CMS-1385-P-10260

Submitter : Ms. Nancy Bleam | **Date:** 08/28/2007

Organization : Keene State College

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-10260-Attach-1.DOC

#10260

Dear Sir or Madam:

I am a certified athletic trainer and lecturer at Keene State College in Keene, New Hampshire. I am just beginning my tenth consecutive year here and celebrated my 25th year as a member of the National Athletic Trainer's Association in February 2007. I love this profession and continue to be concerned about attempts to change rules that govern how hospitals and clinics staff their facilities regarding the employment of certified athletic trainers.

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

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

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

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

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

Sincerely,

Nancy K. Bleam, MAEd, ATC

CMS-1385-P-10261

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

Organization : **American Association of Nurse Anethetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 28, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,

Mary Nichols, CRNA, APRN
704 Ridge Road
Wethersfield, CT 06109

CMS-1385-P-10262

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

Organization : **Whitworth University**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Russ Richardson and I am the Athletic Training Program Director and Athletic Trainer at Whitworth University in Spokane Washigton. I am a licensed, certified health care practitioner and have concers about the proposed changes in 1385-p.

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

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

As 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,

Russell J. Richardson, ATC
Director of Athletic Training
Whitworth University
Spokane, WA 99251

CMS-1385-P-10263

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

Organization : Dr. robert sprague

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I strongly urge that anesthesia fees be increased to at least meet cost of living and overhead increases. Many of my colleagues are either considering retirement or boycotting of Medicare patients due to the actual loss of income in caring for this increasing demographic.

CMS-1385-P-10264

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

Organization : MUHLENBERG REGIONAL MEDICAL CENTER.

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I THINK IT IS IMPERITIVE THAT PAYMENT SHOULD BE MADE FOR SERVICES PROVIDED BECAUSE WE ARE LIABLE AND HAVE A RESPONSIBILTY TO THE PATIENTS POPULATION WE SERVE

CMS-1385-P-10265

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

Organization : **Student at Des Moines University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Caleb Pinegar. I graduated with a degree in Athletic Training from Brigham Young University and certified with the NATA at the end of 2006. As an Athletic Trainer I decided to further my education and am currently attending medical school at Des Moines University. I try to remain involved in Athletic Training opportunities and club at my university.

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

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

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

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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,

Caleb Pinegar, ATC

CMS-1385-P-10266

Submitter : **Mr. Bob Dykes** **Date: 08/28/2007**

Organization : **Advanced Rehab Center**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

We presently operate a private physical therapy practice in Southwest Georgia. Since our opening in 2001, four different orthopaedic physician groups offered us the opportunity to join their practice and be employed by them. We declined these offers because we opened with the intent to serve the entire community of physicians and not to isolate ourselves. We however, depend on referrals for our business to survive and cannot compete with the present system in place. In any other business venture, if you provide a good service, you can count on having customers. For example, one physician that sees us for his aches/pains, is part of a group that employs physical therapists. This same physician stated that it was no longer about the quality of therapy care, but about the money that could be generated from therapy. One physicians' group that has employed therapists for the last 3 years insisted that another group was missing out on the significant money that they were generating from therapy. In less than six months, that same group employed physical therapists and were providing therapy in a portion of their existing waiting room. We also have had prior patients note that they were not given a choice when referred to therapy from physicians that had therapy in-house. Home-health agencies and outpatient hospital-based clinics are seeing significant changes as well. An incident occurred at a local hospital in which a patient wanted to see the same therapist for outpatient services after being discharged from the inpatient side, but the physician's office told them that was not part of their "protocol" and they would need to see the physician's therapist. This is an out of control situation that needs to be stopped. Our practice does not want to see all of the patients that need therapy, but we do want to be allowed to survive if we provide a good quality service. Physical Therapy services should NOT be included in the in-office ancillary services exception.

CMS-1385-P-10267

Submitter : Dr. Kent Diveley

Date: 08/28/2007

Organization : Dr. Kent Diveley

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I entered private practice as an Anesthesiologist after 9 years in the US Navy in 1992. I have been shocked at the level of current reimbursement for Anesthesia serviccs. I srongly support the proposed increase in payment to bring some small equity to what wc are asked to accept to care for thc nation's elderly. Thank you, Kent Divcley, MD

CMS-1385-P-10268

Submitter : **Mrs. Jennifer Tortorici** **Date: 08/28/2007**

Organization : **Mrs. Jennifer Tortorici**

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.

CMS-1385-P-10269

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

Organization : **University of Indianapolis**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer with approximately 20 years of experience providing health care for physically active individuals in intercollegiate, interscholastic, and recreational athletics, as well as industrial workers trying to maximize time on the job. Physicians and patients have come to rely on my expertise in the areas of injury prevention and rehabilitation.

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

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

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

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

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

Sincerely,
Katherine Newsham, PhD, ATC

Submitter : **Mrs. Jo Tortorici** **Date: 08/28/2007**

Organization : **Mrs. Jo Tortorici**

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.

CMS-1385-P-10271

Submitter : **Miss. Laura DeVries** **Date: 08/28/2007**

Organization : **Anesthesia Medical Consultants P.C.**

Category : **Other Health Care Provider**

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.

CMS-1385-P-10272

Submitter : Mr. Tony Tortorici **Date:** 08/28/2007

Organization : Mr. Tony Tortorici

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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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. Kristin Hook **Date:** 08/28/2007

Organization : OK. Society of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please increase medicare reimbursement for Anesthesia. Anesthesia is critically important and very much underappreciated and underreimbursed. Please act now.

Sincerely,
Kristin Hook

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

Organization : **Mr. Glen Tortorici**

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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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-10275

Submitter : **Miss. Miranda Tortorici** **Date: 08/28/2007**

Organization : **Miss. Miranda Tortorici**

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. Kathleen Kendra** **Date: 08/28/2007**

Organization : **Kendra Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

TheCMS desision not to re-imburse providers for x-rays if used by a chiropractor is utterly STUPID. The only one the gets hurt are the people that can least afford it. This is just another way to deny Chiropractors the will to give the best care possible to our patients.

Dr. Kathleen Kendra
Norco, California

CMS-1385-P-10277

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

Organization : **American Society of Anesthesiologist**

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.

Sincerely,
Dr. Cara F. Peggs
320 East Saint Joseph Street
#2
Indianapolis, Indiana
46202
317-408-7811

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

Organization : **Mr. Paul Tortorici**

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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Thank you for your consideration of this serious matter.

CMS-1385-P-10279

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

Organization : Sports Medicine Associates

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"
Dear Sir or Madam:

My name is Robert Leslie. I am a Certified Athletic Trainer, licensed in the state of Georgia. I have been a practicing Athletic Trainer since 1994 and have worked in many different practice settings. I am currently working with a Physician owned sports medicine practice as a Senior Athletic Trainer in charge of medical outreach to local high schools. I also work with many active people in developing workout protocols to enhance their already active lifestyle as well as with others to reduce their risk of injury by conditioning and starting and maintaining healthy eating habits.

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,

Robert W. Leslie, ATC, CSCS

CMS-1385-P-10280

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

Organization : Union Anesthesia and Pain Management

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Please note that surgery centers such as the ones our practice utilize make access for patients easier and provide a more pleasant experience than hospital settings. The ASCs are more efficient and save time and money. My patients prefer when I treat them at the ASC. Pain mangement procedures should only be performed in a sterile environment such as an ASC. Flouroscopy MUST be utilized to perform interventional techniques accurately and safely! Flouroscopy equipment is expensive and therefore, interventional pain management procedures should not be forced into the office setting. If they are, physicians will perform them without the proper equipment (ie. flouroscopy) which will put patients at risk.
Thank you for your attention.

CMS-1385-P-10281

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

Organization : Oklahoma Society of Anesthesiology

Category : Physician

Issue Areas/Comments

Impact

Impact

Please look at Anesthesia reimbursement. Anesthesia is critical to successful surgery and must be fairly reimbursed.
Sincerely,
Kyle Hook

CMS-1385-P-10282

Submitter : Ms. Ellen Epping

Date: 08/28/2007

Organization : University of Central Arkansas

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10282-Attach-1.DOC

CMS-1385-P-10282-Attach-2.DOC

#10282

August 28, 2007

Dear Sir or Madam:

My name is Ellen Epping. I am a Certified, Licensed Athletic Trainer and the Program Director of the Athletic Training Education Program at the University of Central Arkansas. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

I am concerned that these proposed rules will create an additional lack of access to quality health care for patients, especially those in rural areas, such as you find in the great state of Arkansas.

