Submitter : Dr. Trent Nessler **Date:** 08/29/2007

Organization : Baptist Sports Medicine

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

As a physical therapist who has practiced in western US and southern US, I have personally seen the negative impact that physician self referral of PT services has had. A negative impact that is felt by the patient, the community and the health care system. With self referral for physical therapy, you reduce competition and with that you no longer have the need for clinicians to have the "competitive edge" over another PT provider. Hence there is no longer the desire to push clinicians in physician owned practices to pursue their own clinical advancement or excellence. As such, the quality of physical therapy care provided, over time, to patients and the community is drastically reduced. This leads to longer episodes of care and increased health care expense. This has been so widely known that it has been widely published in the medical literature for over 10 years (Florida Health Care Cost Containment Study: September 1991 & New England Journal of Medicine Nov. 1992).

More recently, the OIG report, OEI-09-02000200, found that 91% of Physical Therapy services billed by Physicians in the first 6 months of 2002 failed to meet program requirements, resulting in improper Medicare payments of $131 million. Increased expense with a less efficient outcome! The end result is that the patient and the system pay more while the patient recieves less.

The only way to resolve this problem is to place provisions in the current legislation to prevent physician self referral for physical therapy services.

Thank you so much for you time.

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#10652

INCREASED COSTS AND RATES OF USE IN THE CALIFORNIA WORKERS' COMPENSATION SYSTEM AS A RESULT OF SELF-REFERRAL BY PHYSICIANS

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Abstract *Background.* There is widespread concern that ownership by physicians of testing or treatment facilities to which they refer patients leads to overuse of such facilities. We determined the patterns of use of three services — physical therapy, psychiatric evaluation, and magnetic resonance imaging (MRI) — among physicians treating patients whose care was covered under workers' compensation. We then compared the rates of use among physicians who referred patients to facilities of which they were owners (self-referral group) with the rates among physicians who referred patients to independent facilities (independent-referral group).

Methods. We used a large data base to analyze claims under workers' compensation in California from October 1, 1990, through June 30, 1991, to determine the frequency and cost of these three selected services and determined whether the referring physicians were practicing self-referral or independent referral. We evaluated the cost per case for all three services, measured the frequency with which physical therapy was initiated, and evaluated the medical appropriateness of MRI.

Results. We found that physical therapy was initiated 2.3 times more often by the physicians in the self-referral group (68 percent) than by those in the independent-referral group (30 percent; $P<0.01$). The mean cost per case for physical therapy was significantly lower in the self-referral group ($404±102) than in the independent-referral group ($440±167; $P<0.01$).

The mean cost of psychiatric evaluation services was significantly higher in the self-referral group than in the independent-referral group (psychometric testing, $1,165±728 vs. $870±482; $P<0.01$; psychiatric evaluation reports, $2,056±1,063 vs. $1,680±578; $P<0.01$). The total cost per case of psychiatric evaluation services was 26.3 percent higher in the self-referral group ($3,222±1,451) than in the independent-referral group ($2,550±742; $P<0.01$).

Of all the MRI scans requested by the self-referring physicians, 38 percent were found to be medically inappropriate, as compared with 28 percent of those requested by physicians in the independent-referral group ($P<0.05$). There was no significant difference in the cost per case between the two groups.

Conclusions. This study demonstrates that self-referral increases the cost of medical care covered by workers' compensation for each of the three types of service studied. (N Engl J Med 1992;327:1502-6.)

THERE is growing concern about conflict of interest in medicine in the United States.[1-6] Recent studies have focused on whether physicians' ownership of testing or treatment centers increases the number of tests and services performed.[7-10] Research in Florida indicates that physician-owned facilities generate significantly higher rates of use and costs than independently owned facilities.[7,8] Studies of physician ownership in California have found that the higher concentration of physician-owned magnetic resonance imaging (MRI) facilities in California has increased rates of use between 34 percent and 56 percent above the rates for the rest of the country.[9] The study by Hillman et al. of diagnostic imaging demonstrated that physicians who referred patients to facilities of which they were owners (those who practiced self-referral) charged 4.4 to 7.5 times more per episode of care than other physicians.[10] In response to these findings, the states of Florida, Michigan, and New Jersey have enacted legislation that restricts self-referral by physicians.

The American Medical Association (AMA) Council on Ethical and Judicial Affairs stated in December 1991: "In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility."[11] In June 1992, however, the AMA's House of Delegates adopted a new policy that allows doctors to make such referrals if patients are informed of the doctor's financial interest in the facility and of any available alternatives.[12] This reversal on the part of the AMA reflects the lack of consensus within organized medicine about physicians' ownership of medical facilities. There have also been two recent efforts by the federal government to limit self-referral on the part of physicians. Since January 1992, physicians have been prohibited from referring patients to clinical laboratories in which they have an ownership interest. In addition, the "safe harbor" regulations published in the *Federal Register* defined more clearly the investment, ownership, and reimbursement arrangements in which physicians may participate without fear of violating anti-kickback provisions of Medicare and Medicaid.[13]

To our knowledge, the effects of physician self-referral within the workers' compensation system have not been systematically analyzed. To investigate this issue, we evaluated a total of 6581 California workers' compensation cases for which claims were filed with a large workers' compensation insurance company during a nine-month period in 1990 and 1991. We analyzed the effect of physicians' self-referral on three high-cost medical services covered under workers' compensation: physical therapy, psychiatric evaluation, and MRI. We evaluated the cost per case for all three services, measured the frequen-

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cy with which physical therapy was initiated, and prospectively analyzed the medical appropriateness of MRI.

Methods

This study was designed to compare the patterns of use of three services — physical therapy, psychiatric evaluation, and MRI — among physicians who refer patients to facilities of which they are owners (self-referral group) and physicians who refer patients to independent facilities (independent-referral group).

Since differences in case mix between physicians in the self-referral and independent-referral groups might account for differences in rates of use or cost, we classified all cases according to the Ambulatory Visit Groups (AVG) classification scheme,[14] which we have modified for workers' compensation cases.[15] The AVG system is analogous to the system of diagnosis-related groups currently used by Medicare to reimburse acute care hospitals. On the basis of the patient's diagnosis (the diagnostic code from the *International Classification of Diseases, 9th Revision, Clinical Modification*) and the medical-procedure codes of the California Relative Value Studies and *Current Procedural Terminology* for outpatient services in each case, the AVG system is used to assign that case to 1 (and only 1) of 571 groups.

Type of Referral

Throughout the study, self-referral was defined as a referral for a medical service made by a physician or clinic to an entity owned entirely or in part by the referring physician or clinic. Self-referral was defined by either of the following two patterns: referral services were provided under the same tax identification number as the primary service, or referral services were provided under a different tax identification number from the primary service, but one or more owners were common to both entities.

When services were delivered under different tax identification numbers, we searched commercially available data bases that list officers, stockholders, and partners of facilities (the California Fictitious Business Name Listing, the Executive Business Listing, and other state and national data bases on corporations and limited partnerships available from Information America, Atlanta). If this search failed to identify common ownership, we then directly telephoned the referring physician's office and inquired about common ownership.

Physical-Therapy and Psychiatric-Evaluation Services

We used one of California's largest data bases on workers' compensation claims (that of the Industrial Indemnity Co., San Francisco) to analyze the frequency and cost of physical-therapy and psychiatric-evaluation services provided to injured workers. The data base was selected because it was complete and contained information on a large number of patients distributed throughout California. Information about each case was stored longitudinally; thus, the data base contained claims information for all services provided to the injured worker during the entire nine-month period of the study.

Data on all patients covered by workers' compensation in California who received physical-therapy or psychiatric-evaluation services from October 1, 1990, through June 30, 1991, were analyzed. Our analysis compared the rates of use and costs of physical-therapy and psychiatric-evaluation services for physicians in the self-referral and independent-referral groups.

Since musculoskeletal injuries make up the majority of all workers' compensation medical cases, we were able to limit our evaluation of physical therapy to providers with substantial experience in treating industrial musculoskeletal injuries. We defined this degree of experience as the treatment of 10 or more cases of musculoskeletal injury during the study period. There were 76 providers who met this criterion; they treated 1257 cases of musculoskeletal injury. Using the method described above, we were able to determine in all instances whether the referring providers were in the self-referral group or the independent-referral group.

In California, patients covered by workers' compensation are most frequently referred for psychiatric-evaluation services to document a claim of "stress." This evaluation virtually always includes both psychometric testing and a psychiatric-evaluation report. (We documented this fact in a preliminary analysis of our data base.) We therefore limited our analysis of psychiatric-evaluation services to cases in which there was both psychometric testing and a psychiatric-evaluation report. Altogether, 1751 (39 percent) of the cases within the data base met this criterion. A random sample of 220 cases (13 percent) was selected for analysis of ownership. We were able to determine ownership and self-referral or independent-referral status in each of these cases.

