CMS-1385-P-10091

Submitter : **Dr. Christian Losch** **Date: 08/28/2007**

Organization : **Dr. Christian Losch**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Just a quick note to say thanks for considering the very long overdue payment increase for anesthesia services in 2008. Anesthesia services have long been extremely undervalued in current and previous payment plans. I strongly support the increase.

CMS-1385-P-10092

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

Organization : Carle Foundation Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dcar Sir or Madam:

I work for Carle Foundation Hospital as an athletic trainer in an outreach clinic that provides rehabilitation services and event coverage for our community. I have a Bachelor's degree and I am nationally certified and licensed by the State of Illinois to perform these services.

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

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

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

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

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

Sincerely,

Jason Heinold, ATC, NAMS-PES

Submitter : Dr. Bryan Reuss

Organization : Orlando Orthopaedic Center

Date: 08/28/2007

Category : Physician

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am an Orthopaedic Surgeon working in Orlando at the Orlando Orthopaedic Center.

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

Submitter : **Dr. Keith Brickell** **Date: 08/28/2007**

Organization : **Brickell Chiropractic Center**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

While subluxation need not always be detected by X-ray, it is very often the case that a patient requires an X-ray to rule out any contraindications to chiropractic care or to determine appropriate treatment options. X-rays may also be required to help determine the need for further diagnostic testing, such as an MRI, or for a referral to an appropriate health care specialist.

CMS-1385-P-10095

Submitter : Dr. Sheila Rajaratnam **Date:** 08/28/2007

Organization : Dr. Sheila Rajaratnam

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Sheila Rajaratnam, M.D.

Submitter : Mr. Christopher Frey **Date:** 08/28/2007

Organization : NovaCare

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 at North Penn High School.

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

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

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

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

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

Sincerely,

Christopher Frey, M.Ed., ATC

Submitter : Ms. persis flor **Date: 08/28/2007**

Organization : Ms. persis flor

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a self employed Athletic Trainer and Nutritionist practicing in the state of New York.

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,

Persis Flor, MS ATC

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

Organization : **Dr. James Earley**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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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,

James R. Earley, M.D.

CMS-1385-P-10099

Submitter : **Miss. Catherine Bowen** **Date: 08/28/2007**

Organization : **Miss. Catherine Bowen**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Three months ago I became a certified athletic trainer. The preparation to take the certification exam was a long, intense, but worthwhile process. Thanks to the good preparation I was given, I was able to pass the board of certification exam on the first attempt. I believe an athletic training undergraduate program is one of the most rigorous programs a university can offer. I graduated from my program with a great deal of diagnostic and medical knowledge. I am currently finishing my second undergraduate degree in secondary education. My specific area is life science. Many of the courses I have taken for the science education degree have also included students from medical pre-professional programs. I have had many conversations with these students and have found that athletic trainers receive the most extensive knowledge of the human body and medicine than any other undergraduate student. I realize these other students go on to learn much about medicine in their graduate programs, but athletic trainers are very qualified to work as allied health care professionals after their undergraduate studies.

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,

Catherine Bowen, ATC

CMS-1385-P-10100

Submitter : **Miss. Dusti O'Berry** **Date: 08/28/2007**

Organization : **Department of Veterans Affairs-Alvin C. York VAMC**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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

BRIEF INTRO ABOUT SELF:Name: Dusti J. O'Berry. Place of Practice: Alvin C. York VAMC Registered Kinesiotherapist. Provide broad scope of therapies to all Veterans including acute and long term psychology involvement in exercise, Drug and Alcohol Abuse Programs, Outpatient Exercise Clinics, Personalized exercise instruction, Prosthetic/Orthotic equipment evaluations, gait training acute and chronic cardiac, stroke and debility rehabilitation, participating provider in the MOVE! exercise program. Graduate of The University of Southern Mississippi, B.S. degree in Health and Human Performance Emphasis: Kinesiotherapy. Registered Kinesiotherapist, member of the AKTA in active/good standing since 2003.

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,

Dusti J. O'Berry, RKT

CMS-1385-P-10101

Submitter : **Mrs. Marilyn Houck** **Date: 08/28/2007**

Organization : **Mercersburg Academy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To whom it may concern:

I am a NATA Certified Athletic Trainer working in a private high school setting for 21 years. I am responsible for the immediate care, treatment and rehabilitation for approximately 275 high school athletes. My education has consisted of 6 years of coursework and training under qualified NATA 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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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,

Marilyn Houck, ATC, MSE
Head Athletic Trainer
Mercersburg Academy
300 E. Seminary St.
Mercersburg, PA 17236

CMS-1385-P-10102

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

Organization : Cornerstone University

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Philip Keith. I am employed as a Certified Athletic Trainer at Cornerstone University in Grand Rapids, Michigan. I have A MS in Education and a BS in Sports Medicine. I am certified by the National Athletic Trainers' Association and the National Strength and Conditioning Association.

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,

Philip Keith MS, ATC, CSCS

Submitter : Mr. Richard Frazee **Date:** 08/28/2007

Organization : University of West Florida

Category : Academic

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am a certified arthletic and have been involved in the education of entry-level athletic trainers for the past twenty years. I am very proud of the contributions that our profession makes toward the delivery of quality health care to all levels of physically active individuals. The athletic training profession has long been recognized as ahighly qualified provider of healthcare.
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,
Richard Frazee, ATC, LAT
Program Director, Athletic Training Education
University of West Florida
Building 72, Room 247
Pensacola FL 32514

Submitter : **Dr. Jason McIntyre, DPT, ATC** **Date: 08/28/2007**

Organization : **UPMC Sports Medicine and UPMC Braddock Hospital**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I'm a doctor of physical therapy and certified athletic trainer working in Pittsburgh, PA. My physical therapy patients have benefited from the access to Certified Athletic Trainers as supplemental staff in the outpatient physical therapy clinic. Certified Athletic Trainers (ATC's) are highly skilled in rehab exercise and modalities and are much more useful aides in the clinic than uncertified physical therapy aides that are usually undergraduates in college seeking clinical observation experience.

