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

Organization : Comprehensive Care Anesthesia Services

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10527-Attach-1.DOC

#10527

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.

Carl Gregory Conrad MD

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

Organization : Northern Physical Therapy Services

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10528-Attach-1.DOC

#10528

Northern Physical Therapy Services

709 W. Superior **Wayland,** MI 49348 269-792-4440 • fax: 792-4475
From the Desk of Janis Kemper, PT

August 23, 2007

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

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

Dear Mr. Weens:

Thank you for the opportunity to express my opinion regarding **Physician Self-Referral Issues**.

I am a physical therapist and have been in practice since 1988. I have been the co-owner of Northern Physical Therapy Services (NPTS) since 2003. NPTS is a rehab agency with 5 rural locations surrounding the Grand Rapids, MI area.

I wish 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. It is my opinion, that there is an inherently abusive nature to physician-owned physical therapy services. I strongly recommend the removal of physical therapy and occupational therapy as a permitted service under the in-office ancillary exception.

The potential for fraud and abuse arises whenever physicians are able to refer Medicare beneficiaries to entities in which the physician has a financial interest. A physician's referral to therapy should be based solely on the best interest of the patient. The physician's focus should be who can provide the best quality care and who is in a convenient location for the patient. The unavoidable financial bias that is present with physician owned physical therapy, often results in patients receiving lesser quality care, traveling to inconvenient locations, and overutilizing services. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS can reduce a significant amount of programmatic abuse, curb overutlization of physical therapy services under the Medicare program, and enhance the quality of patient care.
The following are examples of personal experiences that I believe clearly demonstrate why physician owned physical and occupational therapy should not exist.

We at NPTS have worked very hard to develop a reputation for excellent quality care within our market. We frequently are told by patients from our communities that when seeking a referral for therapy at NPTS, their physician (or physician's office manager)

Northern Physical Therapy Services
709 W. Superior **Wayland,** MI 49348 269-792-4440 • fax: 792-4475
From the Desk of Janis Kemper, PT

redirects them to a clinic we know to be owned by the physician. In fact, recently, my own sister's doctor recommended physical therapy and she requested to be seen at one of my offices, but instead, her physician strong armed her into a clinic he owns. I'm sure we all understand how intimidated a patient can be by their physician.

Similar stories are all too common and usually include the physician's explanation that "their therapists will work closely under the physician's supervision" or they provide more "expert care". In fact neither of these are the case, the only reason the doctor pushes their own clinic is for financial gain.

Our clinics are located in outlying areas. Frequently, I see physicians forcing their patients to travel long distances to reach urban clinics only because the physician owns the clinic. I am certain that given the option, patients would have preferred to receive therapy at a local clinic. Travel can be especially difficult for the elderly. In an extreme case, I experienced a physician that refused to refer a patient to therapy unless the patient agreed to use the physician's therapy clinic. Coming to our clinic saved the patient a 20 mile one way drive. I doubt this physician was looking out for the patient's best interest.

Physician's "expertly trained therapists" are often new graduates that can be hired at the bottom of the wage scale. I have seen several examples of physicians looking to recruit experienced therapists/practices that they have been happy with. When the therapist/practice agrees to set up shop within the same building, but does not agree to be physician owned, the deal is immediately broken. Another example of how quality care is sacrificed for financial gain.

I am aware of situations that exist within our market that involved physicians employing athletic trainers, personal trainers, massage therapists and other unqualified individuals to provide physical therapy care. These physicians are using these unqualified individuals as physical therapists and billing as such. We in the physical therapy field are not able to use aides or athletic trainers to assist our qualified therapists, yet we are forced to compete with those who seem to be bound by a much lower standard of care.

Again and again a physician's ability to objectively direct his or her patients to therapy is clouded by their own desires for profit. As long as physicians remain the gate keeper for therapy services, I believe both the patient, and the insurance carrier can only be fairly served by removing the distraction that is physician owned practices. If allowed to continue, physician owned practices seriously jeopardize the existence of the independent physical therapy practice. I strongly believe that patients and insurance carriers both benefit from the existence of and the competition between independent therapy sources. For our patient's sake, CMS' sake, and for all private PT owned practioners, I urge you to establish a level playing field.

I would like to thank you for taking the time to review and consider my comments.

Sincerely,

Janis Kemper, PT

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

Organization : **Children's Hospital of Michigan**

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 sincerely believe that this is a step in the right direction. The proof is in the fact that graduate medical education will significantly improve by this step. 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.

To me that worst fact is that CMS had no justification to reduce the reimbursement rates for anesthesiology even when they initiated the rule. Its time to undo the injustice.

Sincerely,

Z.Ahmed, M.D.