MRI

We also compared the cost and appropriateness of MRI scans in the self-referral and independent-referral groups. Appropriateness of referral for an MRI scan was determined under a prospective precertification program. All physicians' requests for MRI scans (regardless of the body part to be examined) were referred by Industrial Indemnity to a national, independent utilization-review firm for precertification review of medical appropriateness. The firm's criteria for appropriateness were established by a panel of board-certified specialists in orthopedics, industrial medicine, and radiology. After initial development by an independent board-certified radiologist and the medical directors of the utilization-review firm and its parent (one of the three largest companies managing health maintenance organizations in the United States), the criteria were reviewed and revised by a panel of independent, practicing experts in managed care who were all board-certified in orthopedics, neurology, neurosurgery, or radiology.

On the basis of medical documentation of the patient's injuries and conversations with the physician who requested the MRI, the review firm gave an opinion on the medical appropriateness of the procedure before it was performed. The reviewers were blinded to the physician's relation with the MRI center.

The classification of a procedure as medically inappropriate could be appealed. To be certain that the reviewer's decision did not merely defer an appropriate scan to another date, cases in which the MRI was categorized as medically inappropriate were followed for an additional six months. In all cases in which a scan was approved within six months after the original request, the MRI was considered to be medically appropriate.

All 864 requests for MRI scans from January 1, 1991, through June 30, 1991, were evaluated. We were able to determine whether the physician had an ownership interest in the facility in 502 (58 percent) of these cases.

Statistical Analysis

Continuous variables are presented as means ±SD and were compared by two-tailed t-tests. The proportion of cases in each group was assessed by the chi-square test. For all analyses, a P value of less than 0.05 was considered to indicate statistical significance. Results were analyzed with use of the Crunch4 Statistical Package (Oakland, Calif.).

Results

Physical Therapy

Table 1 shows the 1257 cases of musculoskeletal injury (whether or not the patients received physical therapy) according to AVG and type of provider (whether the provider practiced self-referral or independent referral). Four AVGs account for 92 percent of all cases; there was no significant difference in the distribution of AVGs between the self-referral and independent-referral groups.

As shown in Table 2, physical therapy was initiated more than twice as often by physicians in the self-referral group (in 68 percent of the cases) as by those

in the independent-referral group (30 percent; P<0.01). The mean cost per case for physical therapy in the self-referral group ($404±102) was significantly lower than that in the independent-referral group ($440±167; P<0.01).

Psychiatric-Evaluation Services

Table 1 classifies the random sample of 220 cases in which patients received both psychometric testing and psychiatric-evaluation services, according to AVG and provider type. There was no significant difference in the distribution of AVGs between the two types of providers. As Table 2 shows, the mean cost per case for psychiatric-evaluation services was 26 percent higher in the self-referral group ($3,222±1,451) than in the independent-referral group ($2,550±742; P<0.01). This difference was due to the higher cost of psychometric testing ($1,165±728 vs. $870±482; P<0.01) and the greater number of tests per case and to the higher costs of psychiatric-evaluation reports ($2,056±1,063 vs. $1,680±578; P<0.01) (since psychometric tests are reimbursed according to the California Official Medical Fee Schedule, which pays the same amount for each psychometric test regardless of the test, the cost per case for these reports is directly proportional to the number of tests performed).

Table 1. Distribution of AVGs and Mean Cost per Case in the Self-Referral and Independent-Referral Groups.*

AVG Code and Category	Cases		Cost per Case	
	Self-referral	Independent referral	Self-referral	Independent referral
	no. (%)		mean ±SD ($)	
Physical therapy				
824 Medical back problems†	632 (62)	135 (56)	406±98	448±131
825 Tendonitis	162 (16)	43 (18)	384±119	451±177
829 Strain of arm or shoulder	87 (9)	18 (8)	413±88	360±234
826 Wound or fracture of arm or shoulder	58 (6)	18 (8)	381±122	401±188
828 Trauma to fingers or toes†	42 (4)	12 (5)	416±95	261±200
Other‡	36 (4)	14 (6)	444±111	789±1
Total‡	1017 (100)	240 (100)	404±102	440±167
Psychiatric services				
824 Medical back problems‡	61 (39)	24 (37)	3,230±1,493	2,340±697
2120 Minor wounds and injuries	58 (37)	18 (28)	3,215±1,420	2,887±743
1941 Individual supportive therapy	14 (9)	8 (12)	3,114±1,465	2,214±626
1945 Unscheduled crisis	10 (6)	3 (5)	2,929±1,153	2,314±929
1923 Other mental disturbances	6 (4)	7 (11)	4,372±1,967	2,744±748
Other	6 (4)	5 (8)	2,780±1,091	2,751±736
Total‡	155 (100)	65 (100)	3,222±1,450	2,549±742
MRI				
824 Medical back problems	273 (87)	165 (88)	981±231	994±171
829 Strain of arm or shoulder	30 (10)	14 (7)	936±179	874±79
Other	12 (4)	8 (4)	964±199	1,103±180
Total	315 (100)	187 (100)	976±226	990±170

*AVG denotes the Ambulatory Visit Groups classification.[14] There were no significant differences in the distribution of AVGs for physical therapy, psychiatric-evaluation services, or MRI between the self-referral group and the independent-referral group, by the chi-square test. Percentages do not always total 100, because of rounding.

†Differences in cost between the self-referral and independent-referral groups were significant (P<0.05) by t-test.

‡Differences in cost between the self-referral and independent-referral groups were significant (P<0.01) by t-test.

MRI Scans

Tables 1 and 2 show the results of our study of the medical appropriateness of MRI scans. A total of 502 requests for precertification were received from imaging centers in which ownership could be identified. In Table 1, these cases are classified according to AVG and provider type. There was no significant difference in the distribution of cases between the self-referral and independent-referral groups.

As shown in Table 2, 38 percent of the scans requested by physicians in the self-referral group were found to be medically inappropriate, as compared with 28 percent of those requested by physicians in the independent-referral group (P<0.05). There was no significant difference in cost per MRI procedure between the two groups.

Discussion

This study demonstrates that self-referral increases the cost of medical care under workers' compensation for each of the three types of service studied, but by a different mechanism in each instance: by substantially increasing the percentage of injured workers who receive physical therapy (which more than offsets the slight decrease in cost per case); by increasing the number of psychometric tests and the cost of psychiatric-evaluation reports; and by increasing the frequency of requests for clinically inappropriate MRI scans. These higher rates of use and higher costs have important implications for workers' compensation expenditures, since self-referral is the predominant form of referral for these services.

Physical Therapy

According to the California Workers' Compensation Institute (CWCI) 1990 Medical Fee Survey of 39 private and public insurers, physical therapy represents 56 percent of all outpatient procedures and 34 percent of all outpatient costs for the treatment of injured workers in California.[16] This represents an increase of 31 percent in the volume of services in relation to other outpatient procedures since the CWCI's 1988 study.[16]

Injured workers usually receive a prescription for treatment from a physician (an orthopedic specialist or physician at an industrial medical or multispecialty clinic) to the physical therapist for specific treatment. Over the years, many physicians and clinics that treat patients covered by workers' compensation have established physical-therapy departments within their general operations or have established separate phys-

Table 2. Frequency of Use of Services and Cost per Case in the Self-Referral and Independent-Referral Groups.

Variable	Cases			Cost per Case		
	Self-Referral	Independent Referral	Self/Independent Ratio*	Self-Referral	Independent Referral	Self/Independent Ratio*
	no. (%)			mean ±SD ($)		
Physical therapy						
No. of musculoskeletal injuries	1017 (100)	240 (100)	—	—	—	—
Cases with physical therapy	690 (68)†	71 (30)	2.3	404±102‡	440±167	0.9
Psychiatric services						
Cases with psychiatric-evaluation reports	155 (100)	65 (100)	—	2,056±1,063‡	1,680±578	1.2
Cases with psychometric testing	155 (100)	65 (100)	—	1,165±728‡	870±482	1.3
Cost of total evaluation	—	—	—	3,222±1,451‡	2,550±742	1.3
MRI						
Requests for scans	315 (100)	187 (100)	—	—	—	—
Scans found medically inappropriate	121 (38)§	52 (28)	1.4	976±226	990±170	1.0

*The ratio of the number of cases or the cost per case in the self-referral group to that in the independent-referral group.

†The proportion of cases in which physical therapy was ordered in the self-referral and independent-referral groups differed significantly ($P<0.01$), by the chi-square test.

‡The mean cost per case differed significantly between the self-referral group and the independent-referral group ($P<0.01$), by t-test.

§The proportion of cases in which MRI scans were found to be medically inappropriate differed significantly between the self-referral group and the independent-referral group ($P<0.05$), by the chi-square test.

ical-therapy facilities that they own but that are operated as distinct financial entities.

