasonable percentage of the hospital APC rate for the same family of procedure codes.

As COCA stated both in our 2006 written comments and during our August 12, 2006 meeting with you and your senior staff, the costs of performing these services in facility and non-facility locations are remarkably similar based on actual experience from COCA members who administer both facility and non-facility cardiac catheterization centers. We view APC payment levels as a reasonable benchmark when accurately evaluating the Medicare Physician Fee Schedule payment methodology for outpatient cardiac catheterization procedures where the technical component can be billed separately.

Conclusion

We believe that you have no interest in supporting a flawed process that would drive non-facility cardiac catheterization centers out of business. We base this belief not only on our face-face discussions, but also on the statement CMS made in the July 2 Proposed Rule when expressing concern with service furnished under arrangement with a hospital because it *"not only costs the Medicare program more, but also costs Medicare beneficiaries more in the form of higher deductibles and coinsurance"* (CMS-1385-P, pages 349-50). This concern about increased Medicare program and beneficiary costs must also apply to other services...which is exactly the point we have expressed about

non-facility outpatient cardiac catheterization centers from our first formal written comments about the proposed reimbursement cuts in 2006.

We thank you for the opportunity to describe our concerns about the proposed rule, specifically as it relates to payment for cardiac catheterization-related procedures and the development of standards for centers that perform these procedures on an outpatient basis.

We look forward to meeting with you and your staff after the comment period is over and before CMS finalizes the 2008 Physician fee Schedule. If you have any questions, please do not hesitate to contact me at (615) 776-1810.

Sincerely yours,

Steve Blades
President

Submitter : **Dr. Thomas Kozhimannil** **Date: 08/28/2007**

Organization : **Brigham and Women's Hospital**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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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 : **Melanie Kunze** **Date: 08/28/2007**

Organization : **River View High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a nationally certified and Ohio licensed athletic trainer employed in a rural high school setting. I hold a masters degree and attend over 25 hours of continuing education seminars each years. I have served as an athletic trainer for the past 13 years, yet I am concerned about provisions that may take away my livlihood.

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 Kunze, MS, ATC

Submitter : **Mr. Jason Nussbaum** **Date: 08/28/2007**

Organization : **Erskine College**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer, and currently work in the college and university setting. I am certified by the National Athletic Trainers Association and The 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.

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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 P Nussbaum, ATC

Submitter : Dr. Linda Meyer **Date:** 08/28/2007

Organization : California University of PA

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1385-P-10482-Attach-1.PDF

#10482

Dear Committee Members:

My name is Linda Platt Meyer and I am a certified athletic trainer in southwest Pennsylvania. I have earned a doctorate degree in Educational Leadership that has taught me to voice my opinion and lead others to do so as well. Leadership has also taught me to look to the future; be a visionary person who looks for better solutions to accomplish set tasks. I have been an educator and certified athletic trainer for 25 years; therefore I have observed and assisted our profession to evolve into an excellent, well-respected allied health profession that works directly (by law) with medical physicians. For the last 15 years, I have taught in an accredited undergraduate athletic training curriculum, and recently have begun to teach in an on-line master's degree program in exercise science and health promotion.

I need to voice my strong opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P for many reasons. I am gravely concerned that the proposed rules will create additional lack of access to "quality health care" for our everyday US citizens, including me in a few years down the road! This really scares me to think that our government would allow CMS to close the doors to a well-qualified professional (the certified athletic trainer) who has the skill set and education to provide quality medical services to a "soon-to-be" very large population in need. It would be very different if my profession was not educated to work as an allied health professional, but we are qualified and educated to do so! I know, because I teach athletic training education and leadership every day and know what my students are studying, learning, seeing and doing as they work directly with physicians.

I am sure that you know, 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 college education, clinical experience, and national certification exam ensure that my patients receive top quality health care. As our population ages, we have many health related epidemics rising that include issues such as obesity, CVD, Diabetes, and CA, to our many thousands of military heroes who are injured and come back to our Country in dire need of quality healthcare. By the way, do you know there are certified athletic trainers providing medical services within the athletic training domains that work directly with our military in Iraq and other parts of the world, as well as on military bases here in the United States? The military understands what athletic trainers can provide! What can't CMS?

