Submitter : Dr. Hector Zepeda **Date:** 08/28/2007

Organization : Rio Grande Pathology Services, PA

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir/Madam:
Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in El Paso, Texas as part of a two-pathologist group and we service two Hospitals in El Paso and a rural facility in Alpine, Texas.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.
Sincerely,

Hector Zepeda, MD

Submitter : **Mr. robert mackie** **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.

Sincerely,
Robert Mackie

CMS-1385-P-10187

Submitter : Ms. Thomas Wilson **Date:** 08/28/2007

Organization : None

Category : Other Technician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing this letter to give my thoughts as well as personal experience on the athletic trainers involvement in the rehab industry. I read the prepared letter sent out by NATA and its pretty predictable. First, I want to express to you that unlike what is stated in the NATA letter, Rehabilitation work and Physical Therapy is one in the same. Why NATA doesn't admit that I don't know. The Athletic Trainer spends 4 years in college passes a national test and then applys and usually receives a license in the state they live. But thats about as far as it goes. Athletic Trainers usually do no more than RICE treatments and basic first aid work anyway. There usually isn't enough injuries to go around for Athletic Trainers to absorb the experience they need. Lots of AT's usually move on to other professions within 3 years of becoming licensed. When there is a serious injury, a doctor is involved and if needed a physical therapist, who has a clinic. This procedure has been proven over the years to be the best option in the healing phase of any injuried athlete as well as non-athlete. Physical Therapist usually maintain a much busier schedule than athletic trainers and therefore have a more qualified and a more experienced approach to a patient. AT's usually work out of a bag. Thats not good reliable healthcare. To physical therapist's, they deal with patients with a doctors involvement. The athletic trainer also terms individual's as patients, when they should be termed 'clients'. This is a good law to have in place to keep the highest level of health care. Athletic trainers are just another middle man in the health care industry. In the sports world, paramedic's or licensed EMT's should be used as medical emergency responders along with Physicians, and if needed Physical Therapists for the rehabilitation phase. Athletic Trainer's should stick to initial first responder duties and first aid and taping. Leave the rest to medical professionals. Thank You Tom Wilson

CMS-1385-P-10188

Submitter : **Ms. JoAnn Williams** **Date: 08/28/2007**

Organization : **VA Greater Los Angeles Healthcare System**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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

BRIEF INTRO ABOUT SELF: I work for the Veteran's Health Administration. I am a Rehab Therapist working in Spinal Cord Injury and Driver training. I am a Registered Kinesiotherapist with a Driver Training Specialist Certificate.

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,
JoAnn Williams, RKT

Submitter : **Ms. Deborah Mason** **Date: 08/28/2007**

Organization : **Orthopaedic**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

CMS: www.cms.hhs.gov/eRulemaking
Re: In Office Physical Therapy/Stark Regulations

August 28, 2007

As a Licensed Physical Therapist practicing in a physician owned clinic I feel compelled to address the upsurge of anti Physician Owned Physical Therapy Services (POPTS) commentaries. I am employed at Orthopaedic & Sports Medicine Center in Norman, OK. I have worked in this facility for 16 years and can attest to the quality of services that are given to our patients.

First and foremost, our facility provides outstanding continuity of care for our patients. The communication between physician and physical therapist is excellent. Due to our close working relationship we are able to respond more rapidly to any change of status the patient might have (i.e. potential blood clots, infection, or complications). The physical therapist has immediate access to the patients medical record, providing more accurate information regarding the patients medical diagnosis and pre and post operative procedures performed.

The physicians in my facility do not dictate the number of patients seen, or the number of units charged. Due to our close relationship the therapists have been able to educate the physicians regarding appropriate reimbursement and referral duration. There are many corporate facilities that have quotas, and I feel these are much more questionable regarding patient care. Our patients are also given the option to obtain physical therapy at the facility of their choice.

My experience is that all physicians will develop a close relationship with and tend to refer to particular PT s, ours just happen to be in the same building with us. I don t really see how this is much different from a hospital facility referring an inpatient to go to their outpatient physical therapy clinic upon discharge from the inpatient facility.

I believe one of the major concerns is that physical therapy care in a POPTS will be provided by unlicensed individuals. I have that same concern, however in my facility that has never been an issue. It would be more useful to go after the facilities which only provide PT as an incident to situation where untrained/unlicensed individuals are billing as if a licensed professional were providing the rehabilitation services.

Over utilization is frequently mentioned when discussing POPTS situations. In my facility I do not feel that I have ever been given an inappropriate PT referral. Quite frankly, I feel that the physicians generally don t refer PT soon enough and wait until diagnoses are so chronic that they are more difficult to treat. Also, because of our close relationship with the physicians, we will actually discharge early as appropriate per our recommendation to the physicians.

I feel that POPTS facilities do benefit the patient and in my facility provide the best quality care.

Sincerely,

Deb Smith Mason, MS, PT
Director - Physical Therapy
Orthopaedic & Sports Medicine Center - Norman
825 E Robinson
Norman OK 73071
405-364-7900
dmason@orthonorman.com

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

Organization : **University of Connecticut**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
Hello, my name is James Doran. I am an Assistant Athletic Trainer for the University of Connecticut. I have a Bachelor of Science degree in Kinesiology/Pre-Physical Therapy and a Master of Science degree in Exercise Physiology. I have been a certified by the National Athletic Trainer s Association (NATA) as an Athletic Trainer for 9 years.

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

James W Doran Jr, MS, ATC
University of Connecticut
860-486-0481

Submitter : Dr. Dustin Wiemers **Date:** 08/28/2007

Organization : KUMC

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.

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

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

Thank you for your consideration of this serious matter.