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

Organization : **Marquette University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Elizabeth Rozumalski MS, LAT and I work Marquette University Sports Medicine. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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

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

Sincerely,
Elizabeth Rozumalski, MS, LAT
Assistant Athletic Trainer
Marquette University
414-288-0341
clizabeth.rozumalski@mu.edu

Submitter : Dr. Paul J. Poppers **Date:** 08/28/2007

Organization : Amer. Society of Anesthesiologists

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Anesthesiology, a relatively recent medical specialty, is a vital and constantly growing medical specialty. It saves my patients who now can benefit from new surgical, obstetrical and pain-management procedures. Thus, it plays an increasingly important role in increasing and improving the general health of our patients from infancy to very old age.

Submitter : **Mrs. Donna Olson** **Date: 08/28/2007**

Organization : **Regional Physical Therapy Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Donna Olson. I work for Regional Physical Therapy Center in Lufkin, Texas as a Certified National Athletic Trainer. My position is very diverse within our clinic. As well as being the Coordinator of our Sports Medicine Outreach program which contracts with seven local high schools and a local Junior College I perform many duties within the clinic. I assist the Physical Therapist in inplementing treatment protocols for patients, perform Functional Capacity Evaluations and oversee the rehabilitation of injured athletes. I have a Master's degree in my chosen field as well as nine hours toward an Education Specialist degree. Upon moving to Texas I acquired my state licensing in Athletic Training.

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

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

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

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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,

Donna Olson, MEd., ATC, LAT

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

Organization : **Dr. David Kerr**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **joseph middleton**

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.

Submitter : **Mr. Ronald Steinwehr** **Date: 08/28/2007**

Organization : **Self Employed**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Ron Steinwehr. I am a certified and licensed athletic trainer in the State Of Florida. I am currently self-employed, however I am deeply concerned about recent proposed changes that might hinder my future employment.

I am writing today to voice 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 restriet 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,

Ronald Steinwehr, MS, ATC, LAT
191 Bayside Drive
Palm Coast, FL 32137
386-246-3223

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

Organization : **Anesthesia Associates PSC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please ammend the current Medicare payment schedule to include the increase to anesthesiologists - we work hard for these patients, as they are the sickest and most in need of care. They often need large procedures and require complcx anesthetics - I hope the board will see to it to do the right thing -

Edward Alexander, MD
Lexington, Ky

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

Organization : **Dr. Keith McFarland**

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.

Keith A. McFarland MD

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

Organization : california anesthesia associates

Category : Physician

Issue Areas/Comments

GENERAL

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

Thank you for consideration of this serious matter.

Submitter : **Mrs. Christina McFarland** **Date: 08/28/2007**

Organization : **Mrs. Christina McFarland**

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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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Christina McFarland

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

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

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

Organization : **Montefiore Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

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

Organization : **Lee University Student Athletic Trainer**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Kayla Hood and I am currently a student at Lee University in Tennessee. I am a student athletic trainer. I am 20 years old and I am a junior here in the program at Lee.

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

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

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

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

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Sincerely,

Kayla Hood, Athletic Training Student

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

Organization : Dr. Michael Jett

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Not reimbursing patients for x-rays will hamper the safety of these patients when securing a correct diagnosis as well as ensuring their welfare. Abdominal aneurisms, neoplasms and fused joints need to be ruled out as well as understanding the nature of a geriatric patient's subluxations.

Submitter : **Ms. Priscilla Karam** **Date: 08/28/2007**

Organization : **Patient Care Advocate**

Category : **Nurse**

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.

Sincerely,

Priscilla Karam, RN

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

Organization : **The Urology Center of Spartanburg**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs,

I am amazed by the continued pressure that CMS puts on competent and compassionate physicians. In the name of "money" CMS and Congress continues to demonstrate a complete lack of understanding of the current health care system. Special interests and lobbyists will buy their way again and none of you has the guts to do what is "right" for the health care system and for the american taxpayer. Implementation of the current agenda items will dramatically reduce access to care for medicare beneficiaries and continue to promote the poorer quality care that I have witnessed over the past several years. Competent and compassionate physicians will have no desire to practice in the system that you seek to create. I am a member of a large Urology group in Spartanburg. If your current proposals are approved, we will either stop accepting NEW medicare patients completely or I will get a consulting job outside the field of clinical medicine.

I am perpetually amazed at how easy it is for those of you who do not receive care in the medicare system to make sweeping changes throughout that system. Your agenda is ill advised and poorly thought out. Your success, or more likely failure, will not affect you personally. I encourage you not to support any radical change to the current arrangement of services, it could mark the beginning of the end for access to medical care for medicare recipients.

Gary D. Bozeman, M.D.
Spartanburg, SC

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

Organization : **St. Joseph Hospital, Orange**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Adriana Velez and I am a Certified Athletic Trainer. I currently work as an athletic trainer for St. Joseph Hospital, Orange. I worked in a physical therapy clinic for 2 years where athletic trainers and PTs worked together to give quality care to many 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 patients. My National certifying board requires each member to aquire continuing education units to keep their certification. Many PTs and OTs do not take the time to this.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, and national certification exam ensure that 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,

Adriana Velez, ATC

Submitter : Mrs. Xiu Guan **Date:** 08/28/2007

Organization : Mrs. Xiu Guan

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Please support CMS 1385 P. I am a medicare beneficiary and believe that this bill would benefit myself and all others like me in keeping access to quality anesthesia care.