WHY WOULD YOU CHOOSE TO CLOSE DOORS TO A WELL QUALIFIED PROFESSION who already provides a very much needed service to our citizens? To me, this demonstrates very poor leadership; leadership that is choosing not to see the big picture in 5, 10, and 20 years down the road; and leadership who makes decisions before the fact-finding mission is complete and correct.

I am sure you are well aware of the lack of access (forget quality) and workforce shortage to fill therapy positions. Certified Athletic Trainers can assist with that workforce shortage. It is so irresponsible for CMS, which is supposed to be concerned with the health of Americans, to further restrict our ability, as US citizens, 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 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.

Finally, as a student *and* teacher of Steven Covey's "***The 7 Habits of Highly Effective People***", Covey states: 1. Be proactive; 2. Begin with the end in mind; 3. Put first things first; 4. Think win-win; 5. Seek first to understand, then to be understood; 6. Synergize;

and finally, 7. Sharpen the Saw. Let us work together to provide the utmost quality health care that is provided by all qualified professionals, which **ALL** Americans deserve. We ***ARE*** the greatest Country in the world, let's start fulfilling that vision.

My sincere respect to you,
Linda Platt Meyer, EdD, ATC, PES
Associate Professor
California University of Pennsylvania
meyer@cup.edu

Submitter : **Dr. Todd Knox** **Date: 08/28/2007**

Organization : **Associated Anesthesiologists of Spingfield, Ltd**

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. Gina Glick** **Date: 08/28/2007**

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
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Thank you for your consideration of this serious matter.

Sincerely,
Gina M. Glick M.D.

Submitter : **Dr. Robert DiBenedetto** **Date: 08/28/2007**

Organization : **Anesthesiology of Greenwood**

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

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Thank you,

Robert J DiBenedetto MD

Submitter : Dr. Hany Basta **Date:** 08/28/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

sec attachment

CMS-1385-P-10486-Attach-1.DOC

#10486

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

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Dr. Nicole Palmer** **Date: 08/28/2007**

Organization : **Dr. Nicole Palmer**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

Re: TECHNICAL CORRECTIONS
File Code: CMS-1385-P

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,

Nicole Palmer, D.C.

Submitter : **Dr. fatima ahmad** **Date: 08/28/2007**

Organization : **Loyola 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 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. James Noesen** **Date: 08/28/2007**

Organization : **Dr. James Noesen**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

James Noesen, M.D.

Submitter : **Dr. Patrick Boyle** **Date: 08/28/2007**

Organization : **University of Arizona Department of 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

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Thank you for your consideration of this serious matter.

Patrick Boyle
Assistant Professor of Anesthesiology
University of Arizona

Submitter : Mr. John Salva **Date:** 08/28/2007

Organization : ProCare PT

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I am a PT in PA. I work in a PT owned outpatient clinic with 2 major ortho surgeon groups. Each of those groups has opened their own PT clinic in the past year. I personally know PT's that work in each of these practices.

From one point of view, I can see the benefits of such an arrangement. PT's have guaranteed referral sources, an environment to communicate with the MD's, and access to all of the MD's notes on a particular patient.

From the other point of view, I have seen good PT's denied access to patients because they do not provide income for the MD's. I have seen pt's travel 15 or more miles because they were not informed that they could go to the privately owned PT down the street.

As for the knowledge MD's have of PT practice and what techniques would best benefit their pt's, I have found that typically surgeons have out-dated knowledge. They are not aware of current evidence-based practice which leads to "best care" for patients. I regulary see prescriptions for techniques that are out-dated or contraindicated for a particular patient.

I also argue that MD's are not concerned with what is in the best interest of the patient when it comes to quality care. Both of the groups in my area hired PT's that worked in existing practices. If the MD's thought those PT's were exceptional, then why did't they refer all of their patients to them before? Why did practices that received regular referrals see them stop?

I believe that changing the reimbursement to Physicians for POPTS would improve the overall care that patients recieve. PT's would have to prove effectiveness by getting quality results. They would not be able to relax and wait for their guaranteed paycheck.

Thank you for your time.

John Salva MPT, CSCS

Submitter : **Dr. Gina Hendren** **Date: 08/28/2007**

Organization : **Dr. Gina Hendren**

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

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

Thank you for your consideration of this serious matter.