Submitter : **Ms. Shanna Bicknase** **Date: 08/28/2007**

Organization : **Allen Unruh Chiropractic**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Shanna Bicknase and I recently graduated from graduate school in the field of Exercise Science. Before that I received my Bachelors in Athletic Training and, upon graduation, received my ATC (Certified Athletic Trainer) credential. I am currently working at a chiropractic clinic doing rehabilitation and therapies.

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,

Shanna Bicknase, ATC, MS

Submitter : **Mr. Jonathan Renelle** **Date: 08/28/2007**

Organization : **Clark Board of Education**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jonathan Renelle and I am a licensed Athletic Trainer in the state of New Jersey. I work for Arthur L. Johnson high school in Clark as their Head 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.

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Sincerely,

Jonathan Renelle, MS, ATC

Submitter : **Mr. Wayne C. Duncan** **Date: 08/28/2007**

Organization : **Page High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 28, 2007

Dear Sir or Madam:

My name is Wayne C. Duncan and I am a Board Certified and Licensed Athletic Trainer in the state of Arizona. Currently I work at a rural high school on the edge of the Navajo reservation as a teacher and the assistant athletic trainer. I have a master s degree in sports 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.

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Sincerely,

Wayne C. Duncan, MS, ATC, LAT

Page High School

Page AZ, 86040

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

Organization : **Dr. Richard Romer**

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,
Richard A. Romer M.D.

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

Organization : **Associated Anesthesiologists, Inc**

Category : **Physician**

Issue Areas/Comments

Physician Scacity Areas

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

Sincerely,

John R Barnes, MD
Associated Anesthesiologists, Inc
6839 S Canton
Tulsa, OK 74136

Submitter : Dr. Steven Huff **Date:** 08/28/2007

Organization : Dr. Steven Huff

Category : Physician

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Matthew Coburn** **Date: 08/28/2007**

Organization : **Dr. Matthew Coburn**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

The proposed change would specifically eliminate Medicare reimbursement in connection with the referral of a patient by a doctor of chiropractic to a radiologist or other non-treating physician for X-rays. This will incur undue expense on the patient and delay appropriate care by having the patient seek a second opinion and possibly wait weeks or months to see another provider. Chiropractors are extremely well trained to order plain film x-ray. In many cases they may be necessary to determine the area of subluxation, which is the only primary diagnosis allowed by Medi-Care.

I strongly urge you to table or disregard this proposal. Currently X-rays, if needed, are integral to the overall treatment plan of Medicare patients. Ultimately, patients will suffer should this proposal become standing regulation.

Sincerely,

Matthew R. Coburn, D.C.

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

Organization : **Dean Health**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Sincerely,
Thomas Bellehumeur, MD

Submitter : Dr. Jonathan Rubin **Date:** 08/28/2007

Organization : Family Chiropractic Care Inc.

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Jonathan V. Rubin D.C.
269-567-4111

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

Organization : **Aurora BayCare Medical Center**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Sincerely,

David I Kinsman, MD

Submitter : **Dr. Shaun Hennon** **Date: 08/28/2007**

Organization : **Dr. Shaun Hennon**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Kirk Benson** **Date: 08/28/2007**

Organization : **individual**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Comment regarding CMS-1385-P, and addressed to Leslie Norwalk, Acting Administrator, CMS.

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.

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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.

Kirk Benson, MD
5213 W 124th Terrace
Overland Park, KS 66209

Submitter : Ms. Natalie Silva **Date:** 08/28/2007

Organization : Community Regional Medical Center

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See Attached

CMS-1385-P-10204-Attach-1.RTF

#1020

CYBERKNIFE®

At Community Regional Medical Center

Submitted electronically via attachment to
http://www.cms.hhs.gov/eRulemaking

August 22, 2007

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

Re: Comments to Proposed Rule [File Code: CMS-1385-P]

Dear Administrator Weems:

My name is Natalie Silva and I am the Program Manager at The CyberKnife Center at Community Regional Medical Center in Fresno, California. We are a provider of image-guided robotic stereotactic radiosurgery. We thank you for the opportunity to comment to the Centers for Medicare and Medicaid Services (CMS) on CMS-1385-P RIN 0938-AO65 Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008.

Background

Medical linear accelerators (LINACs) were developed in the 1960's and allowed physicians to deliver isocentric radiation treatments of tumors over several weeks to spare normal tissue. Advancements in computer and linear accelerator technology in the 1980's led to 3-dimensional conformal radiation (3D-CRT) and image-guided radiation therapy (IGRT) which combined CT imaging with LINAC technology to register the location of a lesion before and after a treatment session. In the 1990's, intensity modulated radiation therapy (IMRT) further customized the shape of the radiation field to better conform to the lesion.

In the 1960's, frame-based stereotactic radiosurgery (SRS), was developed to deliver radiation with a high degree of accuracy to the brain and skull base. This intracranial treatment relies on placement and adjustment of an external head frame and manual adjustment of the patient. The accuracy afforded by this technology allows delivery of large, single, ablative doses of radiation. Then, in the late 1990's, image guided robotic stereotactic radiosurgery (r-SRS) proved significantly different from traditional radiosurgery in two ways: 1) no head or body frames are required, and 2) the flexibility of non-isocentric treatments allows for highly conformal treatments throughout the body together with significant decrease in normal tissue radiation.

Addendum B: 2008 Relative Value Units and Related Information Used in Determining Medicare Payments for 2008

In the CY 2007 PFS Final Rule, CMS revised the status indicator of level II HCPCS codes for image guided robotic linear accelerator-based stereotactic radiosurgery (G0339 and G0340) to indicate that they would be Carrier priced. We support CMS in maintaining these HCPCS codes for CY 2008 with the current status indicator so that Medicare beneficiaries may continue to have

access to this treatment in the freestanding center setting, and providers may continue to bill for services using the most appropriate codes.