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

Organization : RUSH University Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely yours,
Nanhi Mitter, MD

Submitter : **Ms. Carrie Powell** **Date: 08/28/2007**

Organization : **Carolina West - Sports Medicine**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear To whom it may concern: August 28, 2007

My name is Carrie A. Powell; I am a certified athletic trainer and paramedic. I work at a sports medicine base hospital clinic which I am contracted out to a high school in which I care for over 200 student athletes. As well as serve as a clinical site for the local university (WCU) for their student athletic trainers. As a dual degreed athletic trainer (for eleven years) and paramedics (EMT for six years) I have been able to serve many purposes not just on the athletic fields/clinic for sports medicine and rehabilitation, but also with (other ATC s), EMT s, paramedics, and ER physicians in understanding of how to handle situations together as one, providing truly the best outcome for the patients life and wellbeing. Through the education I received at Lenoir-Rhyne College (Hickory, NC) for sports medicine/athletic training and Western Carolina University (Cullowhee, NC) for emergency medical care both colleges have provided me with a unique background that has and will continue to truly touch lives of our young men and women; taking such a way would be a crime to not just parents/adults, but a greater crime to the son/daughters that could be yours.

I am writing today to voice 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,

Carrie A. Powell ATC, LAT, EMT-P, ACLS, NRP, PALS, BTLS, BLS, ACI
Athletic Trainer, Carolina West Sports Medicine
Sports Medicine, Swain County High School

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

Organization : **Gallatin Valley Anesthesia Services**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Richard M. Barton, M.D.
3330 Sundance Drive
Bozeman, MT 59715

October 28, 2007

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

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

Dear Ms. Norwalk:

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

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

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

Sincerely:

Richard M. Barton, M.D.

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

Organization : **Dr. Allen Maizes**

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.

The current medicare unit value equals $64.76 (pretax) dollars on an hourly rate. This amount is not enough to attract quality care.

Submitter : **Miss. Kristin Romani** **Date: 08/28/2007**

Organization : **Miss. Kristin Romani**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a recent graduate from Carthage College where I studied Athletic Training for 4 years; I am in the process of becoming certified and licensed as an Athletic Trainer in the state if Illinois.

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

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

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

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

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

Sincerely,

Kristin Romani

Submitter : **Ms. Caitlyn Elliott** **Date: 08/28/2007**

Organization : **Butte College Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

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

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

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

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation 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,

Caitlyn Elliott, Student Athletic Trainer

Submitter : **Mrs. Marti VanEenenaam-Iwanicki** **Date: 08/28/2007**

Organization : **Fraser Public Schools**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I am a certified athletic trainer working as a teacher/athletic trainer in a suburban high school in Michigan. I was formerly the Coordinator of Athletic Training Services for Mount Clemens General Hospital and worked side-by-side with PTs and PTAs in our physical therapy department. I have a Bachelor's degree in Sports Medicine from Central Michigan University and I am currently working on a Masters degree.

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

My main concern is that these proposed rules will create additional lack of access to quality health care for my students and their families.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, whtich you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my students/patients receive quality health care. State law and hospital medical professional 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 iwth the health of Americans, especially in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinet 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 seeing 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

Marti VanEenenaam-Iwanicki ATC

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

Organization : **Christine Nieman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : Mrs.

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 28, 2007
Ms. Leslie Norwalk, JD
Acting 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 Ms. Norwalk:

I am writing in support of the Centers for Medicare & Medicaid Services (CMS) proposal to increase the value of anesthesia work by 32%. If passed, Medicare would increase the anesthesia conversion factor by 15% in 2008 compared with current levels (72 FR 38122, 7/12/2007). As a member of the American Association of Nurse Anesthetists, I believe that this proposal is imperative for the providers and recipients of anesthesia services.

As the AANA has previously stated, anesthesia services are not only under-reimbursed, they have also been deprived inflationary adjustments in comparison to other Part B providers. If the proposed changed is not enacted the accessibilty and availabilty of anesthesia services for Medicare & Medicaid recipients will be jeopardized. Certified Registered Nurse Anesthetists provide approximately 65% of the anesthetics in the U.S. and are the predominant providers in rural and underserved areas. Medicare patients, as well as U.S. healthcare, depend on our services. The availabilty of anesthesia services depends in part on fair Medicare payment for services. I fully support the agency's acknowledgement that anesthesia payments have been undervalued, and it's proposal to increase Medicare anesthesia payment.

Sincerely,

Cassandra Maksimczak, RN, BSN, SRNA
13674 Castle
Southgate, MI 48195

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

Organization : **Bethany Lutheran College**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Paul Osterman and I am the Head Athletic Trainer at Bethany Lutheran College in Mankato, Minnesota.