Submitter : **Lisa Langmesser** **Date: 08/28/2007**

Organization : **University of Oregon**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Lisa Langmesser, ATC and I work at the University of Oregon in the Department of Human Physiology. I am a graduate student in an accredited Post-Professional Athletic Training Master s 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,

Lisa Langmesser, ATC

Post-Professional Graduate Athletic Training Program Student

541.731.1387
lragsdal@uoregon.edu

Submitter : **Date: 08/28/2007**

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam: My name is Sara Edwards. I am a certified Athletic Trainer in North Carolina. In May 2005, I received my degrees in Athletic Training and Biomedical Engineering (focus in rehabilitation). I worked in a hospital/school setting after I graduated and received my BOC certification at that point. At this time, I do not currently work in an athletic trainer position because I am a middle school science teacher.

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, Sara J Edwards, ATC

Submitter : **Dr. Robin Harms** **Date: 08/28/2007**

Organization : **Dr. Robin Harms**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to support the proposal to increase anesthesia payments under the 2008 physician fee schedule.

Submitter : sarah dodd **Date:** 08/28/2007

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 Sarah Dodd and I am an NATA certified athletic trainer. I work for NovaCare Rehabilitation, an outpatient physical therapy company. My role there is to provide athletic training services to a local high school as well as assist the physical therapist in the 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.

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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 Dodd, ATC

Submitter : Mr. Brian Coley **Date:** 08/28/2007

Organization : Bishop Kelley High School

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment...

CMS-1385-P-10497-Attach-1.DOC

Submitter : **James Philip** **Date: 08/28/2007**

Organization : **Brigham and Womens Physicians Organization**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re: CMS-1385-P Anesthesia Coding (Part of 5-Year Review)
I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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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 Philip

Submitter : Mr. Mark Brown **Date:** 08/28/2007

Organization : Mr. Mark Brown

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Please see the attached letter of comment regarding CMS-1385-P regarding Phyiscal Therapy Qualification standards.

CMS-1385-P-10499-Attach-1.DOC

#10499

219 Deer Trace
Pineville, LA 71360
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:

I am submitting 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." I strongly recommend 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.

Currently, *all* of the state boards of physical therapy examiners, 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, the state boards have developed a national passing score. The FSBPT has done an outstanding job of meeting the needs of the state boards and licensure examination. Likewise, the NPTE has been a valuable tool in screening physical therapist applicants. Through the NPTE, states have been able to successfully filter applicants. In turn, state boards, 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. 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. State board of physical therapy examiners 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. The passing of a second examination would be absurd and serve no additional level of competency. 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. Licensing bodies have a mission 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 state boards 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.

I strongly urge 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.

I appreciate the opportunity to comment on the proposed rules regarding physical therapist and physical therapy assistant qualification requirements.

Respectfully yours,

Mark A. Brown, PT

Mark A. Brown, PT

Proposed Physical Therapy Rule, 72 Federal Register 38230-28231 (July 12, 2007)
(critical provisions are highlighted for your convenience)

PHYSICAL THERAPIST DEFINITION

A person who is licensed by the State in which practicing and meets one of the following requirements:

(1) Requirements for individuals beginning their practice on or after January 1, 2008. Meets all practice requirements set forth by the State in which the physical therapy services are furnished and meets one of the following educational/training requirements on or after January 1, 2008:

(i) (A) Graduated after successful completion of a college or university physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE); and

(B) **Passed the National Examination approved by the American Physical Therapy Association.**

(ii) **If educated outside the United States or trained by the United States military –**

(A) **Graduated after successful completion of an educational program that, by a credentials evaluation process approved by the American Physical Therapy Association, is determined to be comparable with respect to physical therapist entry level education in the United States; and**

(B) **Passed the National Examination approved by the American Physical Therapy Association.**

***

PHYSICAL THERAPIST ASSISTANT DEFINITION

A person who meets one of the following requirements:

(1) Requirements for individuals beginning their practice on or after January 1, 2008. A person who provides certain physical therapy services under the supervision of a qualified physical therapist and is licensed, registered, certified or otherwise recognized as a physical therapist assistant, if applicable, by the State in which practicing, continues to meet all practice requirements set forth by the State in which physical therapy services are furnished, and meets one of the following educational/training requirements:

(i) Graduated after successful completion of a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association.