Conclusion

In summary, we appreciate the opportunity to comment, and thank the agency for its decision to continue the use of Carrier-priced level II HCPCS codes for image guided robotic stereotactic radiosurgery in CY 2008.

Sincerely,

Natalie Silva
The CyberKnife Center

Program Manager
Community Regional Medical Center

Office Phone: 559-459-2752

nsilva@communitymedical.org
mailto:dsutherland@accuray.com

Submitter : **Dr. Karen Weiss** **Date: 08/28/2007**

Organization : **Dr. Karen Weiss**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter. I trust that you will do the right thing.

Sincerely,

Karen L. Weiss M.D.

Submitter : **Dr. Brad Atherton** **Date: 08/28/2007**

Organization : **anesthesiologist from Louisville, Ky**

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:

Our Anesthesia services have for so many years been so poorly reimbursed that we could not cover all the operating rooms in our hospital and could not recruit new personnel. We were forced to become employees of the hospital to raise our salaries. In other words, the hospital is subsidizing our services. This is a huge problem across the country and there may be 50% of anesthesia groups need the assistance of their hospitals in such a way because of inadequate medicare reimbursement. Forgive me if I am copying the ASA organization letter, but I absolutely agree with every word: 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.

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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.

Again, I apologize for giving you mostly a letter from our Society but it is vitally important to me. Please do not let the payment increase fail to be implemented.

Thanks,
E. Brad Atherton MD
Cornelia Atherton MD
Louisville, Ky

Submitter : **stephanie kaiser** **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:

My name is Stephanie Kaiser, and I am an athletic trainer at Carle Foundation Hospital.

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

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

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

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

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

Sincerely,

Stephanie Kaiser ATC

Submitter : Mrs. Carol Shipley **Date:** 08/28/2007

Organization : Mrs. Carol Shipley

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Yes! To increasing payment index for Anesthesiology.

Submitter : **Dr. Anirudha Bhandiwad** **Date: 08/28/2007**

Organization : **valley anesthesia PC**

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.

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

Organization : Western Cancer Center, Inc.

Category : Physician

Issue Areas/Comments

Impact

Impact

See Attached

CMS-1385-P-10210-Attach-1.DOC

#10210

August 27, 2007

Kerry N. Weems
Administrator Designee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box8018
Baltimore, MD21244-8018

Re: Comments to Proposed Rule [File Code: CMS-1385-P]

Dear Administrator Weems:

My name is Douglas G. Myking and I serve as President, CEO and CFO for Western Cancer Center, Inc. in San Diego, California. Western Cancer Center, Inc. provides image guided robotic stereotactic radiosurgery services at multiple locations throughout San Diego to patients who have cancer.

We thank you for the opportunity to comment to the Centers for Medicare and Medicaid Services (CMS) on CMS-1385-P RIN 0938-AO65 Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008.

Background

Medical linear accelerators (LINACs) were developed in the 1960's and allowed physicians to deliver isocentric radiation treatments of tumors over several weeks to spare normal tissue. Advancements in computer and linear accelerator technology in the 1980's led to 3-dimensional conformal radiation (3D-CRT) and image-guided radiation therapy (IGRT) which combined CT imaging with LINAC technology to register the location of a lesion before and after a treatment session. In the 1990's, intensity modulated radiation therapy (IMRT) further customized the shape of the radiation field to better conform to the lesion.

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may continue to have access to this treatment in the freestanding center setting, and providers may continue to bill for services using the most appropriate codes.

Conclusion

In summary, we appreciate the opportunity to comment, and thank the agency for its decision to continue the use of Carrier-priced level II HCPCS codes for image guided robotic stereotactic radiosurgery in CY 2008.

Sincerely,

Douglas G. Myking
President/CEO/CFO
Western Cancer Center, Inc.

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

Organization : Georgia Tech Athletic Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Richard E. Stewart and I am a certified and licensed athletic trainer for the Georgia Institute of Technology Athletic Association. As an athletic trainer at Georgia Tech I am primarily responsible for the men s basketball, swimming/diving, and men s tennis teams. I received my bachelor s degree in athletic training from Salisbury University and a master s degree in health education from Virginia Tech University. I currently hold a license to practice athletic training in both Virginia and Georgia. 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,

Richard E. Stewart, MSEd., ATC, VATL

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

Organization : Mr. John Shipley

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Increase the Anesthesia reimbursment rates. They are overdue!

Submitter : **Dr. David A. Kohan** **Date: 08/28/2007**

Organization : **Sacred Heart Medical Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Ms. Norwalk:

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

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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 : **Mr. Jeffrey Carter** **Date: 08/28/2007**

Organization : **Vassar College**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jeffrey Carter and I am the Head Athletic Trainer at Vassar College, NY. I currently direct the sports medicine office for our athletic department, which includes two additional Certified Athletic Trainers (ATCs). My staff and I are in charge of the health care of over 500 student-athletes through out the school year. I am graduate of both SUNY Cortland (BS) and Old Dominion University (MSEd). I have been a Certified Athletic Trainer (ATC) since 1998.

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,

Jeffrey Carter, MSEd, ATC, CSCS

Submitter : Mr. Hector Guevara **Date:** 08/28/2007

Organization : Omega Rehabilitation

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

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

BRIEF INTRO ABOUT SELF: Where you work, what you do, education, certification, etc. (3 to 4 sentences in length)

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,
Hector Guevara, RKT

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

Organization : Dr.

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 MD or DO and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

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

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

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

Sincerely,

Dr. Steven E. Longcor

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

Organization : Primary Children's Medical Center

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Dear CMS:

I am writing regarding the proposed change to eliminate CPT 93325 (Doppler Color Flow Mapping) and bundle this code into other echocardiography CPT codes. As a cardiac specialist caring for patients with congenital heart disease, this is of particular concern to me for a number of reasons.

