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

Organization : **Associated Anesthesiologists of Toledo**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Robert L. Thomas, M.D.

Submitter : **Dr. Wendell James** **Date: 08/29/2007**

Organization : **Greenville Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

Wendell James, M.D.

Submitter : **Ms. Recia Orme** **Date: 08/29/2007**

Organization : **Ms. Recia Orme**

Category : **Health Care Professional or Association**

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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Thank you for your consideration of this serious matter.

Sincerely,
Recia Orme

CMS-1385-P-11250

Submitter : **Dr. Brian Wade** **Date: 08/29/2007**

Organization : **Eastern Urology Associates, P.A.**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a urologist in 5 person urology group in Birmingham, Alabama, and am writing in regards to the proposed changes in the self-referral provisions. These changes would have a serious impact on the way my group practices medicine and I do not feel like these changes will help any of my medicare patients. This will only generate more delays and ususally only generates more diagnostic tests from radiologists. We feel that the in-office ancillary service exception should not be limited in any way. If the diagnostic tests rules are changed it will make it almost impossible to provide straightforward radiologic services (plain xrays, CT scans, prostate ultrasounds) to these patients in a timely manner. This will lead to delays in treatment, increased expense, and we feel a disservice to our medicare patients who have come to expect quality medical care. These proposed rule changes go far beyond what is necessary to protect Medicare from fraud and abuse. These will only hurt the practices and patients who abide by the current rules. The rules should be revised to only prohibit those specific arrangements that are not beneficial to patient care.
Thank you for your consideration.

Brian K. Wade, M.D.
Eastern Urology Associates, P.A.

Submitter : **Mrs. Barbara Heffley** **Date: 08/29/2007**

Organization : **Advanced Medical Imaging**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

With the need of expediant diagnosis; for definition of pathology;not always seen or mapped by doppler;Colorflow doppler is the ultimate to define what cannot be seen!Example:I have worked in a trauma hospital/birthing unit.A patient in with possible disection;a CT scan missed the disection where colorflow doppler detected the disection!Ultrasound is a fabulous tool with little inconvience to patient and has major diagnostic abilities!Called in to do stat Pedi echo...baby has multiple congenital issues but Colorflow doppler lets Dr. and myself know of cardiac flow difficulties;measures are taken (such as meds to keep PDA open) to keep baby alive until baby can be transported to Stanford. Things are not always as they seem!Colorflow allows me as a sonographer to know exactly what flow pattern is normal or not!And if not what potentially is going on!It allows me to see unusual flow patterns and such as in the case of someone with CVA.Though anatomicaly heart appears to be normal; a flow pattern detected by colorflow doppler across the atrial septum or ventricular septum tells me different!I had a patient; who,while in the cath lab,Having his study done;had an ASD but was not detected in the cath lab! I detected with colorflow doppler while doing a echocardiogram later that day!!! Dr. was impressed as he had not seen ASD; he was looking over my shoulder during Echo!! The significance of colorflow doppler for it's diagnosis ability is GREAT!!If you were to ask a Cardiologist of the validity of Colorflow Doppler...perhaps you would'nt be asking my thought or belief!Colorflow Doppler allows us in patient care to get the information needed to expedite further testing or not; which for any insurance company or provder should be appreciated as to not "over due"! It saddens me to think that based upon the belief of the system that even one child or one CVA patient should suffer based upon the ingnorance of the system. This is what we call "Patient Care". It's what we do and will keep on doing what we love ...and that's called patient care. That's why we're here. Perhaps someday you or a family member will thank us

Submitter : Ms. R.F. Smith **Date:** 08/29/2007

Organization : Ms. R.F. Smith

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
R.F. Smith

Submitter : **Mrs. Kimberly Thomas** **Date: 08/29/2007**

Organization : **Mrs. Kimberly Thomas**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Sincerely,
Kimberly Thomas

Submitter : **Miss. Jennifer Chu** **Date: 08/29/2007**

Organization : **Keller Army Community Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007

Dear Sir or Madam:
My name is Jennifer Chu and I am a Research Analyst in the Department of Orthopaedic Research at Keller Army Community Hospital at West Point. I am a certified athletic trainer and have worked in various settings including three NCAA Division I universities and an outpatient physical therapy clinic. I received my undergraduate degree from the University of North Carolina at Chapel Hill and master s degree in Athletic Training from the University of Virginia.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for patients.
Certified athletic trainers are qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. Our education, clinical experience, and national certification exam ensure that patients receive quality health care. State law and hospital medical professionals have deemed certified athletic trainers qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of 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,
Jennifer C. Chu, MEd, ATC

Submitter : **Dr. Randall Wilhoit** **Date: 08/29/2007**

Organization : **Greenville Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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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,

Randall Wilhoit, M.D.