In Florida, Mitchel and Scott recently found that 40 percent of physical-therapy facilities were owned by physicians.[7] Our study focused on California physicians who treat large numbers of musculoskeletal injuries and found that 91 percent of all physical therapy was performed by providers who engage in self-referral (Table 2), and the frequency with which physical therapy was initiated was 2.3 times greater in the self-referral group than the independent-referral group. The cost per case of physical therapy, however, was about 10 percent higher in the independent-referral group.

In this study, there was no significant difference in case mix between the self-referral and independent-referral groups (Table 1). In the absence of measures of severity of illness among outpatients, it is therefore impossible to determine whether the lower cost per case in the self-referral group reflects more efficient care or the provision of physical therapy to patients with less severe injuries, since self-referring practitioners initiate physical therapy at more than twice the rate of independent providers.

Regardless of which hypothesis is correct, this small difference in cost per case is more than offset by the dramatically greater frequency with which self-referring providers initiate physical therapy. As Table 3 shows, for every 1000 workers with musculoskeletal injuries, the costs incurred by the California workers' compensation system would be $143,672 (110 percent) higher if these injured workers were evaluated by self-referring rather than independently referring practitioners.

Psychiatric-Evaluation Services

The CWCI estimates that approximately 6 percent of the total medical payments under workers' compensation were for psychiatric services in 1991.[16] California state law defines a valid claim of work-related stress as one in which the work environment contributes 10 percent or more to a worker's total stress level. Some argue that this definition of compensable workplace stress has created a referral environment that encourages excessive evaluation and testing.

We found that 70 percent of all psychiatric-evaluation services were requested by providers who had an ownership interest in the entity that provided both psychometric testing and psychiatric-evaluation reports (Table 2). Furthermore, evaluation costs were 26 percent higher when this ownership relation existed.

As indicated above, a referral for evaluation virtually always results in charges for two services: psychometric testing and a psychiatric-evaluation report that synthesizes the findings of the psychometric tests with the findings from the psychiatric history and examination. Therefore, if a provider with an economic interest in a facility were motivated more by monetary incentives than one without such an economic interest, we would expect this to be reflected in greater use and higher costs of psychometric testing, as well as a more extensive and therefore more costly evaluation report, which would be required to integrate the results of more extensive testing. As shown in Table 2, the cost of each psychiatric service and the mean cost per case were significantly higher in the self-referral group than the independent-referral group; the differences in cost were as follows: psychometric testing, 34 percent; psychiatric evaluation reports, 22 percent; and total evaluation, 26 percent.

As Table 3 shows, for every 1000 workers receiving psychiatric-evaluation services, the costs incurred by the California workers' compensation system would be $672,000 (26 percent) higher if these workers were treated by physicians in the self-referral group rather than the independent-referral group.

MRI Scans

MRI has gained prominence as the diagnostic imaging tool of choice in the assessment and documentation of specific types of injuries. California cur-

Table 3. Additional Cost Incurred by the California Workers' Compensation System for Each 1000 Injuries Treated at Self-Referral Rather Than Independent-Referral Rates.

Service	Self-Referral	Independent Referral
Physical therapy		
No. of musculoskeletal injuries	1000	1000
Rate of referral for physical therapy	× .678	× .296
No. of cases with physical therapy	678	296
Cost per case	× $404	× $440
Total cost of physical therapy	$273,912	$130,240
Additional cost per 1000 cases (%)	$143,672 (110)	
Psychiatric services		
No. of cases with psychiatric-evaluation services	1000	1000
Cost per case	× $3,222	× $2,550
Total cost of psychiatric-evaluation services	$3,222,000	$2,550,000
Additional cost per 1000 cases (%)	$672,000 (26)	
MRI		
No. of requests for MRI	1000	1000
Rate of inappropriate scans	× .384	× .278
No. of inappropriate scans	384	278
Cost per case	× $976	× $990
Cost of inappropriate MRI	$374,784	$275,220
Cost differential for appropriate scans*	—	$10,108
Total cost of MRI scans	$374,784	$285,328
Additional cost per 1000 cases (%)	$89,456 (31)	

*Additional cost ($14 per case) of the 722 approved MRI procedures.

rently has approximately 400 MRI machines (Mitchel J: personal communication). Recent studies have shown that such a concentration of imaging centers is associated with higher rates of use. After adjustment for the characteristics of the population, Californians undergo 51 percent more MRI procedures than the national average.[9] Leape et al. similarly concluded that an increased concentration of providers increases rates of use.[17] In their study, regions with a high rate of carotid endarterectomy had twice as many surgeons performing the operation as regions where the rate was low.

We found MRI scans to be medically inappropriate 38 percent more often when ordered by self-referring physicians, suggesting increased rates of use in this group. The higher rate of inappropriateness in the self-referral group may help explain the Florida study's finding that rates of use in these physician-owned facilities were 14 to 65 percent higher than in a control area.[7]

Table 3 illustrates the effects of these requests for medically inappropriate scans. For every 1000 requests for MRI scans, the costs incurred by the California workers' compensation system would be $89,456 (31 percent) higher if these requests were made by self-referring physicians rather than by physicians in the independent-referral group.

We are indebted to Mr. Will B. Murphey for his support and encouragement in this project.

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10652-#2

Frequently Asked Questions & Facts About Referral for Profit

What does "referral for profit" mean?

"Referral for profit" describes situations in which a referring physician, podiatrist, dentist, or physical therapist refers a patient for physical therapy treatment on the basis of financial gain related to the referral. According to several studies, referral for profit can lead to unnecessary referrals to physical therapy, excessive durations or frequencies of treatment, excessive procedures being administered, excessive ordering of equipment, or higher charges. In other cases, referral for profit can lead to the referring physician having undue influence on the clinical judgment of the physical therapist. Anecdotal evidence exists of cases in which physical therapists have been told to modify their care because too many patients whom the physician expected to require surgery were being discharged with good recovery of function, making surgery unnecessary.

How do physicians gain financially from referrals?

A physician can receive financial gains by having total or partial ownership of the physical therapy practice to which he or she refers, by directly employing the physical therapist, by contracting with physical therapists, or by taking kickbacks from the physical therapist to whom he or she refers. Actual kickbacks are strictly illegal, whereas the legal status of physician ownership of physical therapy services depends on whether the structure of the financial arrangement meets "safe harbor" guidelines under the Stark self-referral rules. The legal status of physician-owned physical therapy services may also depend on state medical and physical therapy practice acts or various state laws that regulate physician self-referral or referral for profit.

How are patients harmed in referral-for-profit situations?

The patient traditionally places great trust in the physician to prescribe and recommend appropriate treatment for their care. When the physician's judgment and referral can be influenced by financial incentives resulting from avoidable conflicts of interest, the trust between the patient and the physician is violated. Further, referral for profit may subject the patient to unnecessary inconvenience, extra expense, and the potential risk of unnecessary treatment. Also, the patient's freedom to choose a physical therapist may also be diminished if the physician directs the patient to a specific location for physical therapy, which may not be the most convenient location for the patient. And, it is possible that another physical therapy practice or hospital department could provide more appropriate care.

How is the physical therapy profession harmed by Referral for Profit?

American Physical Therapy Association

The Science of Healing. The Art of Caring.

Many physician-owned physical therapy service arrangements take referrals away from existing hospital departments and other outpatient centers, harming existing physical therapy resources in the community. Referral for profit arrangements can foster relationships between physical therapists and referring physicians that are based on financial incentives rather than professional collaboration, mutual respect, and patient care. When a practice is owned by a physical therapist or group of physical therapists, it is the physical therapist's license at stake if there are any systematic violations of the practice act within the owner's responsibility. But a physical therapy licensing board has no jurisdiction over non–physical therapists who own or administer physical therapy services, reducing the level of oversight and protection for the public.

FACTS FOR LEGISLATORS

- There is an inherent conflict of interest in the traditional fee-for-service health care system when physicians invest in services to which they refer.

- A study conducted for the State of Florida's Health Care Cost Containment Board found that the number of visits per patient is significantly higher in physical therapy facilities in which the referring physicians invest than those in which there is no such incentive for referral.

- The same Florida study found that joint-venture physical therapy facilities average 62 percent more visits per full-time equivalent licensed physical therapist than do non joint-venture facilities.

- A study by the Office of the Inspector General of the Department of Health & Human Services found that almost four out of five cases (78%) reimbursed as physical therapy in physicians' offices do not represent true physical therapy services.

- According a study done on Medical Referral-for-Profit in California Workers Compensation, this situation generates approximately $233 million in services delivered for economic rather than clinical reasons.

- Such arrangements limit access to health care, drive down quality, eliminate competition, and do nothing to enhance the quality of care for the patient.

APTA

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The Science of Healing. The Art of Caring.