I do not believe the appropriate process has been followed with respect to this proposed change. After significant interaction and research between the Relative Value Scale Update Committee (RUC) and the appropriate specialty societies (ACC and ASE), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that other echo codes be bundled as well with the 93325. Because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

Importantly, there is no proposed change to the RVUs of the codes with which 93325 will be bundled. The proposal would simply eliminate reimbursement for CPT 93325, yet the amount of work performed and time spent by the physician for this service will remain the same.

Color Doppler is typically performed in conjunction with 2D echo to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow velocities. The performance of echo in patients with congenital anomalies is unique in that it is frequently necessary to use color Doppler (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 code for the pediatric population stating that color Doppler is "& even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." There are many other complex anatomic and physiologic issues that we as cardiac specialists face on a daily basis when performing echos on patients with complex heart disease. Color Doppler imaging is a critically important part of many of these studies, requiring additional time and expertise from both the sonographer and the cardiologist interpreting the study. Bundling 93325 with other echo codes does not take into account this additional time, effort, and expertise. I am concerned that this change would adversely impact access to care for cardiology patients with congenital cardiac malformations. Programs caring for this select patient population do so not only for those with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for congenital cardiac services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to our patients will not be sufficient to continue to do so should the proposed bundling of 93325 with other echo codes be implemented.

I strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other cardiology echo codes until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Sincerely,

Robert G. Gray, MD
Assistant Professor, Pediatric Cardiology
Primary Children s Medical Center

#10221

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. Emily Whitson **Date:** 08/28/2007

Organization : Hopedale Medical Complex

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
Hello, my name is Emily Whitson MS, ATC from Bloomington, IL. I work at a small acute care hospital called Hopedale Medical Complex and we provide athletic training services to 4 rural area high schools. I received my Bachelor s degree in Sports Management in 2001 and my Masters Degree in Athletic Training in 2003. I provide athletic training services to the local high schools as well as seeing patients in our outpatient physical therapy clinic.

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

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

Organization : Adirondack Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am registered in the state of NY as a Certified Athletic Trainer. I have worked for 11 plus years in an outpatient rehabilitation and sports medicine facility at Adirondack Medical Center. I work in a rural setting in the middle of northern NY.

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,

Lisa Muscatello, ATC, CSCS

Submitter : **Mr. Douglas Jones** **Date: 08/28/2007**

Organization : **Western Nebraska Community College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Doug Jones, and I am a Certified Athletic Trainer and Certified Strength and Conditioning Coach in Scottsbluff, NE. I am a graduate of Creighton University with a BS in Exercise Science. I am also a member of the National Athletic Trainers Association, by which I became aware of the issue at hand.

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,

Douglas Jones, ATC, CSCS

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

Organization : Bay Area Urology

Category : Physician

Issue Areas/Comments

Impact

Impact

CMS should work with Congress to fix the Sustainable Growth Rate to prevent the upcoming 10% cut to physicians who provide services to Medicare beneficiaries. Drastic cuts will total 40% over the next 8 years. Over that same period, the Medicare Economic Index (MEI) will increase 20%. How long will physicians be forced to ask for a legislative fix from Congress?

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Although no specific proposals exist from CMS, any change to the Stark in-office ancillary exception would unduly harm the ability of urologists to provide efficiencies and needed services to patients. Services provided under the exception are important to healthcare delivery. CMS should not further limit this already complex and burdensome regulation.

Under the proposed rule regarding reassignment and diagnostic testing, the only technical or professional services a medical group could mark-up would be those performed by the group s full time employees. This would significantly would hurt the ability of group practices with in-office imaging equipment to utilize independent contractors and part-time employees to perform professional interpretation services. We understand CMS desire to prevent markups and gaming the system but offices with in-office imaging equipment utilize independent contractors and part time employees to perform high-quality professional interpretation services.

Prohibition of under arrangements rule will prohibit the provision of that are provided to a hospital through a joint venture in which you have an ownership interest, (such as radiation therapy or lasers). This will be detrimental to patient care because of access to these services are expensive in our community and across the country. In addition, CMS has taken efforts through a variety of different regulations through the years to eliminate duplication of services. If CMS or Congress were to prevent or further limit the ability to Joint venture with hospitals or other practices it may create an environment that would induce physicians to provide more services in-house under the practice exclusion . Each practice group will buy their own equipment or subject patients to return to the more costly and inefficient hospital providers.

We understand the importance of striking a balance between eradicating fraud and abuse and promoting efficiency and protecting patient access to care. As a urologist, these regulations, if implemented would have a negative effect on innovation, efficiency and patient access to care. Please consider suggested changes and withdraw these proposals.

CMS should not be considering making significant changes to Stark rules on an annual basis or for inclusion in the Physician Fee Schedule. Too many financial and business arrangements, legal contracts and services are involved to be altered on a yearly basis or through a piecemeal approach. In sum, the proposed rule creates two levels of uncertainty: (1) significant lack of clarity within the specific proposals themselves; and (2) general instability due to the prospect of annual changes to Stark.

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

Organization :

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

There is no reason why chiropractors and their patients should not be reimbursed for xrays.

Submitter : **Mrs. Jacquelyn Hendrick** **Date: 08/28/2007**

Organization : **Mrs. Jacquelyn Hendrick**

Category : **Individual**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Mrs. Jacquelyn J Hendrick
Monroe, LA

Submitter : **Dr. JoEllen Sefton** **Date: 08/28/2007**

Organization : **Auburn University**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a professor of Athletic Training and Biomechanics at Auburn University and the Graduate Athletic Program Coordinator. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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,

JoEllen M. Sefton, Ph.D., ATC, CMT
Director, Neuromechanics Research Laboratory
Athletic Training Graduate Program Coordinator
Department of Kinesiology
2050 Beard-Eaves-Memorial Coliseum
Auburn University
Auburn, AL 36849-5323
Phone: 334-844-1844
Fax: 334-844-1467
Email: jmsefton@auburn.edu

Submitter : **Dr. D. Muhlbauer** **Date: 08/28/2007**

Organization : **Dr. D. Muhlbauer**

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. Wonjae Choi** **Date: 08/28/2007**

Organization : **Dr. Wonjae Choi**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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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.