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,

Dr. Jason McIntyre, DPT, ATC

Submitter : Dr. Mary Ellen Raux **Date:** 08/28/2007

Organization : Dr. Mary Ellen Raux

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.

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

Thank you for your consideration of this serious matter.

Sincerely,

Mary Ellen Raux, M.D.

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

Organization : **Alvin C. York V. A. Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

BRIEF INTRO ABOUT SELF: Tammy Burton, Alvin C. York VAMC. I am a Regristered Kinesiotherapist with a BS in Exercise Physiologist.
Place of Practice: Alvin C. York VAMC Registered Kinesiotherapist. Provide broad scope of therapies to all Veterans including acute and long term psychology involvement in exercise, Drug and Alcohol Abuse Programs, Outpatient Exercise Clinics, Personalized exercise instruction, Prosthetic/Orthotic equipment evaluations, gait training acute and chronic cardiac, stroke and debility rehabilitation, participating provider in the MOVE! exercise program. Registered Kinesiotherapist, member of the AKTA in active/good standing since 1990.

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?

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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,
Tammy Burton, RKT

Submitter : Mrs. Susan Houck

Date: 08/28/2007

Organization : OUHSC Department of Anesthesiology

Category : Individual

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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.

Susan Houck

Submitter : **Ms. LEESA DAVIS** **Date: 08/28/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

RE: CMS 1385 P (BACKGROUND, IMPACT)
ANESTHESIA SERVICES

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

LEESA F. DAVIS, BSN,MSN,CRNA
338 COLINWOOD DRIVE
FAYETTEVILLE, NORTH CAROLINA 28303

Submitter : Dr. Francis kumar **Date:** 08/28/2007

Organization : ouhsc

Category : Physician

Issue Areas/Comments

Impact

Impact

would you please compensate for anesthesia sevices thru Medicare? we need your help. Pay increase will help residency programs

CMS-1385-P-10110

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

Organization : Lindenwood University

Category : Other Health Care Provider

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am a Certified Athletic Training that works in the educational world preparing athletic training students to enter the job market. I have been the Program Director at Lindenwood University for the last 10 years. My previous employment, for 20 years, was in the clinical setting working on physically active individuals. I was one of the first Certified Athletic Trainers to work in the clinical setting.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Randy L. Biggerstaff, MS, ATC, LAT
Manager Health Science Department

Submitter : **Mr. Donnie McCoy** **Date: 08/28/2007**

Organization : **Mr. Donnie McCoy**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mr. Kyle Stanley **Date:** 08/28/2007

Organization : Mr. Kyle Stanley

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Kyle Stanley. I am a NATA board certified athletic trainer that acquired my degree from Washington State University. I currently work at Virginia Mason Medical Center, and Seattle University, both in Seattle Washington. As a certified athletic trainer(soon to be licenced in Washington State per a recently passed law)at Seattle University it is my responsibility to prevent, treat and rehabilitate injuries that athletes incur during regular practices and competitive events. In the hospital I am involved with the Physical Medicine and Rehabilitation program where I work side by side with both physical and occupational therapists in the Work Conditioning 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,

Kyle T Stanley, ATC

CMS-1385-P-10113

Submitter : **Dr. Michael Mullens** **Date: 08/28/2007**

Organization : **UT-Houston Medical School**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-10114

Submitter : Dr. Jane Fitch **Date:** 08/28/2007

Organization : OUHSC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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.

I chair an academic anesthesiology program and we are having difficulty fulfilling our academic mission of training the next generation of anesthesiologist, in part to the inadequate reimbursement. Please increase the anesthesia conversion factor.

CMS-1385-P-10115

Submitter : Dr. francis kumar **Date:** 08/28/2007

Organization : ouhsc

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-10116

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

Organization : Advanced Sports Medicine and Orthopaedics

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 Surgical Technologist working in San Antonio TX.

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,

Jeffery L Potthoff, ATC, LAT, CST

CMS-1385-P-10117

Submitter : **Dr. Stephen J Copeland** **Date: 08/28/2007**

Organization : **Anesthesiology - Wake Forest University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

ATTENTION:CMS-1385-P
I strongly support implementation of RUC's recommendation to increase anesthesia payments under 2008 Physician Fee Schedule. Thank you.

Stephen J Copeland, MD
Assistant Professor of Anesthesiology
Wake Forest University School of Medicine

Submitter : Mr. melvin johnson

Organization : melvin johnson

Date: 08/28/2007

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Melvin Johnson

CMS-1385-P-10119

Submitter : Dr. Marcy Taylor **Date:** 08/28/2007

Organization : Anesthesia Consultants of Indianapolis

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Marcy Taylor, M.D.

CMS-1385-P-10120

Submitter : Mrs. Sandra Weems

Date: 08/28/2007

Organization : Mrs. Sandra Weems

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-10121

Submitter : **Dr. mark willis** **Date: 08/28/2007**

Organization : **anesthesia consultants medical group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Mark L. Willis M.D.

CMS-1385-P-10122

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Points to consider: 1.Having separate ownership creates a checks and balance system between professionals to determine medical necessity.2.Care under physician owned facilities may allow for potentially unlicensed personnel to perform treatment due to physician scope to practice.3.When considering that for a surgery to be fully successful, a pt. must return to normal function, why should a physician be allowed to collect off the work that we are trained as professional to perform. We are not eligible, nor should we be, to collect from the physicians surgery yet we must work hand in hand to achieve the desired outcomes.

Submitter : **Ms. Colleen Whalin** **Date: 08/28/2007**

Organization : **Advantage Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Colleen Whalin and I am a certified athletic trainer working on an outpatient physical therapy clinic in Ventura, CA. I graduated from an accreditied athletic training education program, from Indiana University and recieved my Masters of Science in Sports Medicine from Oregon State University.