#10652-3

JOINT VENTURES AMONG HEALTH CARE PROVIDERS IN FLORIDA

VOLUME II

SEPTEMBER 1991

STATE OF FLORIDA
HEALTH CARE COST CONTAINMENT BOARD

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CHAPTER IX

THE EFFECT OF JOINT VENTURES ON THE PROVISION OF PHYSICAL THERAPY SERVICES

A. Introduction

This chapter analyzes the effects of joint ventures on the provision of services by freestanding comprehensive rehabilitation facilities as well as services rendered by centers specializing in physical therapy. Comprehensive rehabilitative facilities provide physical therapy, occupational therapy and speech pathology. Physical therapy involves the planning and administration of treatment programs that will assist injured or disabled patients in reaching maximum performance and functional levels. In recent years, twenty-six states have enacted direct access laws which allow physical therapists to evaluate and treat patients without a physician's referral for services. Florida and twenty-three other states have not enacted such direct access laws. Therefore, in Florida a patient must be referred by a physician in order to obtain physical therapy treatments.

Unlike physical therapy, occupational therapy and speech pathology do not require a physician's referral. Occupational therapy instructs patients in compensatory methods for improving the level of independence in the activities of daily living and the work environment. Speech pathology involves the examination, evaluation, treatment and counseling of patients suffering from disorders that affect speech or language.

As reported in chapter I, approximately 40 percent of the rehabilitation and/or physical therapy facilities that completed a questionnaire have some ownership arrangement involving physicians who are in a position to make referrals to the facility.

Rehabilitation facilities are classified into two groups according to the type of service: 1) physical therapy services only; 2) comprehensive rehabilitation facilities providing physical therapy, occupational therapy, speech pathology, and in some cases "work hardening" for workers compensation patients. A third group of facilities provided occupational therapy and/or speech pathology services only; this group will not be examined in detail in the analysis because only fifteen such centers completed surveys and only one has physician owners.

The two ownership categories for rehabilitation facilities are: 1) joint venture (with one or more physician owners) and 2) nonjoint venture (no physician owners). Some of the facilities are joint ventures between several referring physicians and a health care entity. In some cases, these health care entity owners are publicly traded corporations. For example, Healthsouth, is such a

company which has at least 15 such joint venture partnerships with physicians in Florida.

Joint ventures and self-referrals could either promote or lessen consumer interests. Physicians involved in joint ventures contend that these arrangements allow them to better monitor the quality of care provided to their patients. On the other hand, self-referral could enrich physicians without benefitting consumers through higher charges and excessive utilization of services. Since treatment by a physical therapist in Florida (as well as in twenty-three other states) requires referral by a physician, joint ventures may create a captive referral system which inhibits competition by nonjoint venture providers.

Profit motivated referrals may also affect the manner in which patients are treated. If physician owners are primarily motivated by profits, they could provide these services at minimal possible cost. One way to lower costs is to employ fewer licensed physical therapists and fewer licensed therapist assistants, and hire instead lower wage workers to perform physical therapy (nonlicensed aides and exercise specialists). Another way to reduce costs and to generate more revenue is to require the physical therapists and other workers to treat more patients per day; this can be accomplished by shortening the standard length of a physical therapy visit. Thus, if profit rather than quality concerns motivate physician ownership, then the ratio of visits to the number of full-time equivalent (FTE) licensed physical therapists should be higher in physician owned centers than in nonjoint venture facilities.

On the other hand, if the quality monitoring explanation motivates ownership, then the number of visits per licensed physical therapist should be comparable or even lower in physician owned centers than in nonjoint venture facilities. These arguments should also apply to comparisons of the ratio of visits to the sum of the licensed physical therapist FTEs and the licensed therapist assistant FTEs.

B. Characteristics of Physical Therapy Facilities

Table 9.1 reports statistics comparing the characteristics of facilities specializing in physical therapy services. About 66 percent of the patients treated at physician owned physical therapy centers are referred by physicians who have an investment interest in the facility. (This percentage is computed using only those facilities that reported the number of referrals from owners.)

Access

Access to various payer groups is indicated by the percent of total revenue received from each payer group. Another indicator is the proportion of gross revenues attributable to bad debt and

charity care. Nonjoint venture physical therapy facilities receive significantly more of their revenues from Medicare patients than joint venture physical therapy centers (15.5 percent for joint ventures versus 22.6 for nonjoint ventures). Nonjoint venture providers also generate a significantly larger share of their revenue from Blue-Cross and commercial insurers; nearly 48 percent for the nonjoint ventures compared about 37 percent for the joint venture physical therapy centers. The results further show that nonjoint venture physical therapy facilities writeoff significantly more of their gross revenues as bad debt and charity care (9.5 percent versus five percent).

Joint venture physical therapy centers, on the other hand, generate a significantly larger share of their revenues from workers compensation patients; nearly 31 percent of the revenue of physician owned physical therapy facilities is derived from workers compensation patients compared to twenty percent for their nonjoint venture counterparts.

Economic and Financial Characteristics

Table 9.1 also reports information on the utilization of physical therapy services. Joint venture facilities provide an average of close to 8000 visits per year, compared to 5,320 for nonjoint venture physical therapy centers; the difference is statistically significant. Thus, physician owned physical therapy render about 50 percent more visits each year than similar businesses without referring physician owners.

The difference in the mean number of physical therapy visits per patient is also statistically significant; the average is 16 for joint venture facilities 16 compared to an average of 11.2 for those physical therapy centers with no physician owners. Thus, patients treated at physician owned physical therapy centers receive 43 percent (4.8) more visits per patient than patients treated at nonjoint venture physical therapy centers. In contrast, there is only a negligible difference in the number of procedures or modalities performed per visit. This finding is not surprising because many insurers have imposed limits on the number of billable modalities per visit in their efforts to control health care costs.

Joint venture facilities charge close to $52 per physical therapy visit, whereas nonjoint venture centers charge slightly more than $57 per visit. This ten percent difference in revenue per visit is significantly higher but does not necessarily mean that patients pay ten percent more. The higher average revenue per visit may be due to the delivery of more complex and costly procedures. Alternatively, the higher charge may be due to differences in the average length of a visit. (Results presented below corroborate these statements). The disparity in net revenue per visit is less, and is not statistically significant.

The differences in dollar amounts for average revenue per patient are significant and reflect the higher utilization rates that characterize physician owned physical therapy facilities. Joint venture facilities have charges that average slightly more than $845 per patient compared to $642 per patient for those without physician owners. Thus, physician owned physical therapy centers generate approximately 31 percent or $200 more revenue per patient than nonjoint venture providers. Since the nonjoint venture ownership group has higher revenue per visit, this significant difference in revenue per patient is attributable to higher utilization of services in physician owned facilities.

The average percent operating income (excluding contract expenses) of physician owned physical therapy centers is significantly higher (42.6 percent versus 33.2 percent) than in otherwise similar nonjoint venture facilities. For physical therapy centers, the percent operating income adjusted for contract expenses is a better indicator of firm profitability because most of the contract expenses of these facilities are wages paid to therapists employed under contract. These adjustments to include payments for contract services in direct expenses further widens the disparity in the percent operating income between the two ownership groups. After contract adjustments, the percent operating income is also significantly higher for physician owned physical therapy centers (37.8 percent versus 26.7 percent).

Expenses are computed as the ratio of expenses to the total number of physical therapy visits provided per facility. Direct expense per visit is significantly higher for nonjoint venture facilities ($37.45 versus $29.10). The most representative measure of the average total cost of producing a physical therapy visit is the sum of direct expense per visit, fixed expense per visit, and contract expense per visit. Contract expenses are included in the calculation of the average total cost of a visit because in physical therapy and/or rehabilitation facilities, contract expenses are primarily paid as wages to licensed physical therapists.

The average total cost per visit in a joint venture physical therapy center is $39.70. The average total cost of a visit in a nonjoint venture physical therapy center is $51.66, which is approximately $12 more than the joint venture facilities. The lower average cost per visit of joint venture facilities can be attributed in part to the greater number of visits that characterize joint venture providers of physical therapy services.

Salaries and wages represent a similar proportion of direct expenses of both ownership groups. Nevertheless, physician owned centers allocate significantly less direct expenses to salaries and wages for licensed physical therapists (32.7 percent versus 47.6 percent). These results suggest that physician owned centers

provide more physical therapy services with fewer licensed therapists.

The data reported in the last three rows of Table 9.1 show the number of visits per full-time equivalent (FTE) licensed physical therapist, visits per (FTE) licensed medical workers (therapists and licensed assistants), and visits per FTE medical workers (includes both licensed and nonlicensed employees). For all three measures joint venture facilities generate significantly more visits per FTE.

Joint venture facilities render an average of 5,114 physical therapy visits per full-time equivalent physical therapist. In contrast, nonjoint venture facilities provide only 3,149 visits per FTE licensed physical therapist. Thus, joint venture facilities provide, on average, 1,965 (62 percent) more visits per licensed physical therapist than nonjoint venture physical therapy centers. Based on the standard assumption of 260 working days, a physical therapist employed by a joint venture facility treats an average of twenty patients per day, whereas in the typical nonjoint venture facility a physical therapist treats an average of 12 patients per day.