Wonjae E. Choi MD

Submitter : Mr. Lee Cohen **Date:** 08/28/2007

Organization : SUNY College at Brockport

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Lee J. Cohen MS,ATC and I am the Head Athletic Trainer for a division 3 college. My responsibilities are to provide preventative, evaluative/assessment, treatment and rehabilitative services to over 500 athletes as well as general population students, faculty and staff. I received my graduate degree in physical education with a concentration in athletic training while my undergraduate degree was in sports medicine. I am certified by National Athletic Trainers Association and the state of New York. Other certifications I possess are in first aid and CPR/AED for professional rescuer.

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,
Lee J. Cohen MS,ATC

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

Organization : **A. T. Still University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

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

I am writing as a healthcare provider with significant concerns about the activities of your office. I serve as an Associate Professor and Chair of the Department of Interdisciplinary Health Sciences and Director of the post-professional degree program (MS) in Athletic Training at A. T. Still University (ATSU). ATSU is a private, not-for profit, health sciences institution that consists of two medical schools (in different states), a dental school, a health sciences school, and a school of health management. I have a PhD in sports medicine and I am a nationally certified and state licensed athletic trainer.

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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Professionally,

Dr. Eric L. Sauers, ATC

Submitter : **Dr. Renee Polubinsky** **Date: 08/28/2007**

Organization : **Illinois Athletic Trainers Assoc**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer for over 21 years and an educator for the past 9 years. I am employed at Western Illinois University and am the Program Director for the Athletie Training Education Program. I take great pride in educating our students who are excited about pursuing athletic training as their chosen profession.

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

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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.

As an educator I would like our students to continue to have hope that there will be jobs available for them upon graduation. But it is legislation like this that makes our jobs difficult.

Sincerely,

Renee Polubinsky, EdD, ATC, CSCS

Submitter : **Dr. Mauricio Perilla** **Date: 08/28/2007**

Organization : **Cleveland Clinic Foundation**

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.

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

Thank you for your consideration of this serious matter

Submitter : Dr. RICHARD Hodish **Date:** 08/28/2007

Organization : Dr. RICHARD Hodish

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Richard L. Hodish, DC

CMS-1385-P-10235-Attach-1.DOC

#10235

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"

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Sincerely,
Richard L. Hodish, DC

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

Organization : University of Idaho

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jeff Seegmiller. I am a faculty in a Medical Education program At the university of Idaho an extension of the University of Washington School of Medicine. As part of My job I teach Gross anatomy to first year medical students. I recieved my education from Brigham Young university in athletic Training and My Masters in Biomechnanics and doctorate in Education from Illinois State University. I still maintain my certification as an Athletic Trainer and truely value what Athletic Trainers do for the public. As an faculty member in medical education I truely have seen how important and educated Athletic Trainers really are.

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,
Jeff Seegmiller Ed.D, ATC

Submitter : **Ms. Diane Sosa** **Date: 08/28/2007**

Organization : **Ms. Diane Sosa**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

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

I am a Kinesiotherapist working in the field of rehabilitation for almost 30 years. A knowledge of EXERCISE devoted to those with physical impairments with an understanding of the diagnoses that lead patients to me. It is not restricted to one profession, not restricted to a catch-all profession, it's about exercise professionals, what-ever they are called, with credentials to do so. As a Kinesiotherapist I have the credentials.

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,
Diane Sosa, RKT, M.Ed

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

Organization : North Country Anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Ms Norwalk,

I will be entering the Medicare coverage in 4 years (I am now 62) and it is more important to me that the Anesthesiologist that I will be using in the future wil be better reimbursed. I think if the reimbursement is significantly better than medicaid the docs will not think of the senior population as another group of welfare patients.
Therefore, 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.

Submitter : **Dr. Burt McKeag** **Date: 08/28/2007**

Organization : **North Platte Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I would like to express my support for an increase in the medicare compensation for anesthesia services. I am president of a small anesthesia group in rural Nebraska. Our payor mix is approximately 40% medicare. We receive about $17/unit for medicare cases, but we charge $80/unit from self pay patient's. This unfortunate imbalance has come about after years of underpayment for medicare patients, in order to make our payroll and hopefully a profit we have been forced to increase our billed charges to insured and self-pay patients. In spite of this we are unable to remain competitive in our market when it comes to recruiting and retaining anesthesia personnel. For this reason we have been forced to consider and most likely will become hospital employees. It is a shame that our specialty has become dependant on hospital handouts to stay in business. A 32% increase would be a huge step in the right direction and help ensure that we continue to have good people in our field.

Thanks.

Sincerely,

Burt McKeag

Submitter : Mr. Eric Misko **Date:** 08/28/2007

Organization : Farmington High School

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

8/27/2007

Dear Sir or Madam:

My name is Eric Misko and I am a NATA certified and Connecticut licenced athletic trainer who has been working at a Connecticut high school for the past 12 years. I received a BA in Athletic Training from Purdue University and an MS in Athletic Training from West Virginia University. Throughout my career I have worked in the college, clinical and high school settings, as well as various state and national athletic organizations. 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.

These proposed changes could have a great impact on the way high schools utilize athletic event coverage which currently is provided solely by doctors and certified athletic trainers like myself. This creates opportunities for Physical therapists and PT aides to attempt to gain access to athletic event coverage for which they have little to no training. This is a situation which would significantly compromise care.