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

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

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

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

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

Sincerely,

Paul J. Osterman, ATC

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

Organization : **AthletiCo**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Rachel Colvin, a certified and licensed athletic trainer currently practicing in Illinois. I graduated with honors from Xavier University in 2006. I proudly work for AthletiCo, where I provide services in a physical therapy clinic as well as at a large high school.

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

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

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

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Sincerely,

Rachel Colvin, ATC

Submitter : Mr. Jay Thompson **Date:** 08/28/2007

Organization : Leesburg High School-Lake County School Board

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified and licensed athletic trainer serving in Central Florida. I received my athletic training education from Valdosta State University in Valdosta, Georgia. I furthered my education by receiving my master's degree from Clemson University in Clemson, South Carolina. I have been nationally certified since 2000, and have worked both in the collegiate and secondary education system since 2002.

I am writing today to voice 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,

Jay Thompson, MEd, ATC, LAT

Submitter : **Ms. Robyn Phelps** **Date: 08/28/2007**

Organization : **Spine and Sport**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I am a Registered Kinesiotherapist treating patients at Spine and Sport Physical and Occupational Therapy clinic, located in San Diego, CA. Having Kinesiotherapists treat patients under the direct supervision of a physical therapist is essential in keeping Spine and Sport a strong competitor within the realm of therapy.

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

Organization : **Sacramento Anesthesia Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-p
Anesthesia Coding

Ms. Norwalk-

I was thrilled to hear of the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. CMS has now recognized the huge disparity in pay for anesthesia services created by the institution of the RBRVS compared to other physician services.

The RUC has recommended an increase of $4.00 per anesthesia unit. This is based on a 32% work undervaluation for our services. I strongly support full implementation of the RUC's recommendation.

I am grateful the CMS recognizes our undervaluation, and can only hope that CMS follows through with the proposal and fully implements the anesthesia conversion factor increase recommended by the RUC.

Thank you for your consideration.

CMS-1385-P-10566

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

Organization : Mobile Urology Group, P.A.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1385-P-10566-Attach-1.DOC

#10566

Center for Medicare and Medicaid Services
Department of Health and Human Services

Re: July 2, 2007 Medicare Physician Fee Schedule Proposed Regulations
Physician Self-Referral Provisions

Dear Sir,

I am a urologist in Mobile, Alabama and have been part of a joint venture partnership with the other urologists in town to provide lithotripsy services to our patients. I previously treated my patients on a lithotripsy machine owned by a large company and we had many problems with maintenance and getting the machine to where it was needed to treat the patients. Since our physician group now owns the machine we are able to give our patients more reliable service and we can move the machine from hospital to hospital as needed to serve our patients. As I understand things Lithotripsy has been exempt from the Stark Laws because you cannot really over utilize this service. You can only treat patients who actually have kidney stones. It almost seems un-American and certainly unfair to change the rules now that most lithotripsy is performed by urologists who own the machines. I can't imagine that the Government would make us sell our lithotripsy venture to some businessmen that do not know anything about what we do. This is not good medical care. I don't understand how you can put a complicated Stark issue in the middle of a Medicare Physician Fee Schedule Proposal.

1) Services Furnished Under Arrangements
The Medicare statute permits providers (physicians) to furnish services (lithotripsy) to patients "under arrangements" with third party vendors. Historically the Stark Statute has applied to the billing entity which in our example is the hospital. Our Partnership has historically relied on this Stark indirect compensation arrangement to comply with the Stark Law. The new MPFS rule proposes to change the Stark definition of entity to also apply to our Partnership (entity that provides the DHS). We have been providing lithotripsy services now for years based on a court case (*American Lithotripsy Society vs. Thompson*) which ruled that lithotripsy is not a DHS. Please do not change the rules now! This will severely impact on the care of our Medicare patients in a negative way.

2) Unit of Service (Per-Click) Payments
Our arrangements with the hospitals provide for payment for services on a per procedure basis which is currently allowed under Stark. The new proposed MPFS rule seems to want to change this which is clearly contrary to the original intent of Congress. Please do not do this.

In conclusion, I ask CMS to separate those beneficial therapeutic joint ventures which are not of themselves DHS from the potentially abusive diagnostic ventures that physicians and hospitals may have propagated. Without a doubt it should be clear to CMS that the urology community's therapeutic joint ventures have broadened access to new technology for Medicare patients, brought needed efficiency to the market, and simultaneously saved CMS hundreds of millions of dollars. As CMS tries to stop abusive arrangements, it would be a great mistake to jeopardize such time tested and proven models.

Sincerely,

William J. Terry, M.D.
Mobile Urology Group, PA
101 Memorial Hospital Drive, Suite #100
Mobile, Alabama 36608

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

Organization : **St Margaret Mercy Health Care**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **Millbrook Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

TRHCA-- Section 201: Therapy CapS

TRHCA-- Section 201: Therapy CapS

Dear Sir or Madam:

I am a Physical Therapist (and certified Athletic Trainer) working in a private outpatient orthopedic rehabilitation practice over the past 7 years. I see a diverse clientele with many Medicare clients who are recovering from joint replacements, back surgeries, radicular symptoms not severe enough for surgery. As such, I feel uniquely qualified to comment on the negative impact a Medicare cap of services would have on these and other clients.