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

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

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

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

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

Sincerely,

Colleen MF Whalin, MS, ATC

CMS-1385-P-10124

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

Organization : **Excel Sports and Physical Therapy**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer (ATC) in the state of Missouri. I am certified by the National Athletic Trainers' Association Board of Certification and licensed in the state of Missouri. I have been practicing as an ATC for 10 years and am currently employed in an outpatient injury rehabilitation clinic. I provide medical services to athletes at a local high school and coordinate wellness programs to area businesses.

My education consists of a four year, bachelor's degree in Athletic Training/Sports Medicine. My education consisted of class instruction in injury evaluation, injury rehabilitation, administration, and counseling. I received both classroom instruction and practical instruction through intense hands-on 'clinicals' in which I was highly trained in the above mentioned areas.

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. To disregard Certified Athletic Trainers as rehabilitation specialists, or even as medical professionals (as the American Medical Association has recognized ATC's as), is to completely ignore and deny the ATC's established qualifications as specialists due to our high quality education and training.

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,

Nathan Place ATC, CSCS

Submitter : **Mrs. marian maher** **Date: 08/28/2007**

Organization : **Bronx VA Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a Registered Kinesiotherapist working for the past 20+ years at the Bronx VA Medical Center.

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.

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,
Marian Maher, RKT

Submitter : **Dr. Seth Wolin** **Date: 08/28/2007**

Organization : **North Castle Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Regarding the proposed rule in the Federal Register that would eliminate patient reimbursement for X-rays taken by a radiologist or other non-treating physician and then used by a doctor of chiropractic, this rule would serve dual negative purposes.

First, it would place an undue financial burden on Medicare beneficiaries, and/or CMS. By eliminating reimbursement for x-rays taken by a radiologist on referral by a D.C., the patient will either have to lay out money from his/her own pocket, or see his/her primary care physician for the purpose of obtaining the referral in order to be eligible for reimbursement. (The PCP will invariably then bill Medicare for the visit - a visit which is unnecessary, other than for insurance coverage purposes re: the x-ray.)

The second negative effect is that this rule would create an impediment to the treating chiropractor obtaining diagnostic information required to accurately diagnose and treat the patient. While x-rays are not usually necessary to diagnose a subluxation, they are often necessary to rule out contraindications to manipulative therapy. On that basis alone, this ruling would create patient safety and risk management concerns which are unacceptable.

Please do not implement this rule. It will most certainly cost the system more money while increasing patient risk and chiropractic physician malpractice exposure.

Thank you,

Seth Wolin, D.C., D.A.B.C.O.

CMS-1385-P-10127

Submitter : Mr. Zachary Hunt **Date:** 08/28/2007

Organization : Lima Memorial Health Systems

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Zachary Hunt. I am a graduate of Anderson University. I have a Bachlor of Arts in Athletic Training. We as athletic trainers are more than capable of working with medicare and or medicaid patients. To say that we are not is a ludicris statement. Atheltic Trainers education is much more intensive than that of a PTA. Therefore, athletic trainers can do anything and everything a PTA can do.

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

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

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

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

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

Sincerely,

Zachary Hunt ATC, LAT

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

Organization : **Ministry**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To whom it may concern,
I have been a Licensed Athletic Trainer in the state of Wisconsin for 16 years. During this time I have provided rehabilitation to the elderly with total joint replacements, emergency services at athletic events for cervical fractures and currently in the occupational health setting to prevent injuries and help reduce worker compensation claims for companies. The limiting of my services causes concern. I feel I provide a crucial service from the elderly man who can now walk pain free, to the young man who would have been in a wheelchair if the coach's would have moved him if I had not stopped them. These patients of mine and many others are now contributing members to society.The political process of health care providers from different domains fighting each other I feel takes services away from patients.Please I urge to consider the patients in this decision, and not lobbyist.
Thank you,
Brian Pacyna
Licensed Athletic Trainer

CMS-1385-P-10129

Submitter : Ms. Allison Tresca **Date:** 08/28/2007

Organization : Nevada State Board of Physical Therapy

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10130

Submitter : Rene' Van Calster

Organization : Prevea Health

Category : Individual

Date: 08/28/2007

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

At Prevea Health in Green Bay Wi, we are in the process of implementing an Electronic Health Record. Our vendor for this product is Epic out of Madison WI. At Prevea we currently fax an average of 24,000 medications a month to area pharmacies, using the Epic system. Some of these pharmacies are larger chains, but many of them are small independently owned pharmacies in the more rural areas of Wisconsin.

By changing to a fax methodology for delivering prescriptions a couple years ago, we have significantly improved the quality of care over what was being done in the paper world. Our system now enables providers to do interaction checking, as well as decreasing the potential for errors not only in ordering but also in the legibility issues that happen with a hand written prescription. We have had a lot of positive feedback from out local pharmacies, as we implemented this new process. By eliminating the exemption for faxing of Medicare Part D prescriptions in the proposed time frame, we will most likely have to revert back to a paper system for all our prescriptions. This could potentially compromise the safety and well being of our patients.

We believe that E-prescribing is the safest and most secure method for communicating prescriptions to pharmacies. We also support the push to make electronic prescriptions the standard for the country. However, we believe that eliminating the ability to fax prescriptions by January 2009 is too soon. A date of January 2010 would give us in the clinic setting, as well as those in the pharmacy setting, more time to make sure that implementing this new technology is done so without adverse outcomes for our patients.

The cost to Prevea Clinic to implement E-prescribing will be approximately $50,000.00. This is a significant cost to incur, and requires careful planning on budgeting to make it happen. In addition to the implementation costs, there is also legislation that needs to be caught up with this requirement as well. Things like how to address scheduled medications, such as narcotics need to be addressed.

Another concern that our organization has is that there are only a few major third party intermediaries. How will these few companies be able to handle the mass system change with so many customers in a limited amount of time?

Finally, other Epic customers we have talked to about E-prescribing shared that they use faxing as a back up if there are transaction failures electronically. What is going to be the back up system available now, if faxing is not an option? So while decreasing the number of faxed prescriptions is desirable, I am not sure realistically that it can be eliminated altogether.