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 board certification ensure that those I and graduates of the UCA program care for receive quality health care. State law and hospital medical professionals have deemed licensed athletic trainers qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of American citizens, to further restrict their access to physical medicine and rehabilitation 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 and care 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,

Ellen Epping MA, ATC, LAT
Director, Athletic Training Education Program
University of Central Arkansas
Prince Center, 133E
Conway, AR 72035-0001
(501) 450-5112
Fax (501) 450-5087

CMS-1385-P-10283

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

Organization : **Sickels Clinic of Chiropractic, Inc.**

Category : **Chiropractor**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

As a chiropractor I would urge you to reconsider allowing chiropractors to take x-rays and or refer patients out for x-rays as these are necessary for proper diagnosis and treatment of many of the ailments my patients present with. For the patient's safety as well as my liability sake. Thank you, Dr. Daniel .L. Sickels

Submitter : **Ms. Patricia Taylor** **Date: 08/28/2007**

Organization : **Metro Hand Rehabilitation**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sirs,

Please stop the practice of physicians self referring patients to physical therapy practices in which they have ownership. To me this is the ultimate kick-back....they directly benefit financially from sending their patients to their own clinics. Often we see patients asked to drive across town just to attend therapy at their clinic....

In the past decade I have watched as multiple physician practices have started clinics....they disguise their ownership by owning a percentage, but obviously they still receive benefit by sending more patients to the clinic......

Please stop this practice....the over-utilization makes all therapists look bad and we have to face the future consequences where allowances are cut due to their abuse.

Thank you

Patricia Taylor

CMS-1385-P-10284-Attach-1.DOC

#10284

August 20, 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 21244-801 **Re: Physician Office PT/OT Services**

Dear Mr. Weems,

I am writing this letter to express my concern regarding the in-office ancillary service arrangements that have impacted the delivery of quality Physical and Occupational Therapy.

Over the past decade, I have observed a dramatic increase in the formation of corporations in which physicians own interest in physical therapy/occupational practices. In the current loophole that exists with the "in-office ancillary services" exception, this allows physicians to make money from their referrals to their own therapists.....this is **not** viewed as a *kickback....**why***? They are directly benefiting financially from their referral which then encourages them to over-utilize. The more they send their patients to their clinic, the more money they make from their referral....why is this considered legal?

I am partners in three clinics in the Oklahoma City area that employ Certified Hand Therapists who are physical and occupational therapists with specialized training and certification through national examination in the field of hand therapy. Physicians that own their own therapy clinics often forego sending their upper extremity patients to Certified Hand Therapists to send them to their clinics without specialists. This is not in the best interest of the patient, only the physician who is making money from their own referral...***why*** is this **not** considered a conflict?

I recently had an orthopaedic surgeon tell me he would refer his patient to his therapists in downtown Oklahoma City rather than allow them to be seen in Edmond, the location of my clinic which is a suburb of Oklahoma City. When I inquired as to whether he was unhappy with our services, he responded "no, we were the best in town, but every time he sent us a patient, that was money out of his pocket". This requires his patients to drive 20 miles to receive care when they

can receive care within 2 miles of where they live. When a patient asks if they can receive care closer to home, the physician presents it in a manner that they work together as a team and he can keep a closer eye on their progress. The teamwork in the process is between the physician and his accountant...***why*** is this considered ethical behavior in the referral process.

Finally, I had another orthopaedic surgeon tell me recently he was puzzled by this loophole. He summed it up better than I have ever heard it done....he said he did not understand....if I approached a physician and offered $25 for every referral he made to me, it would be called a kickback and fraud because the physician would be receiving financial benefit from his referral. I could lose my license for doing so and receive huge fines. BUT, if a physician sends a patient to his own clinic he receives the full financial benefit of his referral and he is considered to be a good business man. Obviously, this particular physician saw it as unethical for physicians to direct their patients to their own therapy practices. ***Why*** does this loophole exist to allow such unethical referral practices?

I have practiced physical therapy for over 30 years. Seeing the change of my profession as it is impacted by the physician owned practices makes me fear for the future of my profession. It is not considered ethical by my professional organization for therapists to practice in physician owned practices, but often therapists are placed in the situation in which they want security in their jobs.....what is more secure than working for the physician who drives the referrals to your clinic? Some states are now beginning to mandate through their practice acts that therapists not be allowed to maintain their license if they practice in physician owned practices. That is how serious the problem is viewed. I would love to see this as a nationwide edict, but therapists have little money for lobbying in comparison to large medical lobbying groups who do not want to see this practice changed. I have been told that state medical associations have been told to block any changes in therapy practice acts that come into their states with such license restrictions. The issue revolves totally around physicians making money from their referrals. It is common for presentations to be made at orthopaedic meetings that promote physician owned therapy practices as a means of passive income for the physicians.

Please change this practice. As therapists we are being increasingly monitored for proper behavior, but the fox is coming in the front door without any chicken wire to stop them. It is time to stop this stop this. If CMS will make changes in the exception, then other payors will be quick to follow. I would be happy to

discuss this with you if you have any questions. Please call my office at (405) 359-7575. I would look forward to the opportunity to speak with you.

Sincerely,

Patricia A. Taylor, PT, CHT

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

Organization : **Mr. Douglas Jex**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

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

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,
Douglas G. Jex CRNA,MS

Submitter : Mrs. Sandra Schneider **Date:** 08/28/2007

Organization : American Association of Nurse Anesthetist

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
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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,
Sandy Schneider CRNA MSN
5802 Franklin Trail Liberty Township Ohio, 45011

CMS-1385-P-10287

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

Organization : Dr. Frederick Lodge

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-10288

Submitter : **Miss. Mary Harbach** **Date: 08/28/2007**

Organization : **Franklin Township School District**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Hello, my name is Mary Harbach, and I am a certified athletic trainer. I became certified in 2001 after passing the NATABOC certification exam. I received my bachelors degree in athletic training from East Stroudsburg University in 2001 and went on to earn my masters degree in sport psychology in 2003 from Ithaca College. I recently earned my certification as a strength and conditioning specialist. I am currently employed at a Group IV high school in Franklin, NJ. I was formerly employed at a hospital's physical therapy clinic, a different high school, and a Division III college. In my role as a certified athletic trainer, I use my medical knowledge and experience to evaluate, identify, treat, manage, and rehabilitate athletic injuries and illnesses. I have treated not only the athletes at the high schools and colleges I have worked at, but also the general population who were injured or recovering from surgery in the hospital's physical therapy clinic. I have worked along side many different health care professionals- other certified athletic trainers, doctors, surgeons, nurses, EMTs, physical therapists, and physical therapy assistants. I have referred athletes to other medical professionals when their injuries or illnesses required me to do so. I have aided injured athletes to return to play, prevented and treated life-threatening illnesses and injuries, and I have aided in general population members to return to their daily activities more comfortably and functionally. I have provided sound medical advice to family and friends who seek my counsel, and aided parents and coaches in the appropriate decision necessary to "do no harm" and allow athletes to heal, or compete if their bodies and health allowed. I have also worked to educate parents, coaches, athletes, and other members of the community about health and nutrition, as well as injury prevention and proper treatment.

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,

Mary B. Harbach, MS, ATC, CSCS
Certified Athletic Trainer
Franklin Township School Distri

CMS-1385-P-10289

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

Organization : **John H. Stroger, Jr. Hosp**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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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.

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Thank you for your consideration of this serious matter.

Ihuoma Ofoma, MD

CMS-1385-P-10290

Submitter :

Date: 08/28/2007

Organization :

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Bonnie Phillips, D.C.

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

Organization : **Manchester Monarchs Hockey Club**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Michael Muir and I now work as an athletic trainer in a setting with a professional team but I have worked in clinical and hospital settings in the past. I am certified by the National Athletic Trainer's Association with over 20 years of experience.