I am writing today to voice my opposition to the therapy cap proposed in 1385-P.

While I am concerned that these proposed changes have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients resulting in unresolved preventable disability, additional/prolonged pain, and ultimately more costly care later as unresolved health concerns do not "go quietly into the night."

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 reinstatement of the therapy cap and consider more quality driven cost containing standards accepted by those who are looking to prevent disability and improve the health and productivity of America's Greatest Generation.

Sincerely,
Christopher J Dayger PT ATC

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

Organization : **Physician Anesthesia Care of Iowa City**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk
CMS-1385-P

Dear Ms. Norwalk,

I encourage you to approve the proposed increase in Anesthesia services payment for 2008. I am certain you are aware of the dispute regarding undervaluation of anesthesiology services since the institution of RBRVS. Allow me to describe why CMS beneficiaries would want better pay for anesthesia services on the local level in Iowa City, Iowa.

The current CMS payment rate for anesthesia services is 30% of the current Blue Cross Blue Shield payment rate, or 30 cents to one dollar. Anesthesia providers, M.D.s, CRNAs, have large education costs, which may take a decade to pay off. Finding practices with limited percentages of CMS beneficiaries is becoming an important factor in finding a better paying job. The large senior population of Iowa drives our graduates to leave the state for better pay or to pursue practices with hospitals, surgery centers, that have small percentages of CMS patients. The end result for the CMS patient is fewer services rendered by less and less highly qualified providers. The gap in payments is immense and the proposed increase will help revert these changes in progress.

All CMS beneficiaries, todays and tomorrows senior citizens, and patients of all ages want to entrust their life during surgery to an individual that is of the highest caliber, honest, highly trained, and the proposed increase in payment is an investment to insure that for tomorrow.

James J. Noesen, M.D.

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

Organization : **OJOS, Eye Surgery Specialists of PR**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

About Anesthesia Coding CMS-1385-P is well known that anesthesia services had been underpayed. Its time to recognize the value of the live of medicare patients under responsible care of an anesthesiologist.
Dr.Torres

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

Organization : **Dr. Talal Ghazal**

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.

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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. Robert Constantine **Date:** 08/28/2007

Organization : Anesthesia Group of Onondaga

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Submitter : **Maria Larnie Boquiren** **Date: 08/28/2007**

Organization : **Crossroads School**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam

My name is Maria Larnie Boquiren and I am a certified athletic trainer at Crossroads School in Santa Monica, California. I completed my undergraduate degree at California State University, Fullerton in Kinesiology with an emphasis in athletic training. I went on to earn my masters degree in Sports Health Care/ Athletic Training at A.T. Still University, Arizona School of Health Sciences in Mesa, Arizona. My master's program was 92 units. I received a a very comprehesive education in researched based upper/lower extremity evaluation, human disease, tissue healing, rehabilitation, conditions in special populations, biomechnics, and evidenced based research. The following year after my master's degree, I accepted a fellowship with the New Hampshire Musculoskeleta Institute. During my fellowship, I participated in various allied health care settings such as ambulatory medicine, neurology, dematology, radiology, podiatry, bracing and prothesis, orthopedics, opthamology, physical therapy, occupational therapy, and general practicioner clinics. You might question why an athletic trainer would need to have affiliations with all these other health care professionals? The answer is easy. Athletic trainers are educated in these areas to better educate and provide care to their paticnts. My experience and education allows me to provide quality health care to my athletes/patients. At Crossroads, myself and another athletic trainer provide our middle school and high school athletes with preventative care such as braces, taping, wrapping, sport specific exercises for the prevention of overuse injuries. We provide practice and game coverage. We serve as educators to our campus community providing our student-athletes and their parents with valuable information in regards to the goals and management of sustained injuries.

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

Sincerely,

Maria Larnie Boquiren, MS, ATC

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

Organization : FCA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10574-Attach-1.DOC

#10574

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,
Martin Warren, D.C.

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

Organization : Anesthesia Consultants of Athens

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs,

It is very important that anesthesia be granted an increase as the cuts are now impacting on delivery of health care. 80% of groups around the country must now receive payments from hospitals in order to staff anesthesia departments, and this will only get worse without reasonable Medicare reimbursements. Thank you.
Warren Horn

Submitter : **Mrs. christine klenk** **Date: 08/28/2007**

Organization : **Rowan university**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Christine Klenk and I am a Certified Athletic Trainer who currently teaches at Rowan Universtiy.

I am writing today to voice 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,

Christine Klenk, ATC (and/or other credentials)

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

Organization : **Gregg Glass**

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.
Gregg Glass

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

Organization : **Ron Bierma, M.D., 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
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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 : **Kari Cunningham** **Date: 08/28/2007**

Organization : **Beaverton School District**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certfied Athletic Trainer in the secondary school setting. I have my bachelor of science degree in Athletic Training, and hold the national certification for athletic training and am licensed by the State of Oregon Health Licensing Board.