Thank you for your consideration of these recommendations.

CMS-1385-P-10131

Submitter : **Mr. michael Gnacinski** **Date: 08/28/2007**

Organization : **concordia university of wisconsin**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Michael Gnacinski, I am a graduate assistant athletic trainer at concordia university of wisconsin. I provide athletic training services to the student athletes here at the university. I have recently graduated from the niversity of wisconsin eau claire with a BS in athletic training and am currently pursuing my masters in Rehabilitation Science.

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

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

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

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

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

Sincerely,

Michael Gnacinski, ATC
Concordia University Wisconsin
Graduate Assistant, Athletic Training
12800 N. Lake Shore Dr.
Mequon, WI 53097
262.893.4505 (cell)
262.243.2969 (fax)
michael.gnacinski@cuw.edu

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

Organization :

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Mark Alcid,MD

Submitter : Ms. Gwendolyn Davis **Date:** 08/28/2007

Organization : Clemson University Athletic Department

Category : Other Practitioner

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Hello, I am Gwendolyn Davis, a graduate assistant athletic trainer for men's track and field at Clemson University. I am a recent graduate of Texas State University - San Marcos. I am licensed in the state of Texas and Certified nationally to practice athletic training.

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

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

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

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

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

Sincerely,

Gwendolyn D. Davis, ATC, LAT

CMS-1385-P-10134

Submitter : **Mr. Horace Elliott** **Date: 08/28/2007**

Organization : **National Board of Chiropractic Examiners**

Category : **Individual**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

As a patient and party interested in fair and unbiased treatment when it comes to chiropractic services reimbursements, I strongly oppose the proposed CMS rule under CMS-1385-P. It is discriminatory and puts chiropractic patients at risk, as it will hinder referrals and the free flow of diagnostic information necessary to treat. I would ask, what is the reason for the new rule and where did it originate? Is it just another attack on chiropractic by the medical establishment?

Submitter : Dr. Jeffrey Miller **Date:** 08/28/2007

Organization : OUHSC-Dept 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
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.

Jeffrey Miller

Submitter : Dr. Szu Nien Yeh

Date: 08/28/2007

Organization : ACI

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-10137

Submitter : Mr. Ryan Clark **Date:** 08/28/2007

Organization : Athletic & Rehabilitation Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Ryan N. Clark. I am the Director or Rehabilitation of Athletic & Rehabilitation Center in Kansas City, MO. I am a certified athletic trainer and have earned my masters degree in exercise physiology with an emphasis in biochemisty and sports nutrition. I have also obtained my certified strength and conditioning specialist certification. (CSCS)

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

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

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

Sincerely,

Ryan N. Clark MS, ATC-LAT, CSCS

CMS-1385-P-10138

Submitter : Mr. Lun Fen Yeh **Date:** 08/28/2007

Organization : None

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Brian Zeller** **Date: 08/28/2007**

Organization : **Winona State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Brian Zeller and I am a Certified Athletic Trainer (ATC), professor and clinical educator at Winona State University in Winona, Minnesota. My primary role at Winona State University is to educate athletic training students into becoming OUTSTANDING allied health professions who are skilled in the prevention, evaluation, treatment and rehabilitation of our patients. Personally, I have an undergraduate and graduate degree specifically in athletic training and a Doctor of Philosophy (PhD) degree in Exercise Science. .

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

Submitter : **Ms. Anne M. Felts** **Date: 08/28/2007**

Organization : **Advance Rehabilitation**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

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

I am concerned that these proposed rules will create additional lack of access to quality health care for my patients. I have been a Certified Athletic Trainer for over 13 years, 10 of which have been spent in the clinical setting rather than a traditional high school or college. I have spent time extending my education by both seeking a Masters Degree and taking classes to enchance my knowledge of complicated subject mattter such as neurological rehabilitation. I and my co-workers who are Physical Therapist see no difference in my standard of care and outcomes.

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

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

Organization : **Eastern Washington University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Eric Gunning. I am a certified athletic trainer at Eastern Washington University, where I provide care for injury pevention, evaluation, and management.

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,

Eric Gunning, MSEd, ATC

Submitter : Mrs. Michele Lorenzo

Date: 08/28/2007

Organization : noen

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Lcslic V. Norwalk, Esq.
Acting Administrator
Ccntcrs for Mcdicarc and Medicaid Scrvices
Attcntion: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

Rc: CMS-1385-P
Ancsthesia Coding (Part of 5-Year Revicw)

Dcar Ms. Norwalk:

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

Whcn thc RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly duc to significant undervaluation of anesthesia work compared to othcr physician scrviccs. Today, more than a decade sincc 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 arcas with disproportionatcly high Medicare populations.

In an cffort to rcctify this untenable situation, the RUC rccommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undcrvaluation-a move that would rcsult in an incrcase of nearly $4.00 per anesthesia unit and scrve as a major step forward in correcting the long-standing undcrvaluation of ancsthcsia scrviccs. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensurc that our patients have access to expert anesthesiology medical carc, 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 considcration of this serious matter.

Submitter : **Mr. Todd martin** **Date: 08/28/2007**

Organization : **Mr. Todd martin**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Todd Martin ATC
Hanover PA
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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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,

Todd Martin ATC

Submitter : **Dr. Martin Lupowitz** **Date: 08/28/2007**

Organization : **Accord Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

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,
Martin Lupowitz, D.C.

Submitter : Dr. Karen Hostetter

Date: 08/28/2007

Organization : New Mexico State University

Category : Academic

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have attached a file with my comments.