A similar pattern emerges when the number of visits are expressed relative to the sum of FTE licensed physical therapists and FTE licensed therapist assistants. This ratio is 3,735 for joint venture centers and 2,668 for nonjoint venture physical therapy centers. Based on these calculations, physician owned physical therapy facilities render about 40 percent or 1,067 more visits per FTE licensed physical therapy worker (includes licensed physical therapists and licensed therapist assistants) than nonjoint venture facilities. Again, assuming a standard of 260 working days per year, the average number of visits per day per FTE licensed medical worker (physical therapists and therapist assistants) in physician owned facilities is 14. The corresponding number for the typical nonjoint venture physical therapy center is 10.

The inclusion of other FTE nonlicensed medical workers in the denominator reduces this ratio to 3,471 for joint venture facilities, a decline of about eight percent. For nonjoint venture facilities this ratio decreases only slightly from 2,668 to 2,594. These findings suggest that nonlicensed workers are substituted for licensed workers in the provision of physical therapy services in joint venture facilities. Nonetheless, this substitution does not make visits per FTE equal as would be expected if joint venture facilities and nonjoint venture facilities provide similar units of labor per visit.

These findings suggest that joint venture physical therapy centers provide a lower quality of care because both licensed therapy workers and nonlicensed workers spend less time with each

patient. The finding that more visits are produced per unit of labor in physician owned physical therapy centers and that these centers use lower-paid labor explains why the direct expense per visit and average total cost per physical therapy visit is less in joint venture facilities than in nonjoint venture firms.

Table 9.2 compares list charges of joint venture and nonjoint venture physical therapy centers. These results show that there are only negligible differences in the average list charges of the two ownership types. Further breakdowns by region revealed that there is no consistent pattern of higher or lower charges within a particular region. For most of procedures or treatments reported in Table 9.2, the difference in average list charges is less than two dollars. Thus, while physician owned physical therapy service have higher utilization rates, there does not appear to be any substantial difference in the charges for these services between the two ownership groups. These results indicate that the higher average revenue per visit at nonjoint venture facilities is attributable to these facilities performing more complex treatments and procedures.

C. Characteristics of Comprehensive Rehabilitation Facilities

Table 9.3 contains statistics regarding the characteristics of comprehensive rehabilitation facilities. Both joint venture and nonjoint venture facilities earn about 80 percent of their total revenues from the provision of physical therapy services. The results on occupational therapy and speech pathology services are not presented here. Nonjoint venture comprehensive rehabilitation centers generate significantly less revenues per patient for occupationla therapy services but significantly more revenues per patient for speech therapy services. Furthermore, about 61 percent of the patients treated at rehabilitation facilities are referred by physicians who have an investment interest in the facility. (This percentage is computed using only those facilities that reported referral information.)

Access

Access is measured by the percent of revenues received from each of the various payer groups. Nonjoint venture rehabilitation facilities generate significantly more of their revenues from Medicare than their physician owned counterparts (40 percent versus 21.3 percent). Physician owned facilities do not treat any Medicaid patients, whereas the nonjoint ventured centers generate an average of two percent of their revenues from services provided to Medicaid patients. Nonjoint venture facilities also generate a greater proportion of their revenues from treating self-pay patients (1.8 percent for joint ventures versus 7.7 percent for nonjoint ventures). This difference is statistically significant.

On the other hand, physician owned rehabilitation centers obtain significantly more revenues from Blue Cross and commercial insurers, (54.2 percent versus 29.2 percent) and they receive significantly more revenues from managed care patients (10.2 percent versus 2.7 percent). Other differences in sources of revenue were not significant.

Rehabilitation centers with referring physician owners provide about 50 percent (4,188) more physical therapy visits than rehabilitation centers without physician owners (12,600 versus 8,412 physical therapy visits. This difference is statistically significant.

The average number of physical therapy visits per patient in physician owned rehabilitation centers is significantly higher (13.8 for the joint venture facilities compared to 10.5 in nonjoint venture rehabilitation centers). Thus, patients treated at physician owned rehabilitation facilities receive 32 percent or 3.3 more physical therapy visits than patients obtaining physical therapy treatments at nonjoint venture facilities. Again, as is the case with facilities specializing in physical therapy, there is little difference between the two ownership groups in the number of procedures or modalities performed per physical therapy visit.

Joint venture rehabilitation facilities generate gross revenues of about $65 per physical therapy visit, whereas nonjoint venture centers generate almost $81 per physical therapy visit. This $16.51 differential in average revenue per visit is significant but can be attributed to the nonjoint venture centers having a longer length of visit and performing more complex procedures during each visit than joint venture facilities. (Average list charges are lower at nonjoint venture facilities; these results are presented below.) The difference in net revenue per visit is about $14 and is also statistically significant.

The impact of the higher utilization rates for physical therapy visits in joint venture rehabilitation centers become evident when one examines the amount of revenue generated by the average physical therapy patient. Physician owned facilities generate revenues of about $916 per physical therapy patient, compared to $834 of revenue per physical therapy patient treated in nonjoint venture facilities even though the average gross revenue per visit is lower. Patients receiving physical therapy treatments in joint venture facilities generate approximately ten percent or $82 more revenue than patients who obtain physical therapy services at nonjoint venture rehabilitation facilities. Yet, despite the fact that nonjoint venture providers generate more revenue per physical therapy visit, the difference in total revenue generated by the average physical therapy patient is still higher for the joint venture facilities due to the higher utilization of physical therapy services. The difference in gross revenue per patient is not statistically significant. (Further, as the list charge

comparison indicates joint venture facilities perform less complex procedures.) The difference in discounts and contractual adjustments by ownership status is also negligible.

The average percent operating income (excluding contract expenses) of joint venture rehabilitation centers is significantly higher (47.7 percent versus 40 percent) for rehabilitation facilities without referring physician owners. Since the production of rehabilitative services involves a significant amount of contract labor for licensed therapists, the percent operating income adjusted for contract expenses is a better measure of overall firm profitability. Making the necessary adjustments for contract expenses widens the disparity in the percent operating income between physician owned rehabilitation centers and those without physician owners; this difference is also statistically significant. After adjusting for contract expenses, the percent operating income is 43.3 percent for physician owned rehabilitation centers compared to 28 percent for nonjoint venture facilities. The difference in the mean operating income per visit between the two ownership groups is negligible.

Expenses are expressed relative to the total number of visits rendered per facility. As discussed in the preceding section, the most representative measure of the average total cost of producing a visit is the sum of direct expense per visit, fixed expense per visit, and contract expense per visit.

Here again, direct expenses per visit are significantly higher at nonjoint venture centers ($43.84 versus $32.41). Also fixed expense per visit and contract expense per visit are significantly higher for nonjoint venture facilities. The average total cost per visit in a physician owned rehabilitation facility is $47.33. In nonjoint venture rehabilitation facilities, the average total cost of a visit is $67.24, which nearly $20 more than the average total cost in joint venture facilities. The lower average cost per visit of joint venture facilities can be attributed, in part, to the larger numbers of visits rendered at joint venture rehabilitation facilities. Another reason these facilities have lower expenses is because they perform less complex treatments.

Salaries and wages represent a larger share of the direct expenses of joint venture rehabilitation facilities. Nevertheless, salaries and wages paid to licensed therapists account for a significantly lower percent of total direct expenses for facilities with physician owners (39.2 percent versus 47.9 percent).

The data reported in the last three rows of Table 9.3 show the total number of physical therapy visits by type relative to the number of full-time equivalent (FTE) licensed and nonlicensed physical therapy workers. Physical therapy services are expressed in three ways: visits per FTE licensed physical therapist; visits

per FTE licensed medical worker (physical therapist and licensed therapist assistants); and visits per FTE medical workers (includes both licensed and nonlicensed physical therapy workers).

Joint venture facilities generate, on average, significantly physical therapy visits per licensed physical therapist (4,024 versus 2,843). Thus, joint venture rehabilitation centers provide about 42 percent or 1,181 more physical therapy visits per licensed physical therapist than nonjoint venture facilities. Assuming a standard of 260 working days, a physical therapist treating patients in a joint venture rehabilitation facility sees more than 15 patients on a typical day. Physical therapists working in nonjoint venture facilities treat an average of 11 patients per day. These findings suggest that physical therapy visits rendered in physician owned rehabilitation centers are of shorter duration than physical therapy visits in nonjoint venture facilities or that services are not administered by licensed physical therapists.

The number of physical therapy visits relative to the sum of FTE licensed physical therapists and FTE licensed therapist assistants is also significantly higher (3,002 versus 1,985). Thus, the number of physical therapy visits per FTE licensed therapist and licensed therapist assistant is 51 percent or 1,017 visits more in joint venture facilities relative to nonjoint venture facilities. Under the assumption of 260 working days, the average number of visits per day per FTE licensed medical worker (physical therapists and therapist assistants) in physician owned rehabilitation centers is 11.5; in nonjoint venture facilities this ratio is 7.6 daily visits per licensed medical worker.