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

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

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

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

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

Sincerely,

Kari Cunningham, ATC

Submitter : **Ms. Pamela Clark** **Date: 08/28/2007**

Organization : **Chaminade College Prep High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Pamela Clark and I am a Certified Athletic Trainer (ATC). I earned my bachelors degree in Exercise Science and Sports Medicine from California Lutheran University and my Masters Degree in Kinesiology from San Diego State University. I sat for and passed the National Exam as required by the National Athletic Trainers Association Board of Certification in 2004. I currently am working as an ATC at a local high school in West Hills California, where I care for all student athletes at the school in aspects of prevention, recognition, care, and rehabilitation of thier athletic injuries.

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

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

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

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

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,

Pamela Clark MA, ATC

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

Organization : **California Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

I know you must be receiving many form letters concerning a revaluation of anesthesia services for Medicare patients. While completely agreeing with those letters I wanted to share with you what this means to me.

I have been practicing anesthesia in a tertiary care medical center, Long Beach Memorial Hospital of Long Beach, California since June of 1980, a little over twenty-seven years. We take good care of a great many elderly patients and do it well. Over the years I have seen this Medicare population become older and sicker. I have gained enormous experience in adapting to their needs. There is no doubt that if you could follow me around at work, you would see how difficult and stressful it is to give good anesthesia to them and to do no harm.

It is an irony that my most difficult patients to give good care and avoid complications are those for which I am valued the least. In a just world I would receive less payment for my younger and healthier patients which are much less stress on me and more for the sicker patients. I enjoy my patients, like them a lot, young and old, but many times have thought about going to work in another facility (Surgery Center or other hospital with a much younger population) to reduce my stress. I know for a fact that our anesthesia group has lost applicants who see how hard we work.

Taking care of the Medicare population with the sickest patients and the least reimbursement is definitely a recruiting problem. An increase in valuing what we do would be a definite incentive to all of us taking care of our elderly patients (which I am rapidly becoming myself).

Sincerely, Corbett Lee Penton, MD

Submitter : Ms. Kelley Gardner **Date:** 08/28/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment. It is important that our voices be heard.

Sincerely,

Kelley Gardner, CRNA,MS
PO Box 4518
Stateline, NV 89449

Submitter : Mr. Edward Sedory **Date:** 08/28/2007

Organization : United Sates Marine Corps

Category : Federal Government

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a civilian working as an atheltic trainer for the United States Marine Corps in Quantico, Virginia. I recieved my undergraduate edueation from Southern Illinois Univeristy and Masters degree from Univeristy of Virginia. I previously worked for the Department of Justice in the FBI and DEA as an atheltic trainer. I have been working for the federal government for long period of time and understand in the importance of partieipating in the government system to create change. I am concerned for the future of my professiona and many of my cohorts in other clincial 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 creatc 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 ensurc that my patients reeeive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposcd 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 restriet 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,

Edward Sedory MEd, ATC, EMT-T

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Eliminating self-referral for profit situations will surely benefit healthcare consumers and payors. Physician-owned physical therapy practices are beginning to eliminate competition from private facilities owned and operated by physical therapists. In our region, I can think of a couple of instances where a PT-owned physical therapy office has been closed or considerably down-sized due to prominent referring physicians "bringing PT in-house". The odd thing is that those same physical therapists will then be providing contract services for those same physicians "in-house". This suggests to me that the move to bring physical therapy "in-house" was not made to improve the quality of care but rather just to maximize profits for the physicians. This is unfortunate in a variety of ways. A physical therapist in private practice has a definite incentive to provide optimal care for all of their patients. In an environment where physician-owned physical therapy practices don't exist, if a therapist in private practice who relies strictly on referrals from physicians is ineffective or incompetent, their practice will cease to exist. It clearly makes sense that competition among private PT-owned practices promotes optimal quality of care for consumers. The absence of competition via the dominance of physician-owned physical therapy practices wouldn't appear to benefit consumers or payors in the long run. From time to time, I will have the opportunity to speak with a patient or friend within the community who is suspicious of a physician's actions related to self-referral. A scenario where an individual is seen in an orthopedic office, undergoes an "in-house" MRI, is issued a brace in the office, and is then referred to begin "in-house" physical therapy despite them living 20 miles from that office has been described. Common sense should tell us all that the allowance of these in-office ancillary services is a slippery slope. The removal of physical therapy from the "in-office ancillary services" exception to the federal physician self-referral laws is clearly warranted.