Submitter : **Miss. Haley Thomas** **Date: 08/29/2007**

Organization : **Miss. Haley Thomas**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Sincerely,
Haley Thomas

Submitter : **Ms. Lauretta Smith** **Date: 08/29/2007**

Organization : **Ms. Lauretta Smith**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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Thank you for your consideration of this serious matter.

Sincerely,

Lauretta Smith

Submitter : **Miss. Robyn Thomas** **Date: 08/29/2007**

Organization : **Miss. Robyn Thomas**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Sincerely,
Robyn Thomas

CMS-1385-P-11259

Submitter : Mr. Scott Helton

Date: 08/29/2007

Organization : St. Elizabeth Medical Center

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11259-Attach-1.WPD

Submitter : **Dr. Mark Carithers** **Date: 08/29/2007**

Organization : **Greenville Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Sincerely,

Mark Carithers, M.D.

Submitter : **Dr. Andrew Kaplan** **Date: 08/29/2007**

Organization : **Philadelphia Institute of Dermatology**

Category : **Physician**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am writing to protest the CMS proposed rule regarding application of multiple surgery reductions to Mohs Surgery on the following grounds.

In its review of the Mohs codes in 1991, CMS agreed that Mohs excisions are separate staged procedures; they will be paid separately with no multiple surgery reductions. This rule was placed in the Federal Register at that time (Federal Register, November 25, 1991, volume 56, #227, pg 59602). In 2004, the Mohs codes were added to the CPT Appendix E list of codes exempt from the -51 modifier and the multiple surgery reduction rule, to eliminate the occasional carrier misunderstanding when the multiple surgery reduction was applied to these codes. The July, 2004 CPT Assistant article reviewed the rationale: The rationale for this policy is that for many surgical procedures some of the work of a procedure is not repeated when two or more procedures are performed. For these procedures the intraservice work is only 50% of the total work, while the other 50% represents pre- and post-service work that overlaps when multiple procedures are performed on the same patient on the same date of service. For Mohs surgery, however, greater than 80% of the work is intraservice work that does not overlap when two or more procedures are performed. The pathology portion of Mohs surgery constitutes a large portion of this total and also is not reduced with multiple procedures. The pre-service and post-service work values are small because there is a zero-day global period. Together there is very little overlap or reduction in work when two or more tumors are treated on the same patient on the same day. Therefore, Mohs surgery codes are exempt from the use of modifier 51.

The exemption of the Mohs codes from the MSRR has been maintained by CMS since 1992 and was not questioned during the CMS mandated five-year review of the Mohs codes undertaken last fall or during presentation of the new Mohs codes to the AMA Relative Value Update Committee (RUC) in October, 2006.

If this proposed change is enacted, we will no longer be able to provide the same kind of high-quality, cost-effective services for our patients in need. We will be forced to change the way we deliver care in order to cover our costs of providing this service.

The consequence of applying the multiple surgery reduction rule to the Mohs codes would be a reimbursement reduction to a value less than the cost of providing the service. Therefore, providers will no longer be able to perform more than one Mohs procedure on any patient on a single day. Multiple tumors are commonly diagnosed on one visit, occurring in 10% of my referral practice population. Treatment of only one tumor per day will inconvenience many patients and their friends and families who accompany them for treatment. It will also inconvenience employers when workers are absent from work more frequently for multiple treatments. More importantly, delays in treatment will further increase risk for high-risk patients such as organ transplant patients with multiple squamous cell carcinomas, and for patients with syndromes such as basal cell nevus syndrome. In addition to its application to multiple cancers treated on the same day, the MSRR would apply to repairs performed on the same day as Mohs surgery. According to this new proposal, when Mohs surgery is reimbursed less than a reconstructive procedure on the same day, even the first Mohs code will be subject to the multiple surgery reduction rule. Since costs would not be covered, this may require patients to have their Mohs surgery and their reconstruction done on separate days, or to be referred to other physicians for reconstruction, usually plastic, facial plastic, or oculoplastic surgeons, who work primarily in hospitals or ambulatory care centers where costs of care are higher. The result would be that healthcare costs will be higher than they are under the current policy of payment.

Andrew L. Kaplan, M.D.