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

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

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

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

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

Sincerely,

Michael Muir, ATC, CSCS

CMS-1385-P-10292

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

Organization : **Charles Frederick**

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.

CMS-1385-P-10292-Attach-1.TXT

10292

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.

CMS-1385-P-10293

Submitter : Mr. Allen Passerallo **Date:** 08/28/2007

Organization : Cleveland Clinic

Category : Hospital

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I have been a certified athletic trainer for 20 years. I am currently employed by the Cleveland Clinic,(one of the top 5 hospitals in the U.S. according U.S. News and World Report, 2007) in Cleveland Ohio as a clinical athletic trainer and clinical manager with responsibilities of overseeing two out patient physical therapy clinics. I earned a Bachelor of Science degree in Sports Medicine and most recently a Masters degree in Business Administration

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

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

As a certified athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. If CMS is concerned about the well being of patients allowing a certified athletic trainer with experience and knowledge in the area of physical medicine and rehabilitation will assist in providing much needed care to this population. Politics and Turf Wars should not be the focus of concern with regard to these proposed changes, but placing patient s first allowing experienced and educated allied health care professionals the ability to provide care to a population that only will grow in the coming years.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. 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.

Respectfully,

Allen J. Passerallo ATC, MBA

CMS-1385-P-10294

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

Organization : **Exeter High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

28 August 2007
Dear Sir or Madam:
My name is Audrey Krause and I am a certified athletic trainer. Currently I am the Head Athletic Trainer at Exeter High School, a large AAAA suburban school. I have completed my undergraduate studies at Temple University, where I had the joy of working with such well known coaches as Dawn Staley and John Chaney. I have also received a Master s in Education from Alvernia College, which allows me to uniquely serve the student-athletes of EHS while also educating the parents, coaches, and administrators about the health and well-being of the children I serve (my patients). Education about my profession is a necessary component of what I do on a daily basis, because not everyone knows what ATC s are trained to do, their inherent skills, and the variety of their work settings. So far, everyone has listened and respect has been born of my efforts. I am concerned, however, that our own government will not provide an ear to our plight as proposed by the CMS ruling.
I am writing to you today to voice my strong opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients. I see many student-athletes who lack any other provider of healthcare, leaving myself and the school nurse as the first line of care for these 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,
Audrey Krause, M.Ed., ATC

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

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-10296

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

Organization : **National Health Services, Inc**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

CMS-1385-P-10297

Submitter : Mr. Koichi Sato **Date:** 08/28/2007

Organization : Athletes' Performance

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

This is Koichi Sato. I am a certified athletic trainer at Athletes' Performance in Los Angeles. I provide athletic training services to elite athletes. I also speak at medical symposiums and conferences internationally.

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,
Koichi Sato, MS, ATC

Submitter : **Ms. Kelly Berardini** **Date: 08/28/2007**

Organization : **Chapman University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Kelly Berardini, and I am a certified athletic trainer employed by Chapman University in Orange, California. I have previously held positions as an athletic trainer in the high school, corporate, outpatient rehabilitation clinic, and hospital settings. Additionally, I have expertise in the area of health care administration.

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 unnecessarily restrict 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, including physicians, 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 health care 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 access those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are critical to 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 responsible for 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,

Kelly Berardini, MHA, ATC

CMS-1385-P-10299

Submitter : Miss. Cindy Anderson **Date:** 08/28/2007

Organization : Pahoa High and Intermediate School

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer and I work at Pahoa High school in Pahoa, Hawaii. I am responsible for the injury prevention, assessment, and rehabilitation for all the athletes at the previous mentioned school. I recieved a bachelors degree from the univeristy of utah and my certification through the National Athletic Trainers Board of Certification. I am also certified in CPR, first aid, and the use of an AED(automated external defibullator) as well as a state professional license in the state of Utah.

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 serviees, 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,

Cindy Anderson, ATC-L

CMS-1385-P-10300

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear CMS
I am writing you concerning my concern that multiple patients from the local hospitals we serve in NW Iowa complaint that the ortho surgeons in Sioux City require them to drive down to their facilty for rehab services they could receive right in the patients home town. They relate to me the increased demands on their time to go 3x per week to see the MDs personnel therapists in the doctors office taking up to a half a day off from work and just get a few minutes of therapy when the same service could be offered locally saving the patient time away from home,save on $3dollar gas cost, and lost vacation or sick leave time etc. The patients relate fear of making the doctor mad at them and the threat of if the patients goes some where besides the doctors therapists then the doctor is no longer responsible for the outcome of the surgery. Essentially the patient is hand cuffed due to fear of reprisal from the doctors and the patients right to choose a provider of their choice is taken away due to a financial interest of the physician and not just concern for proper care as the doctors like the patient and government to think! Please take away the loophole of self referral of therapy services in the doctors office or clinics for profit and give the patients the right to choose without the fear of reprisal from their physician.

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

Organization : American Society of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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-10302

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

Organization : **Sheridan healthcare**

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.

CMS-1385-P-10303

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

Organization : **ryk tanalski**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-10304

Submitter : **Mr. Matt Bradley** **Date: 08/28/2007**

Organization : **Mr. Matt Bradley**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Matt Bradley I am a working athletic training in the private sector, but I am writing to help my fellow athletic trainers in the plight against changes that may lead to decrease in athletic trainers jobs in the clinical setting. I have worked in the clinical setting for many years and know the importance that each athletic trainer adds to patient care and it is an unjust change to limit the interaction with patients and athletic trainers. I would urge you to reevulate your position of change for the benefit of the patients.

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

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

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

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

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

Sincerely,
Matt Bradley, MA, ATC
Elite Athletic Trainer, Owner

CMS-1385-P-10305

Submitter : **Mr. Ross Anderson**

Date: 08/28/2007

Organization : **MVP Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-10305-Attach-1.DOC

#10305

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

RE: PHYSICIAN SELF-REFERRAL ISSUES

August 28, 2007

Dear Mr. Weems:

My name is Ross Anderson. I am a physical therapist who manages a PT clinic for MVP Physical Therapy in Port Orchard, WA. I have been a PT since 1996, operating in a management capacity for the last 8 years.

I am writing to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. My goal is to highlight the abusive nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

During my 12 years as a practicing physical therapist, I have experienced first-hand the negative results of unethical physician-owned practices. The potential for fraud and abuse exists whenever physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to over utilize those services for financial reasons. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, over utilization of physical therapy services under the Medicare program, and enhance the quality of patient care.

I have heard it argued that physicians must have direct supervision of their patients. Let me state first-hand that physician direct supervision is not needed to administer physical therapy services. A large part of my job is to stay in direct contact with the patient's physician - assuring that the patient is receiving the desired therapy and results. We have never had any problem keeping both the doctor and patient satisfied with this arrangement.

Since 1996, I have worked as a physical therapist in 5 different states - Washington, Texas, Tennessee, Connecticut, and North Carolina. Most, if not all of these states have assessed this issue and determined not to allow physician self-referral. They deemed it unnecessary and unethical. In my opinion, it would be nearly criminal for our state to do otherwise.

I hope you will take these comments to heart and make the ethical choice to keep physicians out of the business of self-referral.

Sincerely,

Ross M. Anderson, MPT

CMS-1385-P-10306

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

Organization : Lansing Chiropractic Office, PC

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Medicare has gone from requiring xrays on every patient to making it more expensive and difficult to obtain them. Xray is a service that is covered by CMS when ordered by any other class of physician. By requiring chiropractors to refer the patient to another provider for xrays will significantly raise the cost of providing that service. As a taxpayer and a provider I see no reasonable explanation why CMS should persue this legislation.

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

Organization : **Champion Sports Medicine**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My names is Christopher Riddle. I am a certified athletic trainer and certified strength and conditioning specialist for Champion Sports Medicine. There I provide comprehensive rehabilitation services to a variety of patients and then serve as an outreach provider for high school sports.

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

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

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

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

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

Sincerely,

Christopher Riddle, ATC, CSCS

CMS-1385-P-10308

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

Organization : **Dr. Joshua Eaton**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-10309

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

Organization : **South Denver Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms Norwalk,
I'm writing to show my strong support of CMS-1385-P Anesthesia Coding, an increase for anesthesia payment in 2008. Thank you for your consideration in this matter.
Sincerely,
Wendy Herhahn,M.D.