The inclusion of other FTE nonlicensed medical workers in the denominator does not substantially alter this ratio for either joint venture or nonjoint venture rehabilitation facilities. This evidence suggests that rehabilitation facilities do not lower costs by employing nonlicensed medical workers to provide physical therapy services. Rather, since the length of visit is one proxy for quality, these findings imply that nonjoint venture facilities provide higher quality services because their visits are of longer duration than the average visit in physician owned facilities. These results may also imply that licensed practioners are not delivering these services.

Table 9.4 compares list charges for common procedures and treatments performed in rehabilitation facilities. For ten procedures, the list charges are significantly higher in joint venture rehabilitation facilities than in similar nonjoint venture businesses. In two cases, the charges in nonjoint venture rehabilitation facilites are higher, but the differences are not significant. These findings indicate that joint venture rehabilitation charge more and have higher utilization rates than nonjoint venture facilities.

D. Summary

This chapter compares the characteristics of joint venture and nonjoint venture physical therapy and/or rehabilitation facilities. These facilities are grouped by type of service: 1) physical therapy services only, and 2) comprehensive rehabilitation facilities providing physical therapy, occupational therapy, speech pathology, and in some cases work hardening. Both types of joint venture facilities receive more than 60 percent of their referrals from owners.

Nonjoint venture facilities specializing in the provision of physical therapy services receive significantly higher percentages of their revenues from Medicare and Blue Cross/commercial insurers. Nonjoint venture providers also writeoff significantly more revenue for care provided to bad debt and charity patients. Joint venture providers, on the other hand, generate significantly more of their revenue from workers compensation patients.

The access measures for rehabilitation facilities show that joint venture centers generate significantly more revenue from Blue Cross and commercial insurers and from managed care patients than their nonjoint venture counterparts. On the other hand, nonjoint venture facilities generate significantly more of their revenues from Medicare and self-pay patients in comparison to facilities owned by physicians. Joint ventured rehabilitation facilities do not treat any Medicaid patients, whereas their nonjoint venture counterparts generate about two percent of their revenues from this payer group.

The findings for facilities specializing in physical therapy show that the mean number of visits per patient is significantly higher (16 in joint venture facilities compared to 11.2 for the nonjoint venture centers). Thus, patients treated at physician owned facilities receive 43 percent (4.8) more visits per patient than patients treated at nonjoint venture physical therapy centers.

Joint venture physical therapy facilities average significantly less revenue per visit but generate significantly more revenue per patient. Joint venture facilities average 31 percent or $200 more revenue per patient due to the higher utilization of services. Joint venture physical therapy facilities are also significantly more profitable than their nonjoint venture counterparts.

Joint venture physical therapy facilities provide on average 62 percent (almost 2,000) more visits per FTE licensed physical therapist; this difference is statistically significant. Physician owned physical therapy facilities also render about 40 percent more visits per FTE physical therapy worker (licensed physical therapist and licensed therapist assistants). Further, there is only minimal substitution of nonlicensed workers for licensed workers in the

provision of physical therapy services. These findings indicate that joint venture facilities provide a lower quality of care because both licensed therapy workers and nonlicensed workers spend less time with each patient. These results also explain why the average total cost of a physical therapy visit is less in joint venture facilities than in nonjoint venture facilities.

A comparison of list charges of joint venture and nonjoint venture physical therapy centers shows negligible differences in the average list charges of the two ownership groups. Thus, while nonjoint venture facilities generate significantly higher average revenue per visit, this difference occurs either because the treatment sessions are of longer duration or because these treatments are more complicated than those provided in joint venture facilities.

Patients treated at physician owned comprehensive rehabilitation facilities average 32 percent more physical therapy visits than patients treated at nonjoint venture facilities and this difference is statistically significant. The mean number is 13.8 visits for the joint venture versus 10.5 for the nonjoint venture.

Nonjoint venture rehabilitation facilities receive significantly more revenue per physical therapy visit, however, the average visit is longer than in joint venture facilities. Patients receiving physical therapy treatments in joint venture facilities generate ten percent ($82) more revenue than patients who receive physical therapy at nonjoint venture facilities. The higher revenue per patient is due to the higher utilization of physical therapy visits per patient which characterizes joint venture facilities.

Physician owned rehabilitation facilities are more profitable and have a lower average cost per visit than nonjoint venture providers. Joint venture rehabilitation facilities render about 42 percent more visits per licensed physical therapist than nonjoint venture facilities. The average number of annual visits per FTE licensed medical worker (physical therapists and therapist assistants) is 51 percent higher in joint venture facilities relative to nonjoint venture facilities. These findings imply that nonjoint venture facilities provide higher quality services because there visits are of longer duration than the average visit in joint venture facilities, or, alternatively, that services are not administered by licensed practioners.

In sum, for both joint venture physical therapy and rehabilitation centers average utilization rates (visits per patient) are significantly higher and average revenue per patient is higher; this difference in average revenue per patient, however, is only statistically significant for facilities specializing in physical therapy services. Finally, both joint venture physical

therapy and rehabilitation facilities render significantly more visits per licensed physical therapist. This is also the case when visits are expressed relative to the sum of FTE licensed physical therapists and licensed therapist assistants. This suggest that joint venture facilities provide lower quality services than their nonjoint venture counterparts because their visits are of shorter duration. These findings may also imply that licensed practioners are not delivering these services.

Table 9.1 Characteristics of Physical Therapy Facilities

	JOINT VENTURED FACILITIES (N=43)		NONJOINT VENTURED FACILITIES (N=74)		
Variable	**Mean**	**Standard Deviation**	**Mean**	**Standard Deviation**	**Significance Level**
Percent Referrals by Physician Owners	65.8%	(26.5)	--	--	
<u>Access</u>					
Percent of Revenue/ Medicare	15.5%	(20.5)	22.6%	(25.4)	.084
Percent of Revenue/ Medicaid	--	--	--	--	
Percent of Revenue/ Managed Care	11.0%	(15.4)	7.4%	(13.7)	
Percent of Revenue/ Blue Cross and/or Commercial	36.6%	(28.1)	49.0%	(30.8)	.029
Percent of Revenue/ Self-Pay	8.8%	(13.1)	12.3%	(22.5)	
Percent of Revenue/ Other Including Contract Work	31.0%	(30.1)	19.9%	(27.4)	.041
Percent of Revenue/ Bad Debt and Charity Care	5.1%	(9.0)	9.5%	(19.3)	.110
<u>Utilization</u>					
Physical Therapy Visits	7,967	(4,343)	5,320	(3,995)	.000
Physical Therapy Visits Per Patient	16.0	(5.7)	11.2	(2.5)	.000
Procedures (Modalities) Per Physical Therapy Visit	3.0	(.81)	2.8	(.62)	
<u>Charges and Costs</u>					
Gross Revenue Per Physical Therapy Visit	$51.91	(20.56)	$57.32	(21.71)	.084
Net Revenue Per Physical Therapy Visit	$50.40	(17.81)	$54.31	(21.23)	

Table 9.1 Characteristics of Physical Therapy Facilities (continued)

	JOINT VENTURED FACILITIES (N=43)		NONJOINT VENTURED FACILITIES (N=74)		
Variable	**Mean**	**Standard Deviation**	**Mean**	**Standard Deviation**	**Significance Level**
Gross Revenue Per Physical Therapy Patient	$845.26	(479.09)	$841.97	(312.72)	.001
Discounts and Contractual Adjustments	12.6%	(9.4)	11.6%	(8.6)	
Percent Operating Income Excluding Contract Expenses	42.6%	(18.6)	33.2%	(25.1)	.019
Percent Operating Income Adjusted for Contract Expenses	37.8%	(18.6)	26.7%	(20.5)	.002
Operating Income Per Visit	$21.42	(12.65)	$20.13	(14.36)	
Direct Expense/Visit	$29.10	(12.98)	$37.45	(19.12)	.008
Fixed Expense/Visit	$7.73	(6.36)	$9.15	(7.10)	
Contract Expense/Visit	$2.87	(6.69)	$5.06	(9.83)	
Other Overhead/Visit	$3.34	(4.08)	$4.21	(6.98)	
Interest Expense/Visit	$.77	(1.04)	$.59	(.93)	
Salaries and Wages as a Percentage of Total Direct Expense	68.2%	(18.4)	67.1%	(21.1)	
Salaries and Wages Paid to Licensed Physical Therapists as a Percentage of Total Direct Expense	32.7%	(18.8)	47.6%	(19.6)	.000
<u>Quality</u> Visits Per Full-time Equivalent (FTE) Licensed Physical Therapist	5,114	(2,388)	3,149	(1,808)	.000

Table 9.1 Characteristics of Physical Therapy Facilities (continued)

	JOINT VENTURED FACILITIES (N=43)		NONJOINT VENTURED FACILITIES (N=74)		
Variable	**Mean**	**Standard Deviation**	**Mean**	**Standard Deviation**	**Significance Level**
Visits Per (FTE) Licensed Physical Therapist and Licensed Therapist Assistants	3,735	(2,036)	2,668	(1,699)	.001
Visits Per (FTE) Medical Workers[a]	3,471	(2,049)	2,594	(1,682)	.006

Notes: [a]Medical workers include licensed physical therapists, licensed physical therapist assistants, and nonlicensed medical workers (exercise/fitness specialists, technicians, and PT aides).