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,

Eric Misko MS, ATC, LAT

Submitter : Ms. Glynda Lucas **Date:** 08/28/2007

Organization : Benign Essential Blepharospasm Research Foundation

Category : Other Association

Issue Areas/Comments

Drug Compendia

Drug Compendia

On behalf of the Benign Essential Blepharospasm Research Foundation, Inc. (BEBRF), we are pleased to submit these comments on the Proposed Physician Fee Schedule update for 2008 in general, and particularly on the agency's proposals concerning DRUG COMPENDIA.

Blepharospasm, a form of dystonia, is a chronic, unremitting, bilateral, forcible closure of the eyelids. It is a variably progressive neurological dysfunction in the motor control center of the brain. It is due to involuntary muscle contraction caused by misfiring of neurons within the central nervous system and involves the fifth and seventh cranial nerves. Eyelid spasms may increase in frequency and duration until a patient becomes functionally blind. Facial spasms (Meige) may become more severe, interfering with speech or eating. The ability to drive, read and watch television, or perform other necessary daily activities can become increasingly difficult. Many blepharospasm patients are unable to work. The purpose of BEBRF is to undertake, promote, develop and carry on the search for the cause and a cure for benign essential blepharospasm and other related disorders and infirmities of the facial musculature (Mattie Lou Koster, Founder). The Foundation is the only organization solely dedicated to finding the cause and a cure for blepharospasm and Meige. It is a volunteer organization that relies entirely on public and private charitable contributions.

The patients we represent rely on numerous drugs to control the symptoms associated with dystonia, a movement disorder that causes muscles to contract and spasm involuntarily. They likewise rely on rapid availability of new drugs and new uses of existing drugs to improve their treatment and quality of life.

Our organization is deeply concerned by the prospect of having only one compendium available, even if just for a limited period of time, on which Medicare contractors may rely to make off-label use coverage determinations. We applaud CMS for sharing this concern and for responding by devising a mechanism for evaluating new compendia to serve this purpose.

However, we are concerned that the process CMS is proposing may be too complex, lengthy and restrictive to allow timely adoption of new compendia. Patients need access to and coverage for drugs that treat their conditions. If there are too few compendia covering the drugs most commonly used by patients with neuromuscular or related disorders, and those that are available are not being updated quickly enough as new therapies are approved or as new uses of existing therapies are reported in the clinical literature, our access to these life-altering treatments could be impacted.

We are concerned that CMS is at risk of limiting coverage for important drugs by establishing standards that would leave the agency with too few compendia to adequately evaluate and determine coverage of new drug uses. We urge CMS to develop a process for adoption of new compendia that is flexible and that focuses on adoption of new compendia that are accurate and timely in their updates.

Similarly, we urge CMS to immediately recognize DrugPoints? as the successor publication to the USP-DI. Under any process established by CMS, it could be at least a year, perhaps longer, before a new drug compendium achieves listing status. By recognizing DrugPoints? as a successor publication to USP-DI, CMS ensures that it and its contractors will have at least two compendia available to support coverage while it reviews requests to adopt additional compendia. Thank you for your consideration of our comments.

Sincerely yours,

Glynda J. Lucas
First Vice President
Benign Essential Blepharospasm Research Foundation, Inc.

Submitter : Dr. Matthew Brown **Date:** 08/28/2007

Organization : Oklahoma State University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : The Rose Center for Rehabilitation

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attached comment

CMS-1385-P-10243-Attach-1.DOC

10243

Comment regarding Stark Referral for Profit loophole

This is a request to remove physical therapy from the "in – office ancillary services" exception to federal physician self referral laws.

As a physical therapist in private practice I would like to make a comment regarding physician owned practices. It makes no sense to me as professional or a consumer how a physician is now allowed to be not only the referring entity for an ancillary services but the direct financial beneficiary as well. Research has shown that such arrangements have had an adverse economic impact on the consumer in the past (JAMA 1992, Mitchell et al) where higher costs and higher utilization were documented in Florida , when services were provided by a Physician Owned Physical Therapy practice as compared to privately owned practices . Another article in New England Journal of Medicine also demonstrated 2 times higher utilization of physical therapy services in the workers compensation arena when provided by physician owned practices.

The understanding that this exception was created to provide ancillary services in communities where such services were not available within reasonable distance was a noble idea. Unfortunately the language permitted a loophole for physicians to open such practices in communities where physical therapy practices are abundant and well within easy accessibility to the existing population based on some determining factor which qualified the community as a rural area.

Such practices are unethical and fraudulent based on the simple premise that financial incentives to refer to ones own practice are a breeding ground for corruption and misuse of insurance reimbursement dollars.

I strongly urge CMS to omit physical therapy from the exception rule for "in – office ancillary services.

With great concern,

Andrea Ecsedy, PT, NCS
Redding, California

Submitter : Dr. Kinlap Mak **Date:** 08/28/2007

Organization : Dr. Kinlap Mak

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)

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

Thank you for your consideration of this serious matter.

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

Organization : St. Joseph Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

Organization : **Dr. Frank Green**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Frank Green, M.D.

Submitter : **Dr. Winnie Cheung** **Date: 08/28/2007**

Organization : **Dr. Winnie Cheung**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

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

Organization : Radiation Medical Group, Inc.

Category : Physician

Issue Areas/Comments

Impact

Impact

See Attached

CMS-1385-P-10248-Attach-1.DOC

#10248

Elmhurst Rehabilitation, S.C.

143 Bernice Dr. Benseville, IL 60106
Telephone: (630) 350-2736 Fax: (6300 350-2842)

August 28, 2007

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

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

Physician Self-Referral Issues. Comments on July 12, 2008 proposed physician fee schedule rule "in-office" ancillary services".