(ii) **If educated outside the United States or trained in the United States military, graduated after successful completion of an education program that by a credentials evaluation process approved by the American Physical Therapy Association, is determined to be comparable with respect to physical therapist assistant entry level education in the United States.**

Submitter : **Dr. Justin Gulledge** **Date: 08/28/2007**

Organization : **OU Anesthesiology**

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:

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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.

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

Thank you for your consideration of this serious matter.

Submitter : DARYL SCHLEIFER **Date:** 08/28/2007

Organization : ACA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Chiropractors have been utilizing x-rays for decades. They are necessary not just for knowing the areas to be manipulated and to avoid ,but of the utmost importanace to see possible problems of/in the bones ,joints, surrouding tissues and organs. Doctors of Chiropractic routinely find cancer and other maladies and refer out for necessary care, when the patient if not for the x-ray that we take the patient would not have know about their problem and received necessary/life-saving care. Do not take x-ray medicare/medicaid reimbursement from chiropractic doctors which is so necessary for the patient as stated above. Dr. Schleifer D.C.

Submitter : **Dr. Lucas Njo** **Date: 08/28/2007**

Organization : **D & T Anesthesia, 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:

As a practicing anesthesiologist, it is necessary that I accept CMS patients and I provide the best care I ac possibly give to all my patients. I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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Thank you for your consideration of this serious matter.

Sincerely,

Lucas Njo, MD

Submitter : **Dr. Christopher Piering** **Date: 08/28/2007**

Organization : **Camillus Chiropractic Office**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P. Technical Corrections
Dear sirs, While the goal of reducing unneccessary services is to be lauded, elimination of reimbursement for xrays ordered by a doctor of chiropractic will have a serious and adverse impact on access and costs for essential health care services for eligible Medicare beneficiaries.
This initiative would have the effect of adding the cost of x-ray to the beneficiary's out of pocket costs, or necessitate referral back to a primary care MD to obtain these films.
The effect would be to further clog the GP offices, adding costs to the system at all points.
At present, I refer these services to a medical radiologist, rather than adding to the out of pocket cost of the beneficiary by taking them in house.
Ideally, these necessary services should be covered when provided by a licensed DC, precluding the travel and delay in treatment for a person who is usually suffering and in pain.
Failing that, continuation of the current rule is the only reasonable step available.
Respectfully yours, CM Piering DC
Syracuse NY

Submitter : **Date: 08/28/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have been a physical therapist in private practice in Upland for 18 years. We have a local physcian who owns his own PT clinic and in some instances he has been known to order out patient physical therapy 2 times a day. This is not normal practice and I am sure this would not occur if he was not benefitng from this financially.

Submitter : **Dr. Donald Smith** **Date: 08/28/2007**

Organization : **Children's Hospital of New Orleans**

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.

Donald E. Smith, M.D.
Staff Anesthesiologist
Children's Hospital of New Orleans
Clinical Associate Professor of Anesthesiology
Louisiana State University School of Medicine
Clinical Associate Professor of Pediatrics
Tulane University School of Medicine

Submitter : **Dr. Howard Spang** **Date: 08/28/2007**

Organization : **Anesthesia Medical group of Santa Barbara**

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

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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,

Howard D. Spang, MD
2818 Valencia Dr.
Santa Barbara, CA 93105

Submitter : **Dr. Fernando Gavia** **Date: 08/28/2007**

Organization : **Dr. Fernando Gavia**

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

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Thank you for your consideration of this serious matter.

Fernando Gavia

Submitter : **Jennifer Krug** **Date: 08/28/2007**

Organization : **Corban College**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Currently I work at Corban College in Salem, Oregon as the Head Athletic Trainer. I have a Master of Science, am a Nationally Certified Athletic Trainer and Licensed as one in the State of Oregon. 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 Krug, ATC

Submitter : **Date: 08/28/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am currently a student athletic trainer at a four year accredited university. I am working towards my BS in Kinesiology and hope to become a certified Athletic Trainer. At the university, I assist in care prevention of injuries, first aid, rehabilitation of athletic injuries and some modalities. Being a part of this profession is something I value very much and would like to see become more successful and recognized in the future.

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.

Athletic trainer, 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 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 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,

Alexandria Lacayo

Submitter : **Dr. Joseph Kochan** **Date: 08/28/2007**

Organization : **Physician Anesthesia Service, P.C.**

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)

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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.