Submitter : **Ms. Wendi Corelli** **Date: 08/29/2007**

Organization : **The Center for Physical Rehabilitation**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Wendi Corelli, I am the Sports Medicine Director at an out patient physical therapy clinic, the supervisor of 8 Certified athletic trainers and the Head Athletic Trainer for Davenport University.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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

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

Sincerely,

Wendi Corelli, MS., ATC

CMS-1385-P-11263

Submitter : Ms. Michelle Mills **Date:** 08/29/2007

Organization : Pullano Billing Associates

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. Finally, CMS has recognized the underevaluation of anesthesia services, and that the agency is taking steps to address this issue. For 2007, at 15.50 per unit, this amount does not cover the cost of caring for these patients. Every year our costs(ie malpractice insurance, health insurance, and overhead costs)keep rising but yet our medicare reimbursement keeps going down. To ensure that our patients have access to anesthesia care, it is imperative that CMS follow through with the proposal to increase the anesthesia conversion factor. Thank you for your consideration of this serious matter.

Submitter : **Ms. Maxine Walkup** **Date: 08/29/2007**

Organization : **Ms. Maxine Walkup**

Category : **Health Care Professional or Association**

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

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Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Sincerely,
Maxine Walkup

Submitter : **Mr. Eric Thomas** **Date: 08/29/2007**

Organization : **Mr. Eric Thomas**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Sincerely,
Eric Thomas

Submitter : **Dr. MArk Carlo** **Date: 08/29/2007**

Organization : **Dr. MArk Carlo**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

RE Technical Corrections
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Submitter : **Dr. Stephen Lane** **Date: 08/29/2007**

Organization : **Greenville Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Sincerely,

Stephen Lane, M.D.

Submitter : **Miss. Mia Thomas** **Date: 08/29/2007**

Organization : **Miss. Mia Thomas**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,
Mia Thomas

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

Organization : **M**

Category : **Physical Therapist**

Issue Areas/Comments

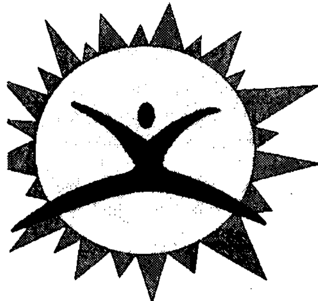
Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attachment

CMS-1385-P-11270-Attach-1.TXT

#11270



M & M Physical Therapy, LLC

1333 E College Ave ♦Suite B ♦ South Milwaukee ♦ WI ♦
E-Mail: mmpt@wi.rr.com
Phone: (414) 571-9146 ♦ Fax: (414) 571-9147

Anne Plewa
Office Manager

Larry Pleva, MPT, CSCS
Physical Therapist
Certified Strength & Conditioning Specialist

Melissa Martin, PT, OCS
Physical Therapist
Orthopedic Clinical Specialist
Owner

August 29, 2007

<u>Physician Self-Referral issues</u>

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

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

Dear Mr. Kerry Weems:

I have been a physical therapist for eleven years and in private practice for the last six years in South Milwaukee, WI. I provide outpatient services to those that have orthopedic conditions such as hip or knee replacements; cervical or low back pain, injuries from motor vehicle accidents or sports injuries and any other sprains or strains. I am not associated with any one physician in the area and rely on my own advertising and contacts for referrals into my office. I have noted a trend in the last two to three years with a decrease in my referrals from the local orthopedic doctors. More patients are receiving care at the physician's office in which the physician has a direct financial interest. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. By eliminating physical therapy as a designated health services (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutilization of physical therapy services under the Medicare program, and enhance the quality of patient care. The "in-office ancillary services" exception has created a loophole that has resulted in the expansion of physician-owned arrangements that provide physical therapy services. Because of Medicare referral requirement, physicians have a captive referral base of physical therapy patients in their offices.

I personally have had several patients that I have seen after they had previously had an episode of physical therapy services at a physician

owned practice. The outcome of their episode of care had been less then favorable and this then has lead them to seek out my services. They locate my office through word of mouth or local advertisements and are treated for the same condition with the outcome being much more favorable due to the higher quality of care. I have also had patients that I treated for one condition a year or two prior that have a new condition, which requires physical therapy. These patients are then encouraged by their physician to seek physical therapy at the physician's office. I have had some patients try it based on their physician recommendation and they have been unhappy with the services and end up coming to my office in the end. This is not cost effective to the Medicare program.

My last point would be that physician direct supervision is not needed to administer physical therapy services. In fact, an increasing number of physician-owned physical therapy clinic are using the reassignment of benefits laws to collect payment in order to circumvent "incident-to" requirements. Therefore, I am strongly urging CMS to remove physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws.