Elmhurst Rehabilitation, S.C. is an outpatient physical therapy clinic that was established in 1980. Our combined therapist staff offers over 200 years of clinical experience. We are writing to you to address several points regarding physician owned physical therapy practices.

1. Physician self-referral increases the number of PT/OT visits and billings per visit as compared to free-standing clinics.
2. Physicians (per our patient reports) tell patients that they "have to go to" their services rather than being free to attend PT/OT as they prefer and/or as convenient.
3. Patients often state that PT/OT they have had previously at the M.D. offices did not always have a physical or occupational therapist working with them.
4. P.T./O.T.'s should have the professional right to control **OUR** profession, not an M.D.

Thank you for attending to these comments and to addressing overuse and abuse of in-office ancillary services.

Sincerely,

Carol Gordon, PT, PhD, OCS
Daniel Hanson, PT
Rita Nemeth, PT
Ellen Ziegler, OTR/L, CHT, MS
Elizabeth Russell, MPT, LANA
Christopher Carlson, MPT, BS

Submitter : Dr. Vijay Ravula **Date:** 08/28/2007

Organization : Dr. Vijay Ravula

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.
Dr. Vijay Ravula

Submitter : Dr. Ira Klimberg **Date:** 08/28/2007

Organization : Urology Center of Florida

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a urologist in practice in Florida in a large group practice. We have carefully constructed our group, and our physical plant to be able to deliver a broad spectrum of Urologic Services to our patients under a single roof. We provide unmatched quality, the latest technology, and expertise in focused urologic focused surgery, radiology and laboratory services.

The proposed changes to the self-referral provisions would drastically reduce our ability to continue to provide these services to our patients. We currently provide CT scan services at our facility, and work closely with our professional colleagues in radiology for interpretation of these studies. In similar fashion we work with pathologists to provide laboratory services to our patients under the auspices of our physician's practice laboratory.

Since these changes to our practice we have demonstrated unsurpassed quality of care with special expertise of uro-specific radiologists and pathologists. Any legislation affecting our ability to do this going forward would compromise the quality of patient care, as well as patient access to care.

Many of the services that we offer, for example Lithotripsy, require expensive technology that must be leased. Any change in current self-referral rules, or per click leases would jeopardize this and many other services in our community. For example. in our county of over 300,000 people there are NO lithotripters! All of the lithotripsy units are mobile, and are brought into surgery centers and the three hospitals on a per click lease basis. The proposed rule would make these arrange ments untenable.

In conclusion, our practice has been very careful to structure our relationships to comply with the current self referral regulations and provide exemplary care to our patients. Any changes in these rules would jeopoardize the quality of care that we are able to offer our patients, severely restrict their access to care, and cause patient hardship. Some services might no longer be available in our community. For THESE REASONS I REQUEST THAT THE CURRENT SELF REFERRAL REGULATIONS BE LEFT INTACT< and these proposed additions REJECTED>

THank you very much for your attention.

Ira Klimberg MD

Submitter : **Dr. Ronald Davis** **Date: 08/28/2007**

Organization : **Cyberknife Centers of San Diego, Inc.**

Category : **Physician**

Issue Areas/Comments

Impact

Impact

See Attached

CMS-1385-P-10251-Attach-1.DOC

#10251

August 27, 2007

Kerry N. Weems
Administrator Designee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box8018
Baltimore, MD21244-8018

Re: Comments to Proposed Rule [File Code: CMS-1385-P]

Dear Administrator Weems:

My name is Dr. Ronald T. Davis and I serve as President and CEO for Cyberknife Centers of San Diego, Inc. in San Diego, California. Cyberknife Centers of San Diego, Inc. provides image guided robotic stereotactic radiosurgery services at multiple locations throughout San Diego to patients who have cancer.

We thank you for the opportunity to comment to the Centers for Medicare and Medicaid Services (CMS) on CMS-1385-P RIN 0938-AO65 Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008.

Background

Medical linear accelerators (LINACs) were developed in the 1960's and allowed physicians to deliver isocentric radiation treatments of tumors over several weeks to spare normal tissue. Advancements in computer and linear accelerator technology in the 1980's led to 3-dimensional conformal radiation (3D-CRT) and image-guided radiation therapy (IGRT) which combined CT imaging with LINAC technology to register the location of a lesion before and after a treatment session. In the 1990's, intensity modulated radiation therapy (IMRT) further customized the shape of the radiation field to better conform to the lesion.

In the 1960's, frame-based stereotactic radiosurgery (SRS), was developed to deliver radiation with a high degree of accuracy to the brain and skull base. This intracranial treatment relies on placement and adjustment of an external head frame and manual adjustment of the patient. The accuracy afforded by this technology allows delivery of large, single, ablative doses of radiation. Then, in the late 1990's, image guided robotic stereotactic radiosurgery (r-SRS) proved significantly different from traditional radiosurgery in two ways: 1) no head or body frames are required, and 2) the flexibility of non-isocentric treatments allows for highly conformal treatments throughout the body together with significant decrease in normal tissue radiation.

Addendum B: 2008 Relative Value Units and Related Information Used in Determining Medicare Payments for 2008

In the CY 2007 PFS Final Rule, CMS revised the status indicator of level II HCPCS codes for image guided robotic linear accelerator-based stereotactic radiosurgery (G0339 and G0340) to indicate that they would be Carrier priced. We support CMS in maintaining these HCPCS codes for CY 2008 with the current status indicator so that Medicare beneficiaries

may continue to have access to this treatment in the freestanding center setting, and providers may continue to bill for services using the most appropriate codes.