Submitter : **Ms. Courtney VanDorpe** **Date: 08/28/2007**

Organization : **Culver Academies**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Courtney Van Dorpe, I am a certified athletic trainer, corrective exercise specialist, and health teacher at Culver Academies in Indiana.

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

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

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

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

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

Sincerely,

Courtney Van Dorpe ATC CES MS

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

Organization : **Fayetteville State University**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is John Townsend, and I am the head athletic trainer at Fayetteville State University of the University of North Carolina school system. I have been a certified athletic trainer for almost 5 years after working hard on my BS at the University of Central Florida and my MS at Montana State University-Billings. My current position charges me with the duty of being the primary medical service provider of the over 200 student-athletes at Fayetteville State University.

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

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

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

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

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

Sincerely,

John D. Townsend, MS, LAT, ATC
Head Athletic Trainer
Fayetteville State University

CMS-1385-P-10312

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

Organization : William Paterson University

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

As a practicing athletic trainer in the state of New Jersey, 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,

Robb S. Rehberg, PhD, ATC, CSCS, NREMT
Director of Athletic Training Education
William Paterson University
Wayne, NJ

Submitter : **Mr. Daniel Carroll** **Date: 08/28/2007**

Organization : **Mercersburg Academy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Daniel Carroll and I am a Certified Athletic Trainer. I hold a B.S. degree from Averett University in Athletic Training and a MEd from the University of Virginia in Sports Medicine. I work at Mercersburg Academy, a private boarding school, as a full-time 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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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Daniel Carroll, ATC

CMS-1385-P-10314

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

Organization : Anesthesiology Group Assoc., Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

CMS-1385-P-10314-Attach-1.DOC

#10314

Leslie V. Norwalk, Esq.

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

James Fenn MD, President
Anesthesiology Group Assoc., Inc.
Baton Rouge, LA.

CMS-1385-P-10315

Submitter : **Mr. Derek Butler** **Date: 08/28/2007**

Organization : **Bay Area Medical Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Derek Butler and I'm the orthopedic service line leader for Bay Area Medical Center in Marinette, WI.

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

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

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

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

PLEASE TAKE A HARD LOOK AT THIS ISSUE!

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. Not only does the athletic training staff support current hospital programs it they also provided a much needed service to many local high schools. This service is currently offered for free to our parterning high schools but this service maybe cut because of the hospitals inability to support its athletic training positions. Please realize that certified athletic trainers support communities and a number of different populations from children to adolesence, to adults. Last year our athletic training staff saved local parents hundreds of thousand of dollars in medical expenses. This decision can and will have larger inpact on smaller communities that just access for seniors. If hospitals and clinics cannot support athletic training jobs and are forced to cut programs the parents will be passed on additional healthcare cost of these lost free services.

Sincerely,

Derek Butler, LAT, ATC
Orthopedic Service Line Leader/
Athletic Trainer
Bay Area Medical Center
Marinette, WI

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

Organization : **University of Oklahoma Health Sciences Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Dr. Todd Gleaves, MD

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

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

CMS-1385-P-10318

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

Organization : **Critical Health Systems of North Carolina**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Anesthesia Coding (Part of 5-Year Review)

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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 and for taking steps which will improve the quality of anesthesia care for our nation's senior citizens.

Sincerely,

Reed M. VanMatre M.D.
Critical Health Systems of N.C.

CMS-1385-P-10319

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

Organization : U. of Oklahoma Health Sci Center

Category : Physician Assistant

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Mrs. Tara L Gleaves, PA-s

CMS-1385-P-10320

Submitter : Mr. DANIEL DOWDY **Date:** 08/28/2007

Organization : AMARILLO UROLOGY ASSOCIATES, LLP

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see our attached letter. Thank you. Daniel A. Dowdy, Chief Operating Officer, Amarillo Urology Associates, L.L.P.

CMS-1385-P-10320-Attach-1.DOC

10320

AMARILLO UROLOGY ASSOCIATES, L.L.P.

1900 Medi Park Drive
Amarillo, Texas 79106
Phone: (806) 355-9447

P. O. Box 51800
Amarillo, Texas 79159
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Richard G. Kibbey, M.D.
Gary L. Brown, M.D.
Ronald W. Ford, M.D.
C. Sloan Teeple, M.D.
Rita Fe G. Tibbs, M.D.

Virgil A. Pate, M.D.
Michael D. Wilkerson, M.D.
David M. Wilhelm, M.D.
Robert H. Ritter, M.D.

August 31, 2007

RE: CMS-1385-P; Physician Self-Referral Provisions

Ladies and Gentlemen:

We are writing to convey our opinions about potential changes to the physician self-referral provisions, as noted in the 2008 Proposed Physician Fee Schedule released July 2, 2007. We are urologists practicing in Amarillo, Texas, and we believe several of the proposed changes will needlessly and unjustifiably harm Medicare patients and providers. Although we understand and support the efforts by CMS to prevent abusive practices, we believe the current proposals will hamper valuable and legitimate joint venture arrangements. We believe that CMS should address its concerns in a much less intrusive manner.

Urologists, as well as other specialists, have seen the beneficial effects that joint ventures have had on the healthcare system. Urology joint ventures have provided patients lithotripsy and other cutting edge therapies for disease that would not have been otherwise available to patients, including Medicare beneficiaries. By accepting the risk of providing these costly services when hospitals refused to do so, urology joint ventures have greatly expanded patient access to worthwhile and effective treatments. Yet the proposals in your 2008 Physician Professional Fee Schedule attack the substance of the very joint ventures that saved Medicare millions of dollars and increased beneficiary access to effective treatments.

In the paragraphs that follow, we will discuss the various anti-physician ownership proposals that we believe will have a negative effect on the healthcare system, if adopted, in the order in which they were presented in the proposed rule.

1. **Proving that Referrals are not made in violation of Stark**

CMS proposes that a provider should bear the burden of proving that referrals were not made in violation of Stark in any appeal of a denial of payment on this basis. This appears to require that providers prove a negative (that a prohibited arrangement

leading to a referral did not exist), which would be difficult if not impossible to accomplish. Complicating matters is that most Stark exceptions require payments to be made at fair market value and in a manner that does not reflect the volume or value of referrals or other business between the parties. Valuation experts often disagree on what is fair market value and we do not know of an efficient and effective method of proving that a payment does not reflect the volume or value of referrals.

This proposal will also mean that CMS or its contractors will sit as judge and jury over complex matters in which experts themselves may have varying opinions – with the burden of proof on the provider. So, not only are we to take care of the health problems of our Medicare beneficiary patients at a price set arbitrarily by CMS, we now face the burden of proving after the treatment that our actions were legal, rather than the governmental agency which writes the law proving that our actions were illegal.

2. Per Click Payments & Percentage-Based Fee Arrangements

It is our understanding that Congress' intent, as recognized by CMS in its Phase I rulemaking, is to permit time-based or unit-of-service-based payments for space and equipment leases. The proposal to prohibit these arrangements, therefore, directly contradicts Congressional intent. CMS should not prohibit an arrangement that Congress expressly intended to permit.

In addition, CMS indicates that it is concerned with "per click" lease arrangements involving designated health services (DHS). However, the proposed rule may apply the prohibition to all lease arrangements in which physicians have ownership in the service, not only those involving DHS. Although we are unconvinced that per click arrangements are by definition abusive, at the very least the ban should not apply to services that are not DHS and, if provided in a hospital, to those services that would not be DHS if provided in another setting.

Historically, hospitals have generally been unwilling to take risks and are often operating on very thin margins. Hospitals are averse to bearing the risk of low volume usage for new and innovative technologies and services. When physician joint ventures bring these beneficial technologies to hospitals, the hospitals may require per click arrangements to protect themselves from the risk of low volume. The physicians who invest in these joint ventures, however, are willing to take the risk of failure. Thus, per click arrangements are essential to bringing new, improved treatments to many places in America, by allowing cash-strapped hospitals to pay risk-taking joint ventures to bring new treatments and technologies to them, without the hospitals having any financial risk for less than projected use or adoption. By banning per click lease arrangements, CMS may inadvertently preclude beneficiary access to innovative treatments.