CMS-1385-P-10147-Attach-1.DOC

#10147

Dear Sir or Madam:

My name is Karen Hostetter. I have been a certified athletic trainer since 1993, and have worked in several settings, including traditional high school and college athletic training rooms, and physical therapy clinics. My current position as Program Director for the athletic training education program at New Mexico State University provides me with the opportunity to encourage students to pursue their goals of working in the health care industry. 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,

Karen Hostetter, PhD, ATC
Athletic Training Education Program Director
New Mexico State University
MSC 3FAC, Box 30001
Las Cruces, New Mexico 88003-0001

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

Organization : **AthletiCo LTD**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Nt name is Jim Tyrrell. I am an athletic trainer employed by an outpatient rehabiliation center in Chicago, Illinois. I have been a certified athletic trainer for 8 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.

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Sincerely,

Jim Tyrrell ATC, CSCS

Submitter : **Ms. Mary Manning** **Date: 08/28/2007**

Organization : **Pasco Hernando Community College**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I currently work at Pasco Hernando Community College as a licensed Athletic Trainer in the state of Florida. I have a masters in education and have been certified by the National Athletic Trainers Association since 1988 and worked in a hospital/clinic setting until I became licensed in Florida 2005.

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 recieved 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 recieve quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attemp 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, espically those in rural areas, to further restrict their ability to recieve those services. The flexibile current standards of staffing in hospitals and the other rehabilitation facilities are pertinent in ensuring patient recieve the best, most cost-effective treatments 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 resoectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Mary C. Manning, ATC

Submitter : **Mr. Jeff Thomas** **Date: 08/28/2007**

Organization : **Chicago Blackhawks / AthletiCo PT**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
BRIEF INTRO ABOUT SELF ie. Where you work, what you do, education, certification, etc.

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

Submitter : **Dr. Nancy Greilich** **Date: 08/28/2007**

Organization : **UT Southwestern Medical School**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Nancy B Greilich MD
Associate Professor,
UT Southwestern Medical Center
Dallas TX 75930

CMS-1385-P-10152

Submitter : Dr. Victor Kuchmaner **Date:** 08/28/2007

Organization : Kuchmaner Chiropractic

Category : Physician

Issue Areas/Comments

Technical Corrections

Technical Corrections

I am writing in concerns to the proposed rule dated July 12th 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 strongly disagree with this proposal. These X-rays are needed for the overall treatment of the patient and are beneficial to the treatment and diagnosis. Please consider the importance of this service.

Thank you,
Dr. V.A. Kuchmaner

Submitter : Dr. Jeffrey Peak **Date:** 08/28/2007

Organization : Dr. Jeffrey Peak

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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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 : Carol Gordon

Date: 08/28/2007

Organization : Elmhurst Rehabilitation S.C.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

see attachment

CMS-1385-P-10154-Attach-1.DOC

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

Organization : Institute for Athletic Medicine

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an Athletic Trainer in the secondary school setting and also in a clinical setting. I am at Coon Rapids High School, MN and also work part-time at a physical therapy clinic in Minneapolis, MN. I have a four year bachelor of science degree in Athletic Training from North Dakota State Univeristy and am BOC certified as an Athletic Trainer

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

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

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

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

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

Sincerely,

Jeremy Donner, ATC

Submitter : Mr. Brian Maddy

Date: 08/28/2007

Organization : OU Physicians

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

see attachment

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

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-10158

Submitter : **Mr. chad hopkins** **Date: 08/28/2007**

Organization : **Carle Foundation Hospital Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Certified Athletic Trainer working in a Sports Medicine department that is affiliated with Carle Foundation Hospital. I have a Master's degree and attend several continuing education seminars each year to keep current with the latest techiques. My duties include providing rehabilitation to concervative care athletes in order for them to return to play safely, as well as post surgical athletes.

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

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

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

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

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

Sincerely,

Chad Hopkins, MS,ATC

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

Organization : **OU Physicians**

Category : **State Government**

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. cheryl mcfarland-bryant **Date:** 08/28/2007

Organization : Better health Chiropractic,P.A.

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

It is important to see recent x-rays to rule out fractures on medicare patients prior to adjusting their spines. You are doing them a disservice to eliminate re-imbursement for this. Please reconsider. Chiropractic patients value this service.

CMS-1385-P-10161

Submitter : **Mr. Scott La Falce** **Date: 08/28/2007**

Organization : **Cherokee Medical**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Scott La Falce. I am a certified athletic trainer who holds a master's degree in education. I have worked as a medical provider, treating patients within the scope of my practice, in the United States Navy for the past four years. I have also worked with professional football teams, high school athletics, and in outpatient physical therapy clinics in my professional career. It is ridiculous that healthcare professionals, such as athletic trainers, have to fight for the right to practice within their scope.

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

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

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

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

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

Sincerely,

Scott La Falce, MA, ATC

Submitter : **Dr. Ernesto Rodriguez** **Date: 08/28/2007**

Organization : **Dr. Ernesto Rodriguez**

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.
Ernesto O. Rodriguez, M.D.

Submitter : **Mrs. Joelle Beaudoin** **Date: 08/28/2007**

Organization : **Northern Michigan Sports Medicine Center**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am a Certified Athletic Trainer who has been practicing for 7 years. I graduated from Central Michigan University with a degree in sports medicine /athletic training. I have worked in northern michigan in an out patient physical therapy clinic, while contracting to a rural secondary high school for athletic training services. Due to schools having such little money to pay full time ATC's salaries, the only feasible option to work full time is to contract with a rehab facility. Our Sports medicine/physical therapy clinic (Northern Michigan Sports Medicine Center) provides jobs to 10 athletic trainers with secondary school contracts. Without clinical positions available for ATC's to practice, this will jepordize thousands of high schools in obtaining athletic training services.
I strongly oppose 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. The amount of jobs and schools that will be harmed by this proposed ammendment will be detremental.

Sincerely,
Joelle Beaudoin, ATC
Out Reach Coordinator of NMSMC

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

Organization : Dr. Robert LoGreco

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.

Robert LoGreco, M.D.

Submitter : Lisa Kluchurosky

Date: 08/28/2007

Organization : Columbus Children's Hospital

Category : Hospital

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 28, 2007

To Whom It May Concern:

My name is Lisa Kluchurosky, and I am a certified and licensed athletic trainer in the State of Ohio. I am the Program Manager for the Sports Medicine Department at Columbus Children s Hospital in Ohio.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the physician self-referral provisions proposed in 1385-P.