Submitter : **Ms. Melinda Burns** **Date: 08/28/2007**

Organization : **Vanderbilt Orthopedic Institute**

Category : **Hospital**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 28, 2007

Dear Sir or Madam:

My name is Melinda Burns and I work at the Vanderbilt Orthopaedic Institute in Nashville, TN where I along with 18 other Certified Athletic Trainers work with outpatient therapy. Each Athletic Trainer on staff has a Master s Degree, is nationally certified and state licensed. I have also completed three additional professional certification programs as a Performance Enhancement Specialist (National Academy of Sports Medicine), Certified Health Education Specialist, and aquatic therapy instructor. I have been able to utilize my education and my specializations to better educate and serve my patients, while achieving the functional objectives required in a rehabilitation environment.

Over the past six years, I have been employed in the clinic-outreach setting. As part of my job responsibilities and profession I am a community advocate for the importance of rehabilitation to reduce the need for surgical procedures, as well as prevent recurrence of injury. In Nashville, I am provided to a metropolitan high school as a community service. There I provide care to athletes, teachers, parents, and students. My exposure in the community serves to reduce medical costs associated with unnecessary emergency room visits, physical therapy visits, as well as general physician follow-up. In a low-income population with little or no health insurance this is an essential service. At Vanderbilt Orthopedic Institute, our rehabilitation model is one of the most efficient in the country and provides the best patient care available by Athletic Trainers. In our model, Athletic Trainer s are utilized as a team member with our physical therapists. The extensive training and education that we as athletic trainers have in the area of orthopaedics is a perfect fit in outpatient therapy and far surpasses that of a PTA or PT tech.

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

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

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

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

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

Sincerely,

Melinda Burns, MS, ATC/L, PES, CHES
Vanderbilt Orthopaedic Institute

CMS-1385-P-10585-Attach-1.DOC

#10585

August 28, 2007

Dear Sir or Madam:

My name is Melinda Burns and I work at the Vanderbilt Orthopaedic Institute in Nashville, TN where I along with 18 other Certified Athletic Trainers work with outpatient therapy. Each Athletic Trainer on staff has a Master's Degrees, is nationally certified and state licensed. I have also completed three additional professional certification programs as a Performance Enhancement Specialist (National Academy of Sports Medicine), Certified Health Education Specialist, and aquatic therapy instructor. I have been able to utilize my education and my specializations to better educate and serve my patients, while achieving the functional objectives required in a rehabilitation environment.

Over the past six years, I have been employed in the clinic-outreach setting. As part of my job responsibilities and profession I am a community advocate for the importance of rehabilitation. In Nashville, I am provided to a metropolitan high school as a community service. There I provide care to athletes, teachers, parents, and students. My exposure in the community serves to reduce medical costs associated with unnecessary emergency room visits, physical therapy visits, as well as general physician follow-up. In a low-income population with little or no health insurance this is an essential service. At Vanderbilt Orthopedic Institute, our rehabilitation model is one of the most efficient in the country and provides the best patient care available by Athletic Trainers. In our model, Athletic Trainer's are utilized as a team member with our physical therapists. The extensive training and education that we as athletic trainers have in the area of orthopaedics is a perfect fit in outpatient therapy and far surpasses that of a PTA or PT tech.

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

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

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

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

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

Sincerely,

Melinda Burns, MS, ATC/L, PES, CHES
Vanderbilt Orthopaedic Institute

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

Organization : Spruce Creek High School

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

As a nationally certified, and state licensed athletic trainer who works within the secondary school setting I would like to voice my thoughts about 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,

Aimee Smith, ATC, LAT

Submitter : **Ms. Rebekah Helton** **Date: 08/28/2007**

Organization : **Clemson University Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Hello, my name is Rebekah Helton and I am a graduate assistant certified athletic trainer at Clemson University. I currently work with the men's soccer team. I am pursuing a master's degree in counseling education with a concentration in student affairs. I received my bachelor of science degree in athletic training in 2006 from Carson-Newman College.

I am writing today to voice 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 ammore concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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

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

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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,

Rebekah E. Helton, ATC

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

Organization : **Grossmont Union School District**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Brenda Niederbergerand I am a Certified Athletic Trainer. I work in a secondary setting as far as my job. I have been a ATC for over 15 years and have a teaching credential as well. I was educated at SDSU in San Diego and hold a Master Degree in biohechanics. I love my job.....

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

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

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

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

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

Sincerely,

Brenda Niederberger, MA ATC

Submitter : **Mr. Bob Splichal, CRNA** **Date: 08/28/2007**

Organization : **Red River Anesthesia, PC**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

August 28, 2007
Ms. Leslie Norwalk, JD
Acting 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 Ms. Norwalk:

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,

Bob Splichal, CRNA
824 Richland St.
Wahpeton, ND 58075
701-642-8994

Submitter : **Ms. Nona Johnson** **Date: 08/28/2007**

Organization : **Temple VA**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

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

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

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

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

Sincerely,
Nona Johnson, RKT

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

Organization : **Richard Covey M.D. P.C.**

Category : **Physician**

Issue Areas/Comments

Ambulance Services

Ambulance Services

Dear Mr. Weems:

I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.