Thank you for you time and consideration of my comments.

Sincerely,

Melissa Martin, PT, OCS

Submitter : **Dr. Harry Sherman** **Date: 08/29/2007**

Organization : **Greenville Anesthesiolgoy**

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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Thank you for your consideration of this serious matter.

Sincerely,

Harry Sherman, M.D.

Submitter : **Mrs. Josephine Santolin** **Date: 08/29/2007**

Organization : **Mrs. Josephine Santolin**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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,

Josephine Santolin

Submitter : **Mr. Sam Bergener** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
____Sam Bergener, CRNA____
Name & Credential
_____2165 Irene Lane_____
Address
_____Idaho Falls, ID 83404____
City, State ZIP

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

Organization : **Mr. Robert Smith**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Sincerely,

Robert Smith

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

Organization : DeKalb Anesthesia Associates, PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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CMS-1385-P-11278

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

Organization : **cody hogeston**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Submitter : **Mrs. Mary Smith** **Date: 08/29/2007**

Organization : **Mrs. Mary Smith**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Thank you for your consideration of this serious matter.

Sincerely,
Mary Smith

Submitter : **Ms. Terry Gibson** **Date: 08/29/2007**

Organization : **Ms. Terry Gibson**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Sincerely,

Terry Gibson

Submitter : **Ms. Brandi Gibson** **Date: 08/29/2007**

Organization : **Ms. Brandi Gibson**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Sincerely,

Brandi Gibson

Submitter : **Ms. Kristi Gibson** **Date: 08/29/2007**

Organization : **Ms. Kristi Gibson**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Sincerely,

Kristi Gibson

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

Organization : **Univ of Wisconsin Sch of Med and Public Health**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Department of Anesthesiology
University of Wisconsin School of Medicine and Public Health
Madison, WI 53792-3272
29 August 2007

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Richard L. Wolman, MD
Professor

Submitter : **Mr. Mitchell Kern** **Date: 08/29/2007**

Organization : **Mr. Mitchell Kern**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
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Thank you for your consideration of this serious matter.

Sincerely,

Mitchell Kern

Submitter : Mrs. Jane Schultz **Date:** 08/29/2007

Organization : Mrs. Jane Schultz

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Acting Administrator
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Thank you for your consideration of this serious matter

Sincerely,

Jane Schultz.

Submitter : **Miss. Molly Cannell** **Date: 08/29/2007**

Organization : **University of Southern Mississippi**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I work as an assistant athletic trainer and co-clinical coordinator at the University of Southern Mississippi in Hattiesburg, Ms. I teach in the Athletic Training Education Program, while I complete duties and co-clinical coordinator and act as the athletic trainer for the baseball team.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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

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

Sincerely,

Molly Cannell, MS, ATC
University of Southern Mississippi
Assistant Athletic Trainer
Co-Clinical Coordinator
118 College Drive #5017
Hattiesburg, MS 39406
Phone: 601-266-5906
Fax: 601-266-6821
Molly.Cannell@usm.edu

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

Organization : **St. Elizabeth Health Center**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I am a urologist in a five-physician urological practice in Youngstown, Ohio. Youngstown is a recovering city from a great loss of industrial-based employers. We have a high percentage of low-income patients and many people with no insurance. Because of the mission of the Humility of Mary Health Partners, many people receive care with no, or only minimal, out-of-pocket payments. The physicians who provide this patient care come from our community and, because of their professional commitment, receive no financial compensation.

We have worked hard to provide contemporary urologic treatment with limited resources. Physician-owned lithotripsy partnerships have been a lifesaver to the hospital's patients and providers. This high-tech treatment has returned patients to their lives with decreased hospital and employer costs. The Medicare Physician Fee Schedule Proposal Rules, unveiled on 7/2/07, threatens to increase hospital costs, decrease availability of local care, and decrease the pool of physicians who can manage these problems.

The proposed "services furnished under arrangement" changes would mean only that hospitals bill for services. Lithotripsy has been outside of the designated health service (DHS) definition. This has worked well; exception status has not been necessary.

There are other aspects of the proposed rules that would increase hospital cost and decrease access to care. The "unit of service per-click payment" is one. If hospitals have to rent technology for block time slots, this increases their costs and increases profits to rental agencies, which is outrageous. The system works and is cost efficient as it stands.