Table 9.2 List Charge Comparison for Physical Therapy Centers

	JOINT VENTURE FACILITIES (N=43)		NONJOINT VENTURE FACILITIES (N=74)	
Procedure or Treatment	**Mean**	**Standard Deviation**	**Mean**	**Standard Deviation**
Hot or Cold Packs	$19.50	(5.25)	$19.69	(5.25)
Ultrasound	$21.48	(5.76)	$21.66	(6.83)
Electrical Stimulation	$23.58	(7.03)	$23.08	(7.44)
Initial Evaluation	$46.08	(16.28)	$46.24	(23.30)
Tens Treatment	$25.00	(6.56)	$27.52	(11.76)
Activities of Daily Living (ADL)	$33.83	(10.92)	$34.75	(18.90)
Manual Muscle Testing	$39.26	(15.35)	$41.15	(15.19)
Therapeutic Exercise (30 minutes)	$26.25	(9.53)	$28.18	(12.75)
Neuromuscular Reeducation (30 minutes)	$25.33	(10.35)	$26.46	(10.97)
Functional Activities	$23.43	(7.01)	$25.10	(8.61)
Stretching for Range of Motion	$23.30	(7.95)	$27.84	(13.71)
Cybex Exercise (each additional 15 minutes)	$20.92	(15.22)	$19.11	(6.70)
Kinetic Activities (initial 30 minutes)	$32.70	(8.66)	$33.62	(10.22)
Kinetic Activities (each additional 15 minutes)	$20.98	(5.54)	$21.08	(7.01)
Isokinetic Exercise	$58.10	(49.32)	$44.76	(24.67)
Computerized Extremity Testing (initial 30 minutes)	$70.70	(46.73)	$65.88	(28.00)

Table 9.3 Characteristics of Rehabilitation Facilities

	JOINT VENTURED FACILITIES (N=28)		NONJOINT VENTURED FACILITIES (N=47)		
Variable	**Mean**	**Standard Deviation**	**Mean**	**Standard Deviation**	**Significance Level**
Percent Referrals by Physician Owners	61.3%	(22.9)	–	–	
<u>Access</u>					
Percent of Revenue/ Medicare	21.3%	(14.5)	40.0%	(27.4)	.001
Percent of Revenue/ Medicaid	–	–	2.3%	(10.9)	
Percent of Revenue/ Managed Care	10.2%	(21.7)	2.7%	(6.1)	.052
Percent of Revenue/ Blue Cross and/or Commercial	54.2%	(30.3)	29.2%	(28.9)	.001
Percent of Revenue/ Self-Pay	1.8%	(3.0)	7.7%	(16.9)	.062
Percent of Revenue/ Other Including Contract Work	24.9%	(33.4)	30.4%	(32.4)	
Percent of Revenue/ Bad Debt and Charity Care	13.2%	(13.8)	9.8%	(10.8)	
<u>Utilization</u>					
Physical Therapy Visits	12,600	(7,708)	8,412	(11,462)	.050
Physical Therapy Visits Per Patient	13.8	(3.5)	10.5	(4.1)	.000
Procedures (Modalities) Per Physical Therapy Visit	2.7	(.91)	2.6	(.62)	
<u>Charges and Costs</u>					
Gross Revenue Per Physical Therapy Visit	$64.76	(27.02)	$81.27	(43.55)	.044

Table 9.3 Characteristics of Rehabilitation Facilities (continued)

	JOINT VENTURED FACILITIES (N=28)		NONJOINT VENTURED FACILITIES (N=47)		
Variable	**Mean**	**Standard Deviation**	**Mean**	**Standard Deviation**	**Significance Level**
Net Revenue Per Physical Therapy Visit	$61.87	(18.97)	$75.49	(31.74)	.025
Gross Revenue Per Physical Therapy Patient	$916.47	(410.47)	$834.53	(712.69)	
Discounts and Contractual Adjustments	11.8%	(10.3)	11.4%	(12.3)	
Operating Income as a Percent of Net Revenues Excluding Contract Expenses	47.7%	(19.1)	40.1%	(21.1)	.067
Operating Income as a Percent of Net Revenue Adjusted for Contract Expenses	43.3%	(19.9)	28.1%	(20.8)	.004
Operating Income Per Visit	$32.03	(17.04)	$32.51	(27.13)	
Direct Expense/Visit	$32.41	(12.60)	$43.84	(20.14)	.010
Fixed Expense/Visit	$8.95	(7.63)	$13.00	(12.92)	.100
Contract Expense/Visit	$5.97	(7.61)	$10.40	(15.53)	.100
Other Overhead/Visit	$10.80	(13.59)	$11.59	(17.45)	
Interest Expense/Visit	$1.25	(1.92)	$1.79	(3.06)	
Salaries and Wages as a Percentage of Total Direct Expense	70.6%	(31.8)	71.7%	(19.0)	

Table 9.3 Characteristics of Rehabilitation Facilities (continued)

	JOINT VENTURED FACILITIES (N=28)		NONJOINT VENTURED FACILITIES (N=47)		
Variable	**Mean**	**Standard Deviation**	**Mean**	**Standard Deviation**	**Significance Level**
Salaries and Wages Paid to Licensed Physical Therapists as a Percentage of Total Direct Expense	39.2%	(14.0)	47.9%	(17.0)	.024
Quality					
Physical Therapy Visits Per Full-time Equivalent (FTE) Licensed Physical Therapist	4,024	(2,127)	2,843	(2,124)	.017
Physical Therapy Visits Per (FTE) Licensed Physical Therapists and Licensed Therapist Assistants	3,002	(1,825)	1,985	(1,759)	.013
Physical Therapy Visits Per FTE Medical Worker[a]	2,934	(1,820)	1,943	(1,696)	.013

Notes: [a]Medical workers include licensed physical therapists, licensed assistants and nonlicensed medical workers such as exercise specialists and physical therapy aides.

Table 9.4 List Charge for Rehabilitation Centers

	JOINT VENTURE FACILITIES (N=28)		NONJOINT VENTURE FACILITIES (N=47)	
Variable	**Mean**	**Standard Deviation**	**Mean**	**Standard Deviation**
Hot or Cold Packs	$22.32	(3.92)	$19.92	(4.73)
Ultrasound	$26.66	(8.05)	$21.18	(5.28)
Electrical Stimulation	$28.11	(7.24)	$23.55	(8.07)
Initial Evaluation	$48.66	(17.59)	$49.73	(20.98)
Tens Treatment	$31.37	(10.34)	$28.42	(10.07)
Activities of Daily Living (ADL)	$39.11	(12.19)	$32.36	(7.00)
Manual Muscle Testing	$49.00	(26.07)	$37.31	(15.55)
Therapeutic Exercise (30 minutes)	$35.44	(10.23)	$32.79	(11.47)
Neuromuscular Reeducation (30 minutes)	$35.05	(17.53)	$32.91	(14.11)
Functional Activities	$42.05	(22.45)	$28.15	(8.04)
Stretching for Range of Motion	$34.18	(11.52)	$26.53	(8.71)
Cybex Exercise (each additional 15 minutes)	$25.95	(12.69)	$20.31	(11.75)
Kinetic Activities (initial 30 minutes)	$39.07	(11.92)	$34.35	(10.12)
Kinetic Activities (each additional 15 minutes)	$25.55	(10.74)	$21.24	(5.03)
Isokinetic Exercise	$51.57	(29.06)	$56.65	(30.55)
Computerized Extremity Testing (initial 30 minutes)	$86.13	(47.81)	$78.68	(52.33)

Submitter : **Dr. vikram Appannagari** **Date: 08/29/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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 : Larry Kuhn **Date:** 08/29/2007

Organization : Larry Kuhn

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P

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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.

Larry Kuhn

Submitter : **Dr. Charles Richards** **Date: 08/29/2007**

Organization : **Dr. Charles Richards**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1385-P-10655-Attach-1.DOC

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

Organization : **Trover Sports Medicine and Rehabilitation**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I have been a certified athletic trainer since 1990. I currently work in a sports medicine clinic with outreach to local high schools.

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 facilitics 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 eare. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to eircumvent those standards.