As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:

a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;

b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:

* the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;

* the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.

c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and

d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,
Richard Covey M.D.
3155 Stillwater Drive Ste. B
Prescott, AZ 86305

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

Organization : **University of New Mexico**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : Dr. Jonathan Anagnostou

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

The current level of support for anesthesiologist services is woefully inadequate to provide this much needed care for our senior citizens. The current payment system results in payments to these physicians which is less than that paid for mechanics at a car dealership, and in many cases is less than the physicians' overhead (malpractice, office, billing, etc.). This has resulted in nation-wide shortages of anesthesia services and some anesthesia practices declining participation in the Medicare program. Senior citizens are beginning to experience significant delays in obtaining major surgical care. It has become critical that CMS implement the increase in the anesthesiology fees (conversion factor) recommended by the RUC.

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

Organization :

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

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The Stark Referral Loophole hurts both PT-owned clinics and the patients they serve. It takes away business from PT-owned facilities and in turn, decreases jobs for physical therapists. It also takes away patients' rights to choose their PT provider. It forces them to inconvenience themselves in order to go to the physician's facility (it may be too far away, not offer hours they need, or not take their insurance). It also forces them to go to a facility that may be too busy or understaffed, and the quality of care could suffer severely. This Loophole also allows physicians to act unethically. For example, it may cause them to prescribe services, such as PT, that may not be required in order to make more money for their practice. Therefore, physical therapy services should be separated from this Loophole in order for ethical and high quality care to be given to each patient.

Submitter : **Mrs. Bridget Winiecki** **Date: 08/29/2007**

Organization : **Wisconsin Physical Therapy Association**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

The Wisconsin Physical Therapy Association would like to comment on multiple areas of the proposed rule changes for 2008. Our membership has commented on several areas in the proposed rules for 2008.

The first comment being the professional standards for PTs and PTAs. Given the existing shortage of PT and PTAs in many regions of our state, we are not in support of the proposed professional standard that PTs and PTAs must "continue to furnish Medicare services at least part time without an interruption in furnishing services for more than 2 years." By making this proposed standard a rule, we fear it would limit the number of PTs and PTAs who would be able to serve Medicare patients, as many PTs and PTAs take time away from the profession for personal reasons, such to have children or care for family. In addition, PTs or PTAs may work in settings such as industry or the schools, not serving the Medicare population for several years. However, their expertise would still benefit the Medicare popluation if they returned to serve this population. Therefore, we are not in favor of this proposed requirement.

Secondly, we support the extension of the physician certification from 30 days to 90 days proposed for outpatient settings. We believe that this will not increase utilization of medicare services and will decrease the burden of tracking down a physician's signature every 30 days. As a standard of professional care, physical therapists are expected to communicate regularly with a patient's physician regarding the plan of care and update the physician regularly on patient progress and changes in the plan. Often time plans of care are sent to physician offices and the physician's office struggles with returning the plan of care timely within the 30 days. The physical therapist is responsible for this certification, but looses control of the process, and the volume of paperwork is much higher to manage with this 30 day certification.

Finally, we are in support of extending the therapy cap for outpatient therapy services. We support continuing the exception process with the automatic exceptions that are currently in place. This exception process is essential to assure that Medicare beneficiaries have access to adequate therapy benefits and that their rehab needs are met, especially in the case of more medically complex patients and patients who have multiple surgeries and procedures.

We appreciate your consideration of these comments and look forward to the final ruling for 2008.

Sincerely

Bridget Winiecki, MPT, MBA
Lynn Steffes, PT
Reimbursement Specialists
Wisconsin Physical Therapy Association

Submitter : **Mrs. Tracie Blanchetti-Knaze** **Date: 08/29/2007**

Organization : **Western Pennsylvania Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Tracie A. Blanchetti-Knaze. I am a certified athletic trainer with a Bachelor of Science in Education in Sports Medicine. I work for a physical therapy clinic and am contracted out to a local high school to provide services of evaluation of injuries, treatment of injuries, education on prevention of sports injuries and proper referral for any further medical assistance beyond my training and education.

While in college,I went through extensive training to be qualified to provide appropriate medical care for athletes and the credentials which I hold by passing our national certification exam, deems me qualified to do provide care to these athletes.

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

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

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

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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,

Tracie A. Blanchetti-Knaze, ATC

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **Metropolitan Anesthesiology Consultants, Inc**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

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Thank you for your consideration of this serious matter.

Sincerely, Michael A. Greenberg, MD

Submitter : **Dr. Linda Stevenson** **Date: 08/29/2007**

Organization : **Oregon Anesthesiologist Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Linda Stevenson, MD

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

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Andrew O'Halloran **Date:** 08/29/2007

Organization : Dr. Andrew O'Halloran

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Andrew P. O'Halloran, DO

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

Organization : **Dr. John Hawkins**

Category : **Physician**

Issue Areas/Comments

GENERAL

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To: Ms. Norwalk
From: John Hawkins, DO
Cardiothoracic anesthesiologist

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

Rc: CMS-1385-P
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John Brandon Hawkins, DO