Initially, I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting. CMS seems to have come to these proposed changes without clinical or financial justification, and without the input of various healthcare professionals who will be tasked with hiring enough staff to adequately treat our therapy patients.

The workforce shortage to fill therapy positions is widely known throughout the industry. Given these known shortages, it would seem CMS would want to do all they can to ensure all Americans have access to the therapy services they need, particularly in some of the more rural or underserved areas of the country. Instead, the provisions in 1385-P would put another obstacle in front of many Americans and deny them the access to qualified healthcare providers to meet their medical needs.

The current standards of staffing in hospitals and other rehabilitation facilities flexibility are pertinent in ensuring patients receive the best, most cost-effective treatment available. Hospital administrators and managers are charged with filling these jobs with the most qualified people to provide therapy services and ensuring the safety and well-being of our patients. I would ask that CMS allow hospital administrators (such as me) to make these staffing decisions in accordance with state law and in the best interest of our patients and our facility.

Current hospital Conditions of Practice, state law and hospital medical professionals have given me the authority to determine who is qualified to provide rehabilitation services. These proposed regulations attempt to circumvent those standards.

I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day healthcare needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B rehabilitation facility.

Sincerely,

Lisa K. Kluchurosky, MEd, ATC

Submitter : **Dr. Lee Berens** **Date: 08/28/2007**

Organization : **Dr. Lee Berens**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Centers for Medicare services
Baltimore 21244

Re: CMS-1385-P

Dear Ms. Norwalk:

I am appreciative that CMS is taking steps to rectify the substantial undervaluation of anesthesia services and am writing to support the proposed increase of payment for anesthesia services.

I appreciate that the Agency has accepted the recommendation of a revision to the RBRVS system and hope that the recommendation will be fully implemented.

Thank you for your attention to this matter.

Sincerely,

Lee Berens MD

Submitter : Dr. Corrie Pillon **Date:** 08/28/2007

Organization : Genesis Chiropractic

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Corrie L. Pillon

CMS-1385-P-10168

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

Organization : **Cleveland Clinic**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Mark Schauer, I am employed by the Cleveland Clinic, Cleveland, OH. I am an Administrator in the Department of Orthopaedics and practicing Athletic Trainer. I have practiced as an Athletic Trainer over the past 19 years in many settings including the clinical outpatient setting, working side by side with Physical Therapists. Recently I became aware of proposed changes that will greatly effect the care that we provide for our patients at Cleveland Clinic as a part of an integrated health care 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.

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

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

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

Sincerely,

Mark D. Schauer, MA, MBA, ATC

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

Organization : **Arkansas Pathology Associates, P.A.**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am submitting comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions To Payment Policies Under The Physician Fee Schedule For Calendar Year 2008 . I am a board-certified Pathologist and a member of the College of American Pathologists. My practice is located in Little Rock, Arkansas, and I am a partner in this group of nine Pathologists who own an independent pathology laboratory.
I am encouraged that CMS is undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark Law prohibition against physician self-referrals, and I support revisions to close the loopholes that allow physicians to profit from pathology services.
In Arkansas, I am aware of a certain large urology group that traditionally performed two part prostate biopsies for years and the local pathology providers turned these diagnostic reports around in 24 hours. There was frequent and collegial communication among the physicians and good continuity of care on subsequent prostatectomies. When this urology group developed their own in-house pathology/histology lab, they began and still perform twelve part (or more) prostate biopsy series per patient. Diagnostic quality and turn-around time did not diminish because of this, but continuity of care was negatively impacted. This also created a poor collegial environment between the urology group and local Pathologists. The statement that twelve part biopsies are a trend or standard of care rings hollow as no other Urologists in the state of Arkansas are routinely performing twelve part biopsies on their patients. Most other Urologists still perform two or six part biopsies per patient.
There also does not appear to be any added benefit to the patient receiving a twelve part biopsy series in terms of treatment. This method of biopsy only results in increased diagnosis of minimal prostate disease or atypical small acinar proliferations which propagate only further biopsies and increased medical costs to the patient/insurer. The Urologist s argument that this is standard of care is made more fallacious by the fact that when members of this particular urology group perform prostate biopsies in local hospitals (out of their own facility), they are only doing two part biopsies on Medicare and non-Medicare patients alike. It is all too obvious that they are using the in-office ancillary exception purely for financial gain at the expense of the patient/insurer. This is an abuse of the current loophole which is the in-office ancillary pathology service exception. This loophole has made a mockery of Pathology as a professional service and threatens the core of our profession.
I implore CMS to consider modification of the current law such that these loopholes which allow for illegitimate and abusive profit will be closed. Specifically I support the expansion of the antimark-up rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary service exception to the Stark Law. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
I agree that the Medicare Program should ensure that providers furnish care in the best interest of their patient s, and restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program

CMS-1385-P-10170

Submitter : **Dr. Stephen Campbell** **Date: 08/28/2007**

Organization : **AAOC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I urge you to continue to ensure access to high quality anesthesia service and support the CMS proposal to increase reembursment to anesthesia providers.

Submitter : Mrs. Carla McSpadden **Date:** 08/28/2007

Organization : American Society of Consultant Pharmacists

Category : Pharmacist

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

See Attachment

CMS-1385-P-10171-Attach-1.PDF

#10171

American Society of Consultant Pharmacists
1321 Duke St.
Alexandria, VA 22314-3563
Phone: 703-739-1300
FAX: 703-739-1321
E-mail: info@ascp.com
www.ascp.com

August 28, 2007

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

Re: CMS-1385-P; PROPOSED ELIMINATION OF EXEMPTION FOR COMPUTER-GENERATED FACSIMILES

To Whom it May Concern:

The American Society of Consultant Pharmacists is pleased to offer comments to the Centers for Medicare and Medicaid Services on the elimination of the exemption for computer-generated facsimiles included in proposed rule CMS-1385-P issued July 2, 2007.