Another matter that must be addressed is the change proposed for "in-office ancillary services exceptions." Changing practice patterns require physicians to make more prompt diagnoses in their offices in order to more quickly and accurately direct patients to contemporary treatment. The incorporation of imaging, lab services, and even radiologic treatment provides "one-stop shopping" particularly for elderly patients and the public in general. Broad-based application of technologies increases competition, decreases cost, and improves quality control opportunities. Although physicians are accused of doing this for a profit, the more overriding contribution is improved community care, which is what we all want.

Finally the "stand in the shoes" proposed restriction collapses outpatient and inpatient services into one. Hospitals have a chance, then, to spread high inpatient costs to the outpatient area. Ambulatory centers have worked to be low-cost, efficient, patient-friendly areas. The combined entities would not be able to contract with vendors who provide technology needed only under special circumstances, such as BPH lasers and mobile lithotripsy.

In the attempt to prevent profit abuse, be sure not to threaten good, effective, patient-friendly care.

Submitter : **Ms. John Patterson** **Date: 08/29/2007**

Organization : **Ms. John Patterson**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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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,

John Patterson

Submitter : **Dr. Mary Ann Gurkowski** **Date: 08/29/2007**

Organization : **Dr. Mary Ann Gurkowski**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk, I am pleased that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue. I strongly support the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. Since 1992 medicare payments to anesthesiologists have been significantly reduced. The Ruc recommends that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation. This move would result in an increase of nearly four dollars per anesthesia unit and would help correct the long -standing undervaluation of anesthesia services. I fully support the RUC's recommendation. I am also concerned about our elderly population and their access to care. This access is being threatened because of the low medicare payments and this increase of four dollars per anesthesia unit would help to improve access to care. Thank you for your attention to this very important issue.
Mary Ann Gurkowski M.D.

Submitter : **Mrs. Mary Patterson** **Date: 08/29/2007**

Organization : **Mrs. Mary Patterson**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Sincerely,
Mary Patterson

Submitter : **Mr. Dan Rasor** **Date: 08/29/2007**

Organization : **Oakwood City Schools**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a BOC Certified Athletic Trainer and Ohio licensed AT.
I have worked in the secondary school seeting for 41 years,

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

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

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

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

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

Sincerely,

Dan Rasor, ATC

Submitter : **Mr. Matthew Hoch** **Date: 08/29/2007**

Organization : **Ohio University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a graduate assistant licensed athletic trainer at Ohio University. I am responsible for providing athletic training services to the student athletes at my institution. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Matthew C. Hoch, LAT, ATC

Submitter : **Mrs. Angela Mackinnon** **Date: 08/29/2007**

Organization : **Mrs. Angela Mackinnon**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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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,

Angela Mackinnon

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

Organization :

Category : **Health Plan or Association**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Submitter : Janet Taylor

Issue Areas/Comments
Date: 07/12/2007
Re: General - Provisions of the Proposed Regulation
Related to the Physician Fee Schedule

Leslie V. Nonvalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS- 1385-P
P.O. Box 801 8
Baltimore, MD 2 1244-80 18
Re: CMS-1385-P

Objections to Proposed Revisions to Payment Policies Under Physician Fee Schedule, and Other Part B Payment Policies for CY 2008

I represent an organization of 165 multi-specialty healthcare providers. We have polled our members to obtain their opinions on the impact of the proposed CMS revisions.

Medicare payments to physicians in 2008 would drop nearly 10% under the July 2, 2007 proposed rule, which projects CMS will pay $58.9 billion to 900,000 physicians and other healthcare professionals next year. Physician groups have pleaded with Congress to replace the sustainable growth rate formula (SGR), which is tied to the health of the economy and is used to calculate physician payments under the Medicare program. It has been estimated that payments will drop by more than 40% by 2015 if the SGR is not replaced. Congress in the past has adopted interim measures to stop previous payment reductions. Efforts are being made on Capitol Hill to revamp the SGR. In a meeting in late June, staff for the House Ways and Means and the Energy and Commerce committees shared with physician organizations a draft proposal to halt the 10% cut from taking effect next year. The proposal would replace the cut with at least a 0.5% increase in 2008 and 2009, and would repeal and replace the SGR payment system.

Given the rationale that CMS recognizes increased practice expenses, and at the same time proposes annual reductions in physician reimbursements; we object to the stated proposal.