Further, per click arrangements are vital to the provision of certain services such as lithotripsy. Patients scheduled for lithotripsy services often will require unexpected additional or separate services. These services may include insertion or removal of a stent, ureteroscopy, or cystoscopy. The hospital and the provider of these services are unable to determine in advance which procedures will be required. Per click fees are the most accurate and fair way to determine compensation.

We also believe that percentage-based compensation arrangements enable new treatments and technologies to be offered to more beneficiaries and are not inherently abusive as CMS seems to believe. Like per click arrangements, percentage-based arrangements allow the apportionment of the risk of low or no volume for new or costly therapeutic modalities. It is unclear to us why a person or entity that brings a service to a hospital should not be compensated in proportion to the payments. Such arrangements may, in fact, more accurately reflect the value of the efforts provided by the entities than a flat fee arrangement. We believe it would be unwise for CMS to adopt a blanket prohibition of percentage-based fee arrangements, which may result in unintended consequences.

3. "Stand in the Shoes" / Indirect relationships

Typically, Medicare reimbursement for services provided at ambulatory surgical centers (ASCs) is lower than reimbursement at hospitals. We believe this causes CMS to encourage more procedures to be performed in ASCs. Many ASCs, however, are owned or controlled partially or entirely by a local hospital. If a referral to an ASC is viewed by CMS as a referral to the hospital, it will become impossible for legitimate physician joint ventures to provide services at those ASCs. The likely result would be for physicians to withdraw from hospital-owned ASCs and build additional ASCs to provide services to their patients. This will add to the cost burden and may squeeze the efficiencies of the current system.

4. Services Furnished "Under Arrangements"

It appears that the goal of the proposed changes to the Stark regulations regarding services furnished under arrangements is to prohibit physician joint ventures from contracting with hospitals to provide diagnostic DHS. Unfortunately, the proposals are so broad that they would ban legitimate, non-abusive arrangements for therapeutic services that are not otherwise DHS except for the fact that they are performed in a hospital setting. The urologic services that will be affected include a variety of laser procedures for the treatment of benign prostate disease and cryotherapy for cancer of the prostate. Based on the commentary in the proposed rule, CMS seems to view that physicians who invest in these joint ventures do so at the expense of good patient care. Our experience refutes this stance. On our urological joint ventures, the primary purpose of physician investment is to improve patient care.

In the healthcare arena, new technologies and innovations to prior technologies are constantly being introduced. Maintaining state of the art technology is expensive. As noted above, hospitals are reluctant to undertake the expense and the risk that today's "best" technology will be obsolete tomorrow. Urology joint ventures, on the other hand, are willing to take and have undertaken that risk. Lithotripsy is a useful illustration of this dynamic. In the mid-1980s, hospitals refused to purchase lithotripters because they did not want to make large capital expenditures and lose an existing revenue source (invasive surgical procedures to remove kidney and ureteral stones that were too large for a patient to pass naturally). Physicians, wanting a better treatment for their patients, formed joint ventures to buy lithotripters and were fought at every turn by the hospitals. This refusal by hospitals to undertake the risk of innovative and

effective new technologies continues. Physicians want to have new technology available for their patients in order to provide the best patient care.

In addition, a single hospital often does not have enough volume to justify the expense of purchasing certain technology. Physicians who want up-to-date treatment for their patients are willing to invest in joint ventures with other physicians practicing at other hospitals to purchase the technology. This way, usage can be spread among several hospitals on a rotating basis. The healthcare system, including CMS, benefits because otherwise unavailable technology is brought to both urban and rural settings, and the cost is spread among several providers, reducing overall capital costs.

As the court in ALS v. Thompson noted, extracorporeal shockwave lithotripsy is not a DHS even though it is provided under arrangement with a hospital. It would be highly beneficial to patients and providers if CMS also exempted procedures that are not otherwise DHS from the proposed prohibitions to under arrangements.

It also appears that the reason CMS wants to ban services under arrangements where there is physician ownership is because it has heard of questionable diagnostic imaging arrangements. CMS does not identify any overuse or improper referrals for therapeutic services such as laser services or other urological procedures. Fairness would dictate that under arrangements should not be prohibited for services that would not otherwise be DHS but for being furnished in a hospital.

The incentive to over utilize which may be present in diagnostic imaging services is not present for most other services furnished under arrangements where the referring physician also performs the professional portion of the referred procedure. Where urologists perform therapeutic procedures, the referring physician receives a professional fee and the professional fee is greater than the distributions for any particular referred procedure that the physician will earn from his or her investment interest in the joint venture. The portion of the technical fee earned in distributions from his investment in the venture is not likely to create an inducement to refer for the procedure. CMS should not prohibit services under arrangements where the investor physician performs the professional portion of the procedure.

In conclusion, we ask CMS to separate beneficial therapeutic joint ventures that are not of themselves DHS from the abusive and questionable diagnostic ventures that physicians and hospitals may have propagated. It should be clear to CMS as it tries to stop abusive arrangements that the urology community's joint ventures are not abusive and in fact have broadened access to new technology for Medicare patients, brought needed efficiency to the market, and saved CMS hundreds of millions of dollars.

Sincerely,

s/ Richard G. Kibbey III, M.D.; s/ Virgil A. Pate, M.D.; s/ Gary L. Brown, M.D.
s/ Michael D. Wilkerson, M.D.; s/ Ronald W. Ford, M.D.; s/ David M. Wilhelm, M.D.
s/ C. Sloan Teeple, M.D.; s/ Robert H. Ritter, M.D.

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

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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-10322

Submitter : **Mr. Gary Gleaves** **Date: 08/28/2007**

Organization : **Mr. Gary Gleaves**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Gary Gleaves, Oklahoma City

CMS-1385-P-10323

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

Organization : **The Permanente Medical Group, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today Medicare payment for anesthesia services stands at just $16.19 per unit (When I started practicing in 1989 Medicare was paying about $35.00 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.

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Thank you for your consideration.

Brian J. Bane, M.D.
28 Castlewood Drive
San Rafael, CA 94901

Submitter : **Mrs. Sherri Gleaves** **Date: 08/28/2007**

Organization : **Mrs. Sherri Gleaves**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Sherri Gleaves,Oklahoma City

Submitter : **Mr. Bill Gleaves** **Date: 08/28/2007**

Organization : **Mr. Bill Gleaves**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Bill Gleaves

Submitter : **Mrs. Margie Gleaves** **Date: 08/28/2007**

Organization : **Mrs. Margie Gleaves**

Category : **Individual**

Issue Areas/Comments

GENERAL

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

Re: CMS-1385-P
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.

Margie Gleaves

Submitter : **Mrs. Connie Drago** **Date: 08/28/2007**

Organization : **Virginia Beach City Public Schools**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Connie Drago, and I am a Certified Athletic Trainer with Virginia Beach City Public Schools. I have earned both a Bachelor's of Science and Master's of Science degree in Athletic Training. I have been working at my current school for the past 10 years where I provide athletic training services to 30 various teams throughout the school year.

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

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

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

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

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

Sincerely,

Connie Alwine Drago, MSEd, ATC

CMS-1385-P-10332

Submitter : Mrs. Terry Freemark **Date:** 08/28/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

This increase in Medicare payment is important for several reasons.

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

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

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

CMS-1385-P-10333

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

Organization : Portland Trail Blazers

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Geoff Clark and currently I hold a position as the assistant athletic trainer for the Portland Trail Blazers of the NBA. Since 1988, I have worked in the clinical and industrial settings, college athletics, as well as professional baseball and basketball. As an athletic trainer, I am trained as an allied health care professional acting as a gatekeeper to the health care industry. My abilities both as a first responder, triage expert, and rehabilitator are vital to safety of the general public, especially those with active lifestyles.

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,

Geoffrey W. Clark, ATC, CSCS, PES, CES

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

Organization : Health Science Center, UT Houston, Medical School

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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.

Maria Matuszczak

CMS-1385-P-10335

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

Organization : **HealthQuest Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To CMS regarding the Stark Referral for Profit loophole which allows physicians to bill for physical therapy under " in office ancillary services". This is an obvious conflict of interest and should not be allowed.