The American Society of Consultant Pharmacists (ASCP) is the international professional association that provides leadership, education, advocacy, and resources to advance the practice of senior care pharmacy. ASCP's 8,000+ members manage and improve medication therapy and improve the quality of life of geriatric patients and other individuals residing in a variety of environments, including nursing facilities, subacute care and assisted living facilities, psychiatric hospitals, hospice programs, and home and community-based care.

Despite having recently completed a successful pilot study on electronic prescribing in the long-term care setting, the current e-prescribing environment is still limited in the long-term care industry. Reasons for this include the costs of buying and installing a system, training involved, time and workflow impact, and lack of reimbursement for costs and resources. However, the distinct difference in the long-term care setting is that all of these potential barriers apply not only to prescribers and pharmacies, but also to the nursing facilities. While pharmacies rely heavily on computer technology and some are already capable of utilizing e-prescribing, many independently-owned nursing facilities have yet to adopt technology other than the computers in their administrative and billing offices. In fact, most long-term care facilities still utilize manual charting processes and the pharmacies provide the

medical records. CMS states in their final e-prescribing rule that "less than 30 percent of nursing homes have computer access at the nursing station." That being said, many long-term care providers realize the potential efficiencies related to technology implementation as evidenced by the increasing implementation of electronic medication administration records (eMARs), stand-alone electronic health records, and computer-generated faxes for order management. However, these are just initial steps toward adoption of fully interoperable electronic health records and data exchange.

CMS has recognized the differences between the long-term care and ambulatory settings in their e-prescribing final rule published on November 7, 2005. In that document, CMS states:

> "We agree that the nursing home industry standard practice is not conducive to early application of e-prescribing standards. The foundation standards that have been adequately tested in the ambulatory setting may not be directly transferable to the LTC setting for several reasons... The current practice is for written orders to be faxed to the pharmacist as well as transcribed onto the Plan of Care at the nursing station. These intermediate steps would need to be developed separately in an e-prescribing system."

The last sentence of the above quote is an important point. The steps necessary for complete medication management in the long-term care setting are quite different than in the ambulatory setting; the unique challenges in long-term care require special planning and a unique timeline for widespread implementation. It is for these reasons that CMS, in the final rule, did not require application of the foundation e-prescribing standards in the long-term care setting:

> "...we exempt from the requirement to use NCPDP SCRIPT Standard prescription transactions between prescribers and dispensers where a non-prescribing provider is required by law to be a part of the overall transaction process."

Because the proposed rule eliminating computer-generated faxes specifically mentions the SCRIPT standard and CMS previously exempted long-term care transactions from using SCRIPT (as seen above), it is our understanding that the new proposed rule does not apply currently to long-term care. However, ASCP is requesting formal clarification on this point.

Eventually, ASCP would like to see full adoption of e-prescribing in the long-term care setting using the SCRIPT standard. Realistically, it is going to take more time before the final goal is realized. However, progress is being made. The long-term care e-prescribing pilot has identified necessary additions to the SCRIPT standard, Version 8, Release 1 (8.1), in order to account for the nuances of the long-term care setting. Through the National Council for Prescription Drug Programs (NCPDP), Work Group 14, the long-term care work group, has already forwarded and championed several modifications to the NCPDP SCRIPT Standard. Thus far, four Data Element Request Forms (DERFs) have been submitted for American National

Standards Institute (ANSI) accreditation with more pending final NCPDP approval and ANSI submission:

DERF 743 – This DERF identified a specific unit, room and bed for medication delivery to the NCPDP SCRIPT Version 10.0 Patient Segment. This NCPDP SCRIPT Version was available for use in October 2006.

DERF 779 – This DERF will create a new Census Update Transaction. This new CENSUS SCRIPT is used to inform the pharmacy when a resident is admitted, discharged, or has a demographic change (e.g. a change in U/R/B or payer) that is not related to an order. Until this CENSUS DERF is available, the pharmacy system should review each NEWRX to see if any resident changes have occurred to insure that the pharmacy system is updated when the NEWRX is processed.

DERF 784- This DERF creates a new prescription modification process to link the current order cancel/DC with the new order to indicate to the pharmacy that this was a change to an existing order. This change was how an order modification was addressed in the pilot.

DERF 795 – This DERF creates a way to send a refill request from the facility to the pharmacy. This new RESUPPLY SCRIPT DERF is designed for use in the LTC environment to allow nursing facilities to request a new supply/refill from a pharmacy.

The DERFs 779, 784 and 795 were recently balloted and approved as part of the NCPDP SCRIPT Standard Implementation Guide Version 10 Release 1 (10.1).

ASCP strongly recommends the adoption of the SCRIPT 10.1 standard as the e-prescribing standard within long-term care by August 2009, the expected completion date of the final long-term care electronic health record certification by the Certification Commission for Health Information Technology (CCHIT). It is important for the long-term care industry to adopt e-prescribing following the CCHIT roadmap and not be hindered by regulations counter to the certification process.

Also, it is important to discuss the impact of the proposed fax exemption elimination on the prescribing of controlled substances. The Drug Enforcement Administration has not yet approved the use of e-prescribing systems for controlled substances and still requires those prescriptions to be written and "manually signed" by the prescriber. There are exceptions, such as when a Schedule II prescription is intended for a resident of a long-term care facility or a patient in a Medicare-covered hospice program, in which case a copy of the prescription may be transmitted entirely via fax without requiring the pharmacy to obtain an original, manually signed copy of the prescription. However, DEA controlled substance prescription regulations do not specifically prohibit a computer-generated fax transmission of a "manually signed" prescription. If the computer-generated fax exemption were

removed completely, a prescriber or facility using a paperless system that involved computer-generated faxes would be required to add an additional step to the prescribing process for controlled substances. Not only could this wreak havoc on current workflows, but it has the potential to negatively impact implementation of health information technology – which is contrary to CMS's intended goal with the proposed exemption elimination. We recommend specifically exempting controlled substances from the elimination of computer-generated faxed prescriptions.