To demonstrate, please refer to the following specifically identified critical factors:
1. Reduced Reimbursement for Physician services - physicians cannot operate an efficient practice with increased practice expenses of 8%+ a year with income decreasing 5%+ a year; if the practice does not thrive, it cannot expand services to keep up with market demand; selected specialties will receive additional reductions (there is proposal in House that PCP reimbursement be tied to GDP)

2. Increased demand for healthcare - number of uninsured is a record high 47 million in 2006; aging population of 35 million are 65+ and 76 million baby boomers are 60;

3. Physician supply - reduced primary care enrollment in medical school (20% of all enrollment is in primary care); Using Massachusetts universal health model, 95% of 270 General Practitioners dropped Medicare; changing dynamics of physicians (aging, work ethic, specialty selection); physicians no longer accepting Medicare patients in practice =

4. Patient Access & Quality Care - physicians will be forced to no longer accept or limit Medicare; Physician Organization Survey Results
1. Will you stop accepting Medicare altogether? No 30%
2. Will you stop accepting new Medicare patients? Yes 50%
3. Will you limit the number of Medicate patients? Yes 80%
4. Will your practice continue to function as it does now? No 95%

5. Geographic Practice Cost Indices (S. 1848(e)9l)(A) - flawed methodology does not adequately reflect actual costs by region to include compulsory regulatory compliance, actual malpractice costs, technology (healthcare industries spend 2% of operating budget on technology development; other industries spend 6%)

Remedy
The Medicare system cannot continue to function if proposed reductions occur. CMS must stop continued erosion of primary care base by appropriately reimbursing for time/services; work in conjunction with Congress and physician organizations such as American Medical Association and State Medical

Societies.

Respectfully submitted.

Submitter : **Mr. Clint Mackinnon** **Date: 08/29/2007**

Organization : **Mr. Clint Mackinnon**

Category : **Health Care Professional or Association**

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
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Thank you for your consideration of this serious matter.

Sincerely,

Clint Mackinnon

Submitter : **Dr. Debbie Bradney** **Date: 08/29/2007**

Organization : **Lynchburg College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Debbie Bradney. I am the Program Coordinator for Athletic Training and Exercise Physiology at Lynchburg College. This legislation will effect not only my clinical practice, but also it will impact my students' future clinical practice.

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,

Debbie Bradney DPE, ATC

CMS-1385-P-11300

Submitter : **Dr. Emilio Bisaccia** **Date: 08/29/2007**

Organization : **Photopheresis of New Jersey**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

See attached Word document which contains my comment letter.

CMS-1385-P-11300-Attach-1.DOC

#11300

August 27, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS--1385--P
Mail Stop C4--26--05
7500 Security Boulevard
Baltimore, MD 21244-1850

Subj: RESOURCE-BASED PE RVUs FOR PHOTOPHERESIS (CPT 36522)

Dear Centers for Medicare and Medicaid Services:

In the interest of improving safety and accessibility for our Medicare patients and reducing overall costs to the Medicare program, I ask that you revisit the cost of photopheresis therapy, and take whatever steps are needed to increase practice expense RVUs to a level where your payment approaches my costs for this procedure. As the proposed 37.04 RVUs in the July 12 Federal Register notice falls at least 20% short of our overall costs, I will be forced to give up on my goal of providing photopheresis therapy in our office setting.

I have provided photopheresis therapy (CPT 36522) for the palliative treatment of skin manifestations of cutaneous T-cell lymphoma (CTCL) since 1988, when this procedure was approved by the FDA for this use. In 1990, I was among the first physicians to move the procedure to the hospital outpatient setting; previously, all patients requiring this treatment were hospitalized for their treatments. Nearly two decades of experience have proven that photopheresis is a very safe procedure. Medicare covers photopheresis in the physician office setting under the supervision of a physician.

In January 2003, I provided photopheresis therapy for the first patient - a Medicare patient - in our new office-based photopheresis suite. I established this service in my clinic despite my knowledge that I would at least temporarily incur financial losses due to inadequate valuation of the procedure at that time. Despite continuing losses, I have continued to do so on a limited basis because there are a number of important advantages - for non-hospitalized patients and for myself - in providing photopheresis in the office setting instead of the hospital.

First, photopheresis patients are physically debilitated by their underlying disease. Most require treatment on a recurring basis to control their disease manifestations. The office setting is far more convenient and easily accessible than large urban hospitals, where, for historical reasons, most photopheresis programs were started and still exist today. It is much safer to receive treatment in the non-hospital setting from the standpoint of serious infection risk: these patients are usually maintained on powerful immunosuppressive drugs which make them susceptible to methicillin-resistant staphylococcus and other serious pathogens that are commonplace in the hospital setting.