Conclusion

In summary, we appreciate the opportunity to comment, and thank the agency for its decision to continue the use of Carrier-priced level II HCPCS codes for image guided robotic stereotactic radiosurgery in CY 2008.

Sincerely,

Ronald T. Davis, M.D.
President and CEO
Cyberknife Centers of San Diego, Inc.

Submitter : **Mr. donald smith** **Date: 08/28/2007**

Organization : **millburn high school**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sirs;

My name is Don Smith and my degress are MAT, ATC,ATl,and CSCS'D. I work in the public high school setting and counsel parents as well as students on sports and health issues. I am writing to you in oppositon to 1385-P. Me and my collegues do great service to the public in many settings. To deprive the general interest of our cousel in physical medicine would not be in the best interest of the public. 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,

Don Smith MAT,ATC,ATL,CSCS'D

Submitter : Mrs. Melanie Fusco **Date:** 08/28/2007

Organization : Anesthesia Associates

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Melanie Fusco CRNA

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

Organization : Northern Colorado Anesthesia Professional Cons.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-10256

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

Organization : North County Radiation Oncology Medical Group

Category : Physician

Issue Areas/Comments

Impact

Impact

See Attached

CMS-1385-P-10256-Attach-1.DOC

#10256

August 27, 2007

Kerry N. Weems
Administrator Designee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box8018
Baltimore, MD21244-8018

Re: Comments to Proposed Rule [File Code: CMS-1385-P]

Dear Administrator Weems:

My name is Dr. Donald Fuller and I serve as Managing Partner for North County Radiation Oncology Medical Group. in Encinitas, California. North County Radiation Medical Group provides image guided robotic stereotactic radiosurgery services to patients who have cancer.

We thank you for the opportunity to comment to the Centers for Medicare and Medicaid Services (CMS) on CMS-1385-P RIN 0938-AO65 Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008.

Background

Medical linear accelerators (LINACs) were developed in the 1960's and allowed physicians to deliver isocentric radiation treatments of tumors over several weeks to spare normal tissue. Advancements in computer and linear accelerator technology in the 1980's led to 3-dimensional conformal radiation (3D-CRT) and image-guided radiation therapy (IGRT) which combined CT imaging with LINAC technology to register the location of a lesion before and after a treatment session. In the 1990's, intensity modulated radiation therapy (IMRT) further customized the shape of the radiation field to better conform to the lesion.

In the 1960's, frame-based stereotactic radiosurgery (SRS), was developed to deliver radiation with a high degree of accuracy to the brain and skull base. This intracranial treatment relies on placement and adjustment of an external head frame and manual adjustment of the patient. The accuracy afforded by this technology allows delivery of large, single, ablative doses of radiation. Then, in the late 1990's, image guided robotic stereotactic radiosurgery (r-SRS) proved significantly different from traditional radiosurgery in two ways: 1) no head or body frames are required, and 2) the flexibility of non-isocentric treatments allows for highly conformal treatments throughout the body together with significant decrease in normal tissue radiation.

Addendum B: 2008 Relative Value Units and Related Information Used in Determining Medicare Payments for 2008

In the CY 2007 PFS Final Rule, CMS revised the status indicator of level II HCPCS codes for image guided robotic linear accelerator-based stereotactic radiosurgery (G0339 and G0340) to indicate that they would be Carrier priced. We support CMS in maintaining these HCPCS codes for CY 2008 with the current status indicator so that Medicare beneficiaries

may continue to have access to this treatment in the freestanding center setting, and providers may continue to bill for services using the most appropriate codes.

Conclusion

In summary, we appreciate the opportunity to comment, and thank the agency for its decision to continue the use of Carrier-priced level II HCPCS codes for image guided robotic stereotactic radiosurgery in CY 2008.

Sincerely,

Donald B. Fuller, M.D.
Managing Partner
North County Radiation Oncology Medical Group

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

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

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

Thank you for your consideration of this serious matter.

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

Organization : Minnesota State University

Category : Academic

Issue Areas/Comments

GENERAL

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Dear Sir or Madam:

My name is Patrick Sexton and I currently serve as the Director of the Atheltic Training Education Program at Minnesota 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 and an athletic training educator, 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. In addition, the students I educate to become practicing professionals are impacted by these proposed limitations on their future practice.

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. By making the proposed change the CMS, therefore the United States government will be eliminating the jobs of many highly qualified and highly educated health care professionals. This is contrary to public policy; contrary to quality patient care; and is nothing more the elimination of qualified competitors in the health care arena...all without due process.

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,

Patrick Sexton, EdD, ATC

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

Organization : Radiosurgery Medical Group, Inc.

Category : Physician

Issue Areas/Comments

Impact

Impact

See Attached

CMS-1385-P-10259-Attach-1.DOC

#10259

August 27, 2007

Kerry N. Weems
Administrator Designee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box8018
Baltimore, MD21244-8018

Re: Comments to Proposed Rule [File Code: CMS-1385-P]

Dear Administrator Weems:

My name is Dr. Damon E. Smith and I serve as President and Medical Director of Radiosurgery Medical Group, Inc. in San Diego, California. Radiosurgery Medical Group, Inc. provides image guided robotic stereotactic radiosurgery services at multiple locations throughout San Diego to patients who have cancer.

We thank you for the opportunity to comment to the Centers for Medicare and Medicaid Services (CMS) on CMS-1385-P RIN 0938-AO65 Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008.

Background

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may continue to have access to this treatment in the freestanding center setting, and providers may continue to bill for services using the most appropriate codes.

Conclusion

In summary, we appreciate the opportunity to comment, and thank the agency for its decision to continue the use of Carrier-priced level II HCPCS codes for image guided robotic stereotactic radiosurgery in CY 2008.

Sincerely,

Damon E. Smith, M.D.
President and Medical Director
Radiosurgery Medical Group, Inc.