CMS now requires patients being seen in physican owned practices to be treated by a licensed Physical Therapist(PT). Why? Because there were all sorts of various unskilled persons providing "care" to patients that was being billed as Physical Therapy under in office ancillary service provisions. The patients are the real victims here while the physicians profit handsomely.

CMS now requires closer supervision and attendance by physicians than ever before to patients receiving physical therapy in physician owned facilities. This is the result of a response to stop abusive use of the in office ancillary service provision allowed by physicians.

It is time to stop allowing physicians the ability to provide services for which they have little to no training in (unless they are physiatrists) The autonomy for the field of physical therapy belongs to the professionals who work for years to become educated and proficient at their profession- PHYSICAL THERAPISTS. We are part of a medical team with physicians. Patients are best served when both professions can practice freely in the roles they are most qualified for.

I hope that CMS will see that physical therapy services should not be allowed under the in office ancillary services exception and take such steps to correct this. Thank you. Todd C.

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

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

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

CMS-1385-P-10337

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

Organization : **nathanson chiropractic p.a.**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

This provision create more health care problems and could endanger the health of Medicare recipients. Medicare patients often require x-rays, because of their age and infirmitics.Increasing steps, costs, and more hoops for patients to jump through are counterproductive with respect to quality health care.

CMS-1385-P-10338

Submitter : Cecil Ashby

Date: 08/28/2007

Organization : Cecil Ashby

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

The proposed changes to the radiological requirements for medicare patients with the medical necessity of chiropractic services is offensive. The change is unneccessary and will cause undue burden on those patients seeking sound, thorough, safe care from a chiropractor. It is a general practice of the chiropractic profession to be well trained in radiology and to use radiological studies to determine the proper course of treatment for the patient. At the least to determine any contraindications to care. This change if passed will create obstacles to, the diminishment of, and an overall lowering of the standard of care for U.S. citizens.

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am a physical therapist and an athletic trainer. I work as a supervisor in a hospital-based outpatient orthopedic clinic. I have a Bachelor of Science in Athletic Training and a Master of Physical Therapy.

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

CMS-1385-P-10340

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

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services
I am writing to express my support for the proposal to increase anesthesia payment under the 2008 Physician Fee Schedule.Medicare payment for anesthesia services needs an urgent correction. Not to be glib; but three college age young men who provide my lawn service, charge $45.00 per cutting. They do my lawn and the neighbors on each side. They charge the neighbors the same and are finnished with all of us in twenty to thirty minutes. I can be doing a complex open heart procedure under circulatory arrest,but if it is a medicare patient, the boys doing my lawn are being compensated as well if not better for their services. I hope Medicare will soon begin to pay anesthesia providers realistically for our services.

CMS-1385-P-10341

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

Organization : **Dr. Lisa Royer**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

Re: TECHNICAL CORRECTIONS

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

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

By limiting a Doctor of Chiropractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resourees 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,

Lisa D. Royer, DC

CMS-1385-P-10342

Submitter : **Ms. Matthew Rondeau** **Date: 08/28/2007**

Organization : **Boston University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a licensed certified athletic trainer (ATC) who works at Boston University. I attended two rigorous progams to obtain national certification and further my researeh,clinical and teaching skills (Ithaca College and UNC-Chapel Hill.)I have only been a certified athletic trainer for a couple years but I have already seen the detrimetal affects that bills similar to this have on my profession.

Thus, 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, M.Will Rondeau MA,ATC,LAT,CSCS,PES

CMS-1385-P-10343

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

Organization : **Mr. Jeff Mangus**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

Dear sir:

My name is Jeff Mangus and I am an athletic trainer in Florida. I work at a hospital in Weston, FL. My job duties include helping to treat patients in the outpatient unit as well as ordering all braces and delivering them to the floors to the nurses. I also assisted the physical therapist in the hospitalmin getting patients out of bed. I also work with a local high scholl covering all of their athletic events.I have a bachelor of science degree in athletic training. I am a certified as an athletic trainer by the National Athletic Trainers Association. I am licensed in Florida and Pennsylvania. I have 12 years of experience in physical medicine and rehabilitaion.

I am writing today to voice my opposition to the therrapy standards and requirements inregardsto 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 Participationhave not received the proper and usual vetting. I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients. THe facility in which I work as a 2 to 3 week wait for patients to get an appointment.

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

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

Sincercly

Jeff Mangus, ATC

CMS-1385-P-10344

Submitter : **Mrs. Judy Kaufer** **Date: 08/28/2007**

Organization : **Hesperia Unified School District**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,

I am a certified athletic trainer, working in the secondary school setting for the past 12 years.

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

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

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

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Sincerely,

Judy Kaufer, ATC

CMS-1385-P-10345

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

Organization : **Anesthesia Associates of Opelousas, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

David C. Pearce, MD
President, Anesthesia Associates of Opelousas, Inc.
PO Box 459
Opelousas. LA 70571

Submitter : **Ms. Tina Poliska** **Date: 08/28/2007**

Organization : **ATI Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Tina Poliska, I am an athletic trainer for ATI Physical Therapy. I have been certified for 3 years and love every aspect of my job and am concerned with such regulations. I work in both the clinic and high school settings.

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,

Tina Poliska, MSEd, ATC

CMS-1385-P-10347

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

Organization : ANESTHESIA CONSULTANTS OF INDIANAPOLIS

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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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.

CMS-1385-P-10348

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

Organization : **Dr. Adam Walthall**

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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Thank you for your consideration of this serious matter.

CMS-1385-P-10349

Submitter : **Mr. Will Bauscher** **Date: 08/28/2007**

Organization : **Corvallis Fire Department**

Category : **Local Government**

Issue Areas/Comments

GENERAL

GENERAL

Sec Attached

CMS-1385-P-10349-Attach-1.DOC

ambulance provider or supplier to document that the beneficiary was unable to sign, and the reason no one could sign on behalf of the beneficiary.

Summary of New Exception Contained in Proposed Rule

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. If "provider" in this context was intended to mean a facility or entity that bills a Part A Intermediary, the language should be changed to also include "ambulance supplier". The proposed exception essentially mirrors the existing requirements that the beneficiary be unable to sign and that no authorized person was available or willing to sign on their behalf, while adding additional documentation requirements. Therefore, we believe that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed sub-division (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, we do not see any reason to include the additional requirements of: (1) a contemporaneous statement by the ambulance employee or (2) documentation of the date, time and destination of the transport. Again, the current industry standard relating to encounter documentation are more than adequate to meet the desired goals of the proposed rule.

The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. CFD strongly objects to this new requirement as the following would likely result from it's adoption:

1. Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.
2. Hospital personnel will often refuse to sign any forms when receiving a patient resulting in the beneficiary being responsible for the claim.
3. The ambulance provider or supplier would in every situation now have the additional burden in trying to communicate to the beneficiary or their family, at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.
4. Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ER Admitting Record, etc.

We also strongly object to the requirement that ambulance providers or suppliers obtain this statement from a representative of the receiving facility *at the time of transport*. Since the

proposed rule makes no allowances for the inevitable situations where the ambulance provider makes a good faith effort to comply, but is ultimately unable to obtain the statement, we believe this requirement imposes an excessive compliance burden on ambulance providers and on the receiving hospitals. Consider what this rule requires—the ambulance has just taken an emergency patient to the ER, often overcrowded with patients, and would have to ask the receiving hospital to take precious time away from patient care to sign or provide a form. Forms such as an admission record will become available at a later time, if CMS wants them for auditing purposes.

Institute of Medicine Report on Hospital Emergency Department Overcrowding
The report recommended that hospitals find ways to improve efficiency in order to reduce ED overcrowding. However, the requirement that ambulance providers or suppliers obtain a statement from a representative of the receiving hospital at the time of transport would only confound the existing problem, by adding an additional paperwork burden. To meet this requirement, ambulance crews would be forced to tie up already overtaxed ED staff with requests for this statement. The Institute of Medicine report makes clear that this time would be more efficiently spent moving patients through the patient care continuum.