Joseph J. Kochan III, M.D.
Physician Anesthesia Service, P.C.
1200 E. Michigan Ave, Suite 370
Lansing, MI 48912

Submitter : Sheri Ten Broek **Date:** 08/28/2007

Organization : Sheri Ten Broek

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

I do feel that chiropractors should continue to be able to refer patients for x-rays. Chiropractic is much cheaper treatment in the long run and will save by getting people better with less cost therefore will continue to save medicare dollars. If it is taken out, chiropractors will continue to send their patients to their primary medical doctors which in turn will be more charges and higher tests in the long run. If we(chiropractors) can continue to get people better at less cost, we will save many $$$$.

Submitter : **Dr. Kwame Ohemeng** **Date: 08/28/2007**

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

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

Thank you for your consideration of this serious matter.

Submitter : **Christopher Dayger** **Date: 08/28/2007**

Organization : **Millbrook Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a Physical Therapist (and certified Athletic Trainer) working in a private outpatient orthopedic rehabilitation practice. As such, I feel uniquely qualified to comment on the appropriateness of athletic trainers providing quality physical medicine and rehabilitation services (which you should know is not the same as physical therapy). If it were, then as a physical therapist I would be at odds with my dual credentials.

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.

Athletic Trainers education, clinical experience, and national certification exam ensure that their patients receive quality health care. State law and hospital medical professionals have deemed 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(rehabilitation) 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 J Dayger PT ATC

Submitter : Dr. Vitus Chow **Date:** 08/28/2007

Organization : Dr. Vitus Chow

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10517-Attach-1.DOC

#10517

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)

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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. Jose Ramos** **Date: 08/28/2007**

Organization : **AMGSB**

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

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Thank you for your consideration of this serious matter.

Sincerely,

Jose A. Ramos MD
Anesthesia Medical Group of Santa Barbara
514 W. Pueblo St.
Santa Barbara, CA 93105

Submitter : **Dr. Marc Janson** **Date: 08/28/2007**

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
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Thank you for your consideration of this serious matter.

Submitter : **Dr. Robert Marske** **Date: 08/28/2007**

Organization : **Dr. Robert Marske**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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P.O. Box 8018
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Thank you for your consideration of this serious matter.

Sincerely yours,

Robert P. Marske, M.D.

Submitter : **Miss. Brittany Taylor** **Date: 08/28/2007**

Organization : **University of Toled/ Healtherapy Partners**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Brittany Taylor, Im a master's student at the Univcrity of Toledo in exercise science and Im also a certified athletic trainer working in the high school setting as part of my graduate assistantship.

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,

Brittany L. Taylor, ATC

Submitter : **Mr. James Ferguson** **Date: 08/28/2007**

Organization : **Proven Physical Rehab and Sports Injury Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jim Ferguson and I work for Provena St. Joes Hospital. I am assigned to a high school that with out me could not aford to have 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.

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Sincerely,

Jim Ferguson,ATC,CSCS

Submitter : **Mr. Joseph Neczek** **Date: 08/28/2007**

Organization : **Edward Hines VA Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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

I practice at the Edward Hines VA Hospital. I provide Kinesiotherapy or patients with musculoskeletal, neurological, spinal cord and traumatic brain injuries. I have earned a Masters of Science in Kinesiology/Exercise Physiology. I am a Registered Kinesiotherapist and Certified Strength and Conditioning Specialist.

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,
Joseph S. Neczek, MS, RKT, CSCS

Submitter : **Dr. John Navar** **Date: 08/28/2007**

Organization : **Dr. John Navar**

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 have practiced anesthesia for 30 years in private practice in Corpus Christi, Texas. Over these years I have seen the continued decrease in real dollar payments from Medicare for our services. I strongly applaud and submit for your consideration the recent increase that is being proposed. The availablity of our services to Medicare enrollees is at stake.

Thank you for your consideration of this serious matter.

John J. Navar, MD
607 Del Mar
Corpus Christi, Texas 78404

361-442-5610
Gulf Shore Anesthesia Associates 361-883-6211

Submitter : **Dr. Randolph Gorman** **Date: 08/28/2007**

Organization : **Dr. Randolph Gorman**

Category : **Physician**

Issue Areas/Comments

GENERAL

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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. Grace Huang **Date:** 08/28/2007

Organization : Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

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