While the long-term care industry is still quite dependent on faxed medication orders at this point in time, progress is definitely being made towards the adoption of health information technology, such as e-prescribing. ASCP requests:

- Clarification on the applicability to the long-term care industry of the proposed elimination of the exemption for computer-generated facsimile of prescriptions;
- Adoption of the NCPDP SCRIPT standard, version 10.1, prior to CCHIT certification of long-term care EHRs so that e-prescribing and EHRs will be successful when implemented in this setting; and
- Exemption of controlled substances from the proposed rule to eliminate at least some barriers for those currently using paperless systems.

ASCP would like to thank CMS for taking steps towards the advancement of health information technology. If we can answer any questions or be of further assistance, please let us know.

Sincerely,

Carla Saxton McSpadden, RPh, CGP
Assistant Director, Policy and Advocacy
American Society of Consultant Pharmacists
1321 Duke St.
Alexandria, VA 22314
(703) 739-1316 ext. 129
E-mail: cmcspadden@ascp.com

CMS-1385-P-10172

Submitter : **Dr. Charles Cowles** **Date: 08/28/2007**

Organization : **Univ of Texas -Houston**

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. cary lubet

Date: 08/28/2007

Organization : Dr. cary lubet

Category : Chiropractor

Issue Areas/Comments

Physician Scacity Areas

Physician Scacity Areas

when will you allow chiropractors to participate in this?

Submitter : **Dr. Paul Harkins** **Date: 08/28/2007**

Organization : **Dr. Paul Harkins**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

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

Organization : Dr. James Maddux

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.

Submitter : Miss. Colleen Wittkopp **Date:** 08/28/2007

Organization : Ohio University Athletic Training

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

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

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Administrator,

I am writing in support of CMS proposal to boost the value of anesthesia work by 32%. This will ensure that CRNAs can continue to to provide anesthesia to medicare beneficiaries with a need for anesthesia services.

Currently, according to MedPAC studies; reimbursement is between 40-80%. Boosting the value of anesthesia delivery to 32%, will bring us current in regards to the inflation that has occured over the last several years. I am concerned that Congress will over look the need to reverse the 10%SGR thereby causing our reimbursement, to decrease 17% below 2006 payment levels!!

Appromimately twenty seven million patients in the US, including underserved and rural populations, rely on CRNAs to provide their anesthesia care. The availability of anesthesia services by CRNAs, will be directly affected by fair Medicare reimbursement for anesthesia services rendered. I support CMS's proposal to boost the value our work so as to ensure the continued availability of anesthesia services for the patients who require our services.

Thank you.
Sincerely,
Janice Carey CRNA MS
11 Bnkside Drive
Billerica MA 01821

Submitter : **Dr. Sarah Radabaugh** **Date: 08/28/2007**

Organization : **Thermopolis Chiropractic Clinic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

X-rays, when needed, are integral to the overall chiropractic treatment plan of Medicare patients, and unfortunately in the end, it is the beneficiary who will be negatively affected by this proposed change in coverage. The current X-ray Medicare protocol has served patients well, and there is no clinical reason for this proposed change. If doctors of chiropractic are unable to refer patients directly to a radiologist, patients may be required to make additional and unnecessary visits to their primary care providers, significantly driving up the costs of patient care.

Submitter : Dr. david larson **Date:** 08/28/2007

Organization : california anesthesia associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P

Please increase rsvb for anesthesia by $4 per unit

David D Larson, M.D.

Submitter : **Dr. Shashidhar Subbanna** **Date: 08/28/2007**

Organization : **Medical College of Georgia**

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.

Sincerely

Shashidhar Subbanna
Anesthesiologist
Medical College of Georgia

CMS-1385-P-10181

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

Organization : Intermountain Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To whom it may concern:
My name is Jeremy Wiley, ATC and I am currently working as an athletic Training Lead for a clinical sports medicine outreach program. I work in a rural type setting. Our local hospital is in a well populated college town and we provide services for various rural, mainly agricultural towns.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
I am a Certified Athletic Trainer; I know and feel that I am qualified to perform physical medicine and rehabilitation services, which is not the same as physical therapy. My college education, numerous hours of clinical experience, and passing of a national certification exam ensure that my patients receive quality health care. Multiple states and 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. We have recently had a well paying position for a Physical Therapist open for over 6 months with no qualified applicants. 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.
Thank You,
Jeremy Wiley, ATC

Submitter : Dr. cary lubet **Date:** 08/28/2007

Organization : Dr. cary lubet

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

This will certainly effect the dependency on MDs for our care, personally I would do it for free, but then again this is not allowed, dont take away the ablity for us to render care and rule out underlying disorders.....

Submitter : **Mrs. Tara Humphreys** **Date: 08/28/2007**

Organization : **University of Hawaii @Manoa**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam,
My name is Tara and I am a Certified Athletic Trainer. I am employed by the University of Hawaii to provide care, prevention, and rehabilitative services to our athletes. I went to Loyola Marymount University and have worked in several colleges before coming to UH. I have been here almost 10 years. I am certified by both the National Athletic Trainers Association as an ATC and The National Strength and Conditioning Association as a CSCS.
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,

Tara M. Humphreys, ATC, CSCS

Submitter : **Mr. Charlie Hamilton** **Date: 08/28/2007**

Organization : **Carlsbad High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Scc Attachment

CMS-1385-P-10184-Attach-1.RTF

#10184

Dear Sir or Madam:

My name is Charlie Hamilton, ATC, MA, LAT. I work at Carlsbad High School in Carlsbad, NM, as the athletic trainer for all the team sports and athletics. I have a BS degree from the University of New Mexico in Athletic Training as well as an Health Education certification. I acheived my MA from Towson University in Liberal Studies with an emphasis in Biopsychology and 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.

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Sincerely,

Charlie Hamilton, MA, ATC, LAT