The lack of access and workforee 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 reeeive 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 rcommcndations 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,

Debbie Klinger, MS, ATC

Submitter : **Dr. Keith Lipsitz** **Date: 08/29/2007**

Organization : **Dr. Keith Lipsitz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Sincerely,
Keith Lipsitz, MD

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

Organization :

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

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

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

Submitter : **Mr. Al Hawkins** **Date: 08/29/2007**

Organization : **Federal Law Enforcement Training Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer. I work for the Federal Law Enforcement Training Center in Charleston, SC. I have been an ATC for 20 years. I have a BS degree from the University of South Carolina.

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,
Al Hawkins, ATC
Senior Athletic Trainer
Federal law Enforcement Training Center
Charleston, SC

Submitter : **Mr. Jeffrey Lahr** **Date: 08/29/2007**

Organization : **Winthrop University**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Certified Athletic Trainer and the Head Athletic Trainer at Winthrop University in Rock Hill, South Carolina. I received my undergraduate degree at the University of Toledo and my graduate degree at Michigan State University.

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

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

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Sincerely,

Jeffrey Lahr, ATC
Head Athletic Trainer
Winthrop University

Submitter : **Dr. Richard Bloom** **Date: 08/29/2007**

Organization : **Hodges Chirorpactic Jacksonville**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

Re: TECHNICAL CORRECTIONS

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

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

Sincerely,

Dr Richard R Bloom Sr

GENERAL

GENERAL

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

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Sincerely,

Dr Richard R Bloom Sr

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

technical correction cms 1385 c

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

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Sincerely,

Dr Richard R Bloom Sr

Submitter : **Mr. Christopher Potter** **Date: 08/29/2007**

Organization : **The University of Toledo**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Christopher Potter and I am an athletic trainer. I am currently pursuing my Masters degree at The University of Toledo, but I have worked in the outpatient clinic setting as well as performing Head Athletic Trainers duties at a high school since my Certification in 2004.

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

Christopher Potter, ATC

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

Organization : **State of NJ**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

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

Thank you for your consideration of this serious matter.

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

Organization : **Florence Township Memorial High School**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an Athltcic Trainer in a secondary school setting. I received my masters degree in athlctic training/sports medicine from Temple University with the intent to make a difference in the lives of (active) people of all ages. Additionally I am a certified Strength and Conditining Coach.

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 aceess to quality health care for my patients.

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Sincerely,

Audrey Tannenbaum M.Ed, ATC, CSCS

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I am a physical therapist and would like to add my comments to the argument against self-referral that is currently being practiced by physicians nation-wide under the loophole created by the exception to the Stark Law. There is an inherent conflict of interest in the self-referral occurring so commonly now. Large studies in both California and Florida have shown that physician self referral of physical therapy patients is improper for three important reasons: 1) physicians who own their own physical therapy practice refer more patients to therapy that physicians who do not showing over utilization of services 2) outcomes achieved by the patients in physician-owned clinics is much poorer 3) costs in physician owned therapy clinics are much higher than in private, physical therapist owned clinics. This is a very clear case of greed and questionable ethics at the very best. Please return to the clear intent of the Stark Law as its originators intended by outlawing this clearly misused loophole of self-referral by physicians. Thank you for your consideration.

Submitter : **Mr. Robert Burke** **Date: 08/29/2007**

Organization : **VA Boston Healthcare System**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

My name is Robert Burke, I am a registered Kinesiotherapist and I have been employed by the VA for 24 years. Kinesiotherpy is an approved Allied Health Profession that provides therapeutic exercise and education to our veterans. During my VA employment I have been a staff therapist on the Physical Medicine and Rehab Service at both the Boston VA Medical Center in Jamaica Plain, Ma (5 years) and
the West Roxbuty VA Medical Center (19 years). I have provided quality rehabilitative care to our veterans during this time and I continue to do so presently as a staff therapist on the Spinal Cord Injury Service at the West Roxbury VA. I would like to object to the proposed "Therapy Standards and Requirements" in the CMS regulations
(docket # 1385-P). I concerned that it will limit the ability of PMR therapist to continue to provide quality care and services to our verterans who deserve it.

Submitter : **Dr. Gabriel Chamyan** **Date: 08/29/2007**

Organization : **Miami Children's Hospital**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Miami, Florida as part of a group of three pathologists who provide services for Miami Children's Hospital.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,

Gabriel Chamyan, M.D.

Submitter : **Dr. Richard Bindseil** **Date: 08/29/2007**

Organization : **Longmont Anesthesia Associates**

Category : **Congressional**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Richard F. Bindseil, D.O.
Chief Financial Officer
Longmont Anesthesia Associates

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

Organization : **Greensboro Anesthesia Physicians**

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 : **Mr. Chad Abrams** **Date: 08/29/2007**

Organization : **Rehab Works- Auburn**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Chad Abrams and I work in a outpatient physical therapy setting that provides outreach athletic training services to area high schools

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

Sincerely,

Chad Abrams, ATC

Submitter : **Dr. Brett Schoch** **Date: 08/29/2007**

Organization : **Juno Beach Family Chiropractic, Inc.**

Category : **Physician**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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,

Brett D. Schoch, D.C.

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would like you to consider eliminating physician-owned,referral for profit physical therapy practices. This has the potential to increase health care costs and impairs the patient's ability to choose the clinic that best fits their financial and medical needs. The physician-owned clinic's financial bottom line may be the criteria for referral rather than the patient's need for a certain therapy specialty. Please consider eliminating this loophole. Conflict of interest needs to be eliminated, ESPECIALLY in healthcare.
Thank You.

Submitter : Mr. George Robinson **Date:** 08/29/2007

Organization : V.A.M.C

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

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

BRIEF INTRO ABOUT SELF: My name is George E. Robinson , I have been working at the V.A.M.C in Chillicothe Ohio as a Register Kinesiotherapist for 16 years, in a In and Out pt. setting.

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

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

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

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

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

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

Sincerely,
George E. Robinson, RKT

Submitter : **Mrs. Jennifer Bostic** **Date: 08/29/2007**

Organization : **KDH**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a nationally certified and Indiana state licensed athletic trainer. I am currently working in a hospital owned outpatient rehabilitation setting and secondary high school setting. The proposed changed will most likely cause me to lose this job that I have held for 14 years. I am currently functioning within my scope of practice and abiding by all state licensure guidelines.

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

Sincerely,

Jennifer Bostic, LAT/ATC

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

Organization : Monroe Physical Therapy and Sports Medicine

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Eric Wolfmeier. I'm a nationally certified and state licensed Athletic Trainer. For the past three years I've been working in the clinical setting of a physical therapy clinic and at a secondary high school. I graduated from Southeast Missouri State with a nationally accredited degree. I've worked in conjunction with physical therapists to assist in therapy for a variety of people with many different injuries.

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

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

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Sincerely,

XXXXXX, ATC (and/or other credentials)

Submitter : **Dr. Brad Peltier** **Date: 08/29/2007**

Organization : **Gulf Shore Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Brad Peltier, MD

Submitter : **Miss. kim walter** **Date: 08/29/2007**

Organization : **Vanderbilt orthopeadic Institute**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 28, 2007

Dear Sir or Madam:
My name is Kim Walter and I work at the Vanderbilt Orthopaedic Institute in Nashville, TN where I along with 18 other Certified Athletic Trainers work with outpatient therapy. We are all individuals with Master s Degrees, NATA certification and state licensure. Our rehabilitation model is one of the most efficient in the country and provides the patient the best care available as Athletic Trainers 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.

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, 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.
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,

Kim Walter, M. Ed., ATC/L
Outreach Athletic Trainer
Vanderbilt Orthopaedic Institute

Submitter : **Dr. Nicholas Jevric** **Date: 08/29/2007**

Organization : **Gulf Shore Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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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.

Nicholas Jevric, MD

Submitter : Mr. Todd Hoyt **Date:** 08/29/2007

Organization : St. Marys/Good Samaritan Inc.

Category : Hospital

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Todd Hoyt, I am a certified and licensed athletic trainer working in Centralia Illinois. I have worked for St.Marys/Good Samaritan Hospital for the past 13 years. I am currently working at one of the hospitals off site health clinics. A portion of my day is spent working with patients in our physical medicine clinic. The other portion of my day is spent with our outreach sports medicine program working with student athletes from our local community 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 am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
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Sincerely,
Todd Hoyt, ATC

Submitter : **Dr. Robert Ostheim** **Date: 08/29/2007**

Organization : **Altantic Wellness Center**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

Sincerely,

Dr. Robert Ostheim

Submitter : **Mr. Ryan Grove** **Date: 08/29/2007**

Organization : **Pittsburgh Steelers Football Club**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Ryan Grove and I am a certified athletic trainer for the Pittsburgh Steelers Football Club. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
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Sincerely,
Ryan Grove, MS, ATC
Assistant Athletic Trainer
Pittsburgh Steelers
412.432.7866