Purpose of Beneficiary Signature

a. Assignment of Benefits - The signature of the beneficiary is required for two reasons. The first purpose of the beneficiary signature is to authorize the assignment of Medicare benefits to the health care provider or supplier. However, assignment of covered ambulance services has been mandatory since April 2002. Furthermore, 42 C.F.R. §424.55(c), adopted November 15, 2004 as part of the Final Rule on the Physician Fee Schedule (67 Fed. Reg. 6236), eliminated the requirement that beneficiaries assign claims to the health care provider or supplier in those situations where payment can only be made on an assignment-related basis. Therefore, the beneficiary's signature is no longer required to effect an assignment of benefits to the ambulance provider or supplier.

CMS recognized this in the Internet Only Manual via Transmittal 643, by adding Section 30.3.2 to Pub. 100-04, Chapter 1. As a result, the beneficiary signature is no longer needed to assign benefits of covered ambulance services.

b. Authorization to Release Records - The second purpose of the beneficiary signature is to authorize the release of medical records to CMS and its contractors. However, the regulations implementing the HIPAA Privacy Rule, specifically 45 C.F.R. §164.506(c)(3), permit a covered entity (e.g. an ambulance provider or supplier) to use or disclose a patient's protected health information for the covered entity's payment purposes, without a patient's consent (i.e. his or her signature). Therefore, federal law already permits the disclosure of medical records to CMS or its contractors, regardless of whether or not the beneficiary's signature has been obtained.

Signature Already on File
Almost every covered ambulance transport is to or from a facility, i.e. a hospital or a skilled nursing facility. In the case of emergency ambulance transports, the ultimate destination will always be a hospital. These facilities typically obtain the beneficiary's signature at the time of admission, authorizing the release of medical records for their services *or any related services*.

The term "related services", when used by hospitals and Skilled Nursing Facilities can mean more than only entities owned by or part of the facility. We believe that ambulance transport to a facility, for the purpose of receiving treatment or care at that facility, constitutes a "related service", since the ambulance transports the patient to or from that facility for treatment or admission. Therefore, we believe a valid signature will be on file with the facility. Additionally, for those transports provided to patients eligible for both Medicare and Medicaid, a valid signature is on file at the State Medicaid Office as a product of the beneficiary enrollment process.

Electronic Claims

It is also important to note that, as a result of section 3 of the Administrative Simplification Compliance Act and the implementing regulations at 42 C.F.R. §424.32, with very limited exceptions (e.g. providers or suppliers with less than 10 claims per month), ambulance suppliers must submit claims electronically. Thus, the beneficiary does not even sign a claim form. When submitting claims electronically, the choices for beneficiary signature are "Y" or "N". An "N" response could result in a denial, from some Carriers. That would require appeals to show that, while the signature has not been obtained, an alternative is accepted. As a result, many Carriers allow a "Y", even though the signature was not actually obtained, if one of the exceptions is met.

While this may be a claims processing issue, since you are now looking at the regulation, this would be a good time to add language indicating that the signature requirement will be deemed to be met if one of the exceptions to the requirement exists.

Program Integrity

It is important for CMS to realize that, for every transport of a Medicare beneficiary, the ambulance crew completes a trip report listing the condition of the patient, treatment, origin/destination, etc. AND the origin and destination facilities complete their own records documenting the patient was sent or arrived via ambulance, with the date. Thus, the issue of the beneficiary signature should not be a program integrity issue.

Conclusion

Based on the above comments, it is respectfully requested that CMS:

- Amend 42 C.F.R. §424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that "good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported".
- Amend 42 C.F.R. §424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
- Amend 42 C.F.R. §424.36(b) (5) to add "or ambulance provider or supplier" after "provider".

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

Thank you for your consideration of these comments.

Respectfully,

Will Bauscher B.S. NREMT-P
Emergency Medical Services Chief
Corvallis Fire Department

Submitter : Dr. James Larson

Organization : Pacific Anesthesia

Category : Physician

Date: 08/28/2007

Issue Areas/Comments

GENERAL

GENERAL

Scc attachment

CMS-1385-P-10350-Attach-1.TXT

#10350

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 yours,

James Larson, MD

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

Organization : **Tadahiro Katori**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Tadahiro Katori.
I'm a head athletic trainer for Eastlake High School, Sammamish, WA.
I received Bachelor of Science degree in athletic training at Boise State University and successfully passed national certification exam to become a certified athletic trainer.
I hold a certification of NATA Board of Certification and CPR and First Aid instructor of American Heart Association.

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

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

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

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,

Tadahiro Katori, ATC

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

Organization : Dr. PHILLIP VENABLE

Category : Physician

Issue Areas/Comments

TRHCA--Section 101(d): PAQ1

TRHCA--Section 101(d): PAQ1

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.

CMS-1385-P-10353

Submitter : **Ms. Andrew Stephens** **Date: 08/28/2007**

Organization : **Northside Anesthesiologist Consultants**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please CMS-1385-P. I am an Anesthesiologist Assistant and work as part of the anesthesia care team. My employers currently pay me an overtime rate which is much less than what is reimbersed by the federal goverment. We provide a critical componet to patient care. Support of cms-1385-p would help to assure competent medical care.

CMS-1385-P-10354

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

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Thank you for your consideration of this serious matter.

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

Organization : **Long Beach Memorial HOspital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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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.

CMS-1385-P-10356

Submitter : **Mr. Dwight Randall Jr.** **Date: 08/28/2007**

Organization : **Spring Meadows West Physical Therapy and Sports Me**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Certified Athletic Trainer at a high school in Ohio. I am currently in Graduate School pursuing my Master's Degree. I have been blessed with the opportunity to apply my clinical knowledge and skills in the secondary school setting while working to further my education. I truly believe that access to Athletic Trainers in secondary schools is vital. The proposed legislation would jeopardize the health care of the students involved in sports across the country. I hope that you will take the time to review the proposed changes and consider the opinions of those effected at the grass roots level as well as the experts who are pleading to you as well.

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

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

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

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

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

Sincerely,

Dwight Randall Jr., ATC-L

CMS-1385-P-10357

Submitter : Mrs. Elizabeth Lamb **Date:** 08/28/2007

Organization : Doctors Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

My name is Elizabeth Lamb, and I am a Certified Athletic Trainer. I am also the Director of Outpatient Rehabilitation at a local hospital in Augusta 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.

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Sincerely,

Elizabeth Lamb, ATC

CMS-1385-P-10358

Submitter : Mr. Mark Escandon

Date: 08/28/2007

Organization : Seattle University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

scc attachmcnt

CMS-1385-P-10358-Attach-1.DOC

#10358

Dear Sir or Madam:

My name is Mark Escandon, I am a certified athletic trainer working at Seattle University. I am in charge of the healthcare for 180 varsity athletes. I received a Bachelors of Arts degree from Western Washington University in 1995 and was Certified by the National Athletic Trainers Association in 1995 as well.

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

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Sincerely,

Mark Escandon, ATC

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

Organization : **The RehabGYM**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Michael Landsberg and I am a Certified Athletic Trainer in Vermont. I currently practice in an outpatient sports medicine clinic that treats a broad patient population. The patients that I work with are individuals that are physically active and are recovering from musculoskeletal injuries.

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

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

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Sincerely,
Michael Landsberg, ATC, CSCS, PES

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

Organization : **Maccio Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

CMS has an opportunity to prevent unnecessary surgeries and expenses by not allowing physicians to own Physical Therapy services. This practice has been shown to be abusive, costly and dangerous to the consumer. Physical Therapist evaluate and treat musculo-skeletal conditions that are often corrected with exercise. I have personally prevented hundreds of patients from unnecessary surgery. Could I do that if I worked for a doctor? In my area orthopedist, family practice, and occupational medicine have all owned PT clinics or have had some type of financial arrangement. Neurosurgeons have now opened their own PT clinics and no longer refer to clinics with proven outcomes. I recently had a Blue Shield medical director call to explain how surgical rates have risen dramatically over the past 3 years. This is the same time period that the spine surgeons opened their own clinics. She was interested in my certification as a McKenzie Spine clinic and wanted to know how many of the spine surgeons referred to me. In the past 3 years none. Prior to owning their own clinics they would refer to me exclusively based on our results. A new book has been published titled "Rapidly Reversible Low Back Pain" by Dr. Ronald Donelson. This book identifies specific test done by physical therapist that should be done on every spine patient before surgery is considered. In countries where this is done routinely surgical rates have dropped significantly. I would be more than happy to send you a copy of this book. Please consider eliminating this abusive practice before the physical therapy profession no longer exist. The implementation of this ban would be a major step towards healthcare reform and would result in substantial savings to all and especially to our patients.