Second, since most of my overall patient caseload is seen in our office-based dermatology practice, providing photopheresis in this setting also reduces my travel and time costs. As more procedures have moved out of the hospital in recent years, it has become logistically more difficult to remain at the hospital to oversee the treatment phase of photopheresis procedures, each of which requires several hours to complete.

Finally, appropriate payment for this procedure in the office-based setting should be appreciably less costly than paying for it to be provided in a hospital outpatient department. I don't have direct access to the Medicare reimbursement rate for photopheresis at Morristown Memorial Hospital here in New Jersey, but my office manager has learned that it is about $2,400 per procedure, and is expected to increase next year.

I had hoped that by now photopheresis would be appropriately valued and I could expand its availability to more patients now being treated at the hospital. Below is detailed information about my practice expenses in the hope that CMS can upwardly adjust its "fully transitioned" practice expense RVUs for photopheresis, and I can finally realize my goal of providing this critical service for my patients. Should the valuation not increase appreciably - roughly 20% - to more closely approximate our costs, I will be forced to discontinue offering this service, even on the current very limited basis.

With a valuation that covers costs, I am certain that patient access to photopheresis in the non-hospital setting will improve, as more physicians no longer are deterred by the serious financial disincentive that currently prevails.

Photopheresis: Direct Costs and Operating Overhead for Photopheresis of New Jersey

Cost Description	Amount
Photopheresis procedural kit[1]	$1,013.00
Other supplies and UV light source[2]	$26.00
UVADEX methoxsalen (10 ml vial)	$60.00
RN Specialist (3.5 hours @ $45/hr) +RN benefits/payroll taxes (30%)	$205.00
UVAR XTS Equipment Amortization[3]	$65.00
TOTAL DIRECT COSTS:	**$1,369.00**

[1] UVAR XTS system. Manufacturer: Therakos Inc.

[2] Heparin 10,000 u/ml (1 ml vial); lidocaine 1% or 2% (no epinephrine); oxygen canister/nasal cannula or mask; NaCl (500 ml bags x 2); plastic hemostats (3-6/treatment); underpad (17 x 23 Chux); Terumo AVF fistula needles (17 gauge); 10 cc syringes; 3 cc syringes; 20 gauge needles, 1 inch; 4 x 4 pads; 2 x 2 pads; Sof-Kling 2 inch x 3.5 yd; alcohol wipes; 1 inch tape; specimen bags; non-sterile gloves; UV light source ($1,650/175 procedures).

[3] $65,000 per device; 200 procedures/device/year x 5 year service life

Indirect procedural overhead costs[4]	$480.00

TOTAL DIRECT AND INDIRECT COSTS: **$1,849.00**

I hope it is evident from this breakdown of costs that photopheresis is very resource-intensive. Our cost for the disposable procedure kit now exceeds $1,000 per kit; if we don't purchase a large specified quantity of these kits, the manufacturer's price increases to $1,100 per kit. A specially trained nurse specialist is dedicated to the procedure from start to finish; this is a half-day procedure including the set-up and post-treatment activities. I must pay these nurses $45 per hour, plus benefits, to retain them.

If helpful, I would be happy to provide invoices and any other documentation of supply- and equipment-related costs that you might need. I also invite you to visit my practice and observe a photopheresis procedure first-hand.

At present, Medicare's payment is covering little more than my direct costs of nearly $1,375 for this procedure.

I appreciate your attention to this matter. I hope that you will take corrective measures to make photopheresis financially viable for physician providers, and more broadly accessible to our patients in the office-based setting.

Please do not hesitate to contact me or my office administrator, Robert Lombardi, at (973) 292-1358, if we can offer any additional assistance.

Sincerely,

Emilio Bisaccia, M.D., F.A.C.P.
Medical Director, Photopheresis of New Jersey
Professor of Clinical Dermatology, Columbia University College of Physicians & Surgeons

EB/rl

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[4] Administrative and clerical wages, benefits and payroll taxes; allocated clinic floor space cost; UVAR XTS equipment service contract; inventory financing costs; office supplies; utilities; telephone; postage; computer supplies/maintenance; training/educational expenses; and misc. expenses.

Submitter : **Ms. Marilyn Colby** **Date: 08/29/2007**

Organization : **Ms. Marilyn Colby**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Marilyn Colby

Submitter : **Mr. Roger Tate** **Date: 08/29/2007**

Organization : **Mr. Roger Tate**

Category : **Individual**

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

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Thank you for your consideration of this serious matter.