Joseph G. Maccio, MA, PT, Dip. MDT
jmaccio1@nycap.rr.com
518-273-2121

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

Organization : **Northside Anesthesia Services**

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.

CMS-1385-P-10362

Submitter : Dr. Tona Hetzler

Date: 08/28/2007

Organization : Missouri State University

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Tona Hetzler and I am a Certified Athletic Trainer and the Department Head for the Missouri State University Sports Medicine and Athletic Training Education Program. Because of my passion for athletic training and my role as an educator for future athletic trainers I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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Sincerely,

XXXXXX, ATC (and/or other credentials)

CMS-1385-P-10363

Submitter : **Ms. Kevin Jones** **Date: 08/28/2007**

Organization : **Certified Athletic Trainer**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Kevin M. Jones and I am a certified athletic trainer. I work in Madisonville, KY at Trover Health Systems Sports Medicine. I see patients in the clinic as well as cover a local high school and cover their athletics and take care of the athletes. I also have a Masters degree to go along with my national certification.

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

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

Organization : **Missouri State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

Submitter : **Ms. Kevin Jones** **Date: 08/28/2007**

Organization : **Certified Athletic Trainer**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Kevin M. Jones and I am a certified athletic trainer. I work in Madisonville, KY at Trover Health Systems Sports Medicine. I see patients in the clinic as well as cover a local high school and cover their athletics and take care of the athletes. I also have a Masters degree to go along with my national certification.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
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Sincerely,
Kevin M. Jones, MS, ATC

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

Organization : **Brookhaven Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Thanking you,
Sincerely
Dr.Tanguturi, Director of Anesthesia,
Brookhaven Memorial Hospital,
Patchogue, NY 11772

CMS-1385-P-10367

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

Organization : **Champion Sport Medicine**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My Name is Eric Gahan MS, ATC. I work for champion sports medicine in Birmingham Alabama. I am a certified athletic trainer. I have a BS from Canisius Collge in athletic training and also an MS from the University of Kentucky in kinesiology and health promotion.

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,

Eric W. Gahan, MS ATC

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

Organization : Sheridan healthcare

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

sec Attachment

CMS-1385-P-10368-Attach-1.PDF

#10368

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

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

Organization : **HCA**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an athletic trainer working in a sports medicine rehabilitation clinic in Texas. With my master's degree in applied physiology and kinesiology, I have an important role in our clinic by helping busy physical therapist.

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,

Takashi Onuki, MS, ATC, LAT, CSCS, PES

CMS-1385-P-10371

Submitter : Dr. Robert Wise

Date: 08/28/2007

Organization : Dr. Robert Wise

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

To eliminate payment for xrays referred to a radiologist by a chiropractor is not in the best interest of the patient because patient could be injured do to containdication to treatment was not found because no diagnostic xray was preformed thereby adding to increase cost to the medicare system. Also, this puts additional unneeded liability onto the chiropractor. Referring patient back to their PCP will just add cost to the system and delay care.

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

Organization : **University of Chicago**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer at the University of Chicago and dedicated toward advancing the profession of athletic training.

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

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

Frank Shipley, MS,ATC,LAT

CMS-1385-P-10373

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

Organization : **Tulane 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 a certified athletic trainer (ATC) who is currently employed in the college/university setting. I have over 20 years experience in the prevention, care, assessment, treatment and rehabilitation of injuries. I am concerned that the proposed changes have a dual effect of driving up medical costs and also denying patients (and the Physicians that refer them) their right to choose who provides 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.

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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,

Andrew N. Masset, MAT, ATC

Submitter : **Mr. Yasuaki Okawa** **Date: 08/28/2007**

Organization : **Clemson University**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a graduate assistant Athletic Trainer for Clemson University.

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

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

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

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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,

Yasuaki Okawa, ATC

CMS-1385-P-10376

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

Organization : **Dr. Gayle Whittaker**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dr. Gayle Whittaker,
Chiropractor,
7020 Austin St, Suite 107,
Forest Hills, NY 11375.

August 28, 2007.

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,

Gayle Whittaker, D. C.

CMS-1385-P-10377

Submitter : **Miss. Heather Martin** **Date: 08/28/2007**

Organization : **Salisbury University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer at Salisbury University where I currently provide athletic training services to the men's soccer team. I am also an approved clinical instructor for the Athletic Training Education Program here at the University. I am writing this letter as a young professional who is passionate about her career and about insuring the future of my profession for my students as well.

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

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

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

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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,

Heather L. Martin, ATC

CMS-1385-P-10378

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems: I am a physical therapist in an outpatient physical therapy clinic in Indiana. I have a Doctor of Physical Therapy (DPT) degree and have been practicing for 1.5 years. I am writing with comments about the PHYSICIAN SELF-REFERRAL ISSUES. Specifically, the July 12 proposed 2008 physician fee schedule rule and the issue surrounding physician self-referral and in the 'in-office ancillary services' exception. Physician owned physical therapy (POPT) clinics are especially troublesome because they may often result in referral to PT services for financial gain, and not for patient benefit. These clinics present for the physicians in the practice another avenue to benefit financially from their patient's care, which compromises their ability to think objectively. Physicians are encouraged by their practice to not only prescribe PT for their patient, but to then refer them to their own POPT clinic without ever even suggesting to the patient that they have other options. Physicians are entrusted by their patients to act with their best interests in mind at all times and to never base their decisions on any potential financial gain. If this trust relationship is shaken, physicians will lose credibility with their patients and patient care will suffer as a result. Furthermore, an argument often used by physicians in support of POPT clinics is that the patients receive better care because it is more convenient for the patient and the MDs are available. The only time it may be more convenient for the patient is when they schedule the initial session and may do that in person, instead of over the phone. After that initial scheduling, it is no more convenient for the pt. to drive to their physician's office, instead of the closest outpatient PT clinic to their home. As far as having the physicians available, many of these physicians are orthopedic surgeons and have very limited office hours to begin with and the chances of them being in the office when you have a question for them are not very high. It is not difficult to contact the physician's RN or PA if there is a question about their care via email or telephone and have a very quick, if not immediate response.
The 'in-office ancillary services' exception has created a loophole that has resulted in the expansion of physician-owned arrangements that provide PT services. Because of the Medicare referral requirements, physicians have a captive referral base of PT patients in their offices on a regular basis. Having this exception facilitates the creation of abusive referral arrangements, leading to PT referrals that may not be medically necessary or longer treatment duration with a higher number of visits because of the financial benefits associated with PT care. This results in rising health care costs and suspicion from payer sources, which directly affects reimbursement for all health care providers and other PT providers in particular. Referral to PT is not supposed to be made based on associated financial gains.

Physical therapists attend school for 7 years to get the exceptional training in musculoskeletal and neurological rehab required to offer patients comprehensive care following surgery or an injury. In order to do our job effectively and appropriately, we should not have the financial expectations of physicians hanging over us. We should be able to treat our patients in most appropriate manner in the least number of visits to return the patient to their functional activities. When our boss is our referral source, objectivity is eliminated and there are expectations to treat the patient as long as the services are being compensated. Currently, PTs have input in the duration of services and when the patient is appropriate to be discharged. We request more visits if we feel the patient still needs them from a functional standpoint. PT's should not feel pressure to keep a pt. in clinic if PT is no longer medically necessary. Thank you for your consideration

CMS-1385-P-10379

Submitter : **Ms. Ronda Peterson** **Date: 08/28/2007**

Organization : **Minnesota State University Moorhead**

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 Ronda Peterson. I am a Certified Athletic Trainer at Minnesota State University Moorhead. I work with about 30 patients on a daily basis by preventing injury, performing modalities, and preparing them from everything from activities of daily living to very intense workouts. I have a master s degree and a nursing degree as well, and both of these degrees have given me great satisfaction in the medical profession.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
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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,
Ronda Peterson, MS, ATC