Sincerely,

Roger Tate

Submitter : **Mr. Michael Sypniak** **Date: 08/29/2007**

Organization : **Ohio State University**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Michael Sypniak and I am a Certified Athletic Trainer for Ohio State University. I have been a Certified Athletic Trainer for the past four years and I am starting my first year as a staff Athletic Trainer for Ohio State University.

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

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

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

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

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

Sincerely,

Michael Sypniak, MS, ATC

Submitter : **Dr. Susan Zachmann** **Date: 08/29/2007**

Organization : **Henry Ford Health System**

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.

CMS-1385-P-11305

Submitter : **Mr. O. G. Tate** **Date: 08/29/2007**

Organization : **Mr. O. G. Tate**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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Thank you for your consideration of this serious matter

Sincerely,

O. G. Tate

Submitter : **Dr. Brandan Anderson, DC** **Date: 08/29/2007**

Organization : **Anderson Family Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Brandan Anderson, DC
4132 30th Ave. S.
Suite 102
Fargo, ND 58104

CMS-1385-P-11307

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

Organization : **Charles Frederick**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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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 : **Ms. Heidi Matthews** **Date: 08/29/2007**
Organization : **North Central College**
Category : **Other Health Care Professional**
Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer working in the collegiate setting. I am the Director of the Athletic Training Education Program and an Associate Professor of Health and Physical Education. I have a BS degree from the University of Wisconsin Madison and MS degree from the University of Arizona, both in HPE and Athletic Training. I have been practicing for 25 years. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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

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

Sincerely,

Heidi M. Matthews, MS, ATC
Director, Athletic Training Education Program
North Central College
Naperville, IL

Submitter : **Ms. Virginia Tate** **Date: 08/29/2007**

Organization : **Ms. Virginia Tate**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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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,

Virginia Tate

Submitter : Dr. Ayan Patel

Date: 08/29/2007

Organization : Tufts-New England Medical Center

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Re: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY 2008. CODING --ADDITIONAL CODES FROM 5-YEAR REVIEW.

72 Federal Register 38122 (July 12, 2007)

Dear Mr. Kuhn:

I am a physician who provides echocardiography services in Massachusetts. I am writing to voice my opinion that the CMS proposal to bundle Medicare payment for color Doppler imaging (CPT Code 93325) into echocardiography base services is unfair and disregards the additional time and expertise required to provide color Doppler imaging. The proposed change would discontinue separate payment for color Doppler imaging, based on the presumption that color Doppler is intrinsic to the performance of echocardiography procedures.

While color Doppler imaging is often performed in conjunction with two-dimensional echocardiography, it provides separate and additional information above and beyond two-dimensional echocardiography. Color Doppler imaging plays a crucial role in the detection and the evaluation of the severity of congenital heart disease, cardiac valve disease, and several other forms of heart disease. It provides information that cannot be obtained by two-dimensional echocardiography alone. The acquisition of color Doppler images requires additional time and skills on the part of the sonographer performing the examination, as well as additional equipment resources. Furthermore, the interpretation of color Doppler imaging is complex, and requires additional physician and sonographer time and work compared to two-dimensional echocardiography alone. The additional sonographer, physician, and equipment time and resources necessary for the performance of color Doppler imaging are not included in the RVUs for other echocardiography base procedures.

The assumption that color Doppler imaging is intrinsic to all echocardiography procedures is incorrect. There are clearly situations, such as stress echocardiography (CPT code 93350), or limited two-dimensional echocardiography (CPT Code 93308), where color Doppler is often not employed. There are also circumstances in which color Doppler is not used in conjunction with a complete two-dimensional echocardiogram (CPT Code 93307) or transesophageal echocardiogram (CPT Code 93312).

The CMS proposal would eliminate payment for a procedure that requires distinct time, resources, and skills, and that is critically important for the accurate diagnosis of a number of cardiac conditions. The potential negative impact of such changes on the ability of echocardiography laboratories to continue to provide high quality imaging is of great concern, and I am therefore writing to urge CMS to decide against finalization of the proposed bundling of color Doppler imaging into other echocardiography procedures.

Thank you for your consideration of this important matter.

CMS-1385-P-11311

Submitter : **Mr. James Tate** **Date: 08/29/2007**

Organization : **Mr. James Tate**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

James Tate

CMS-1385-P-11312

Submitter : Mr. Dan Rasor, ATC **Date:** 08/29/2007

Organization : Oakwood City Schools

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a BOC Certified Athletic Trainer and licensed by the state of Ohio.
I am presently employed by Oakwood City Schools and have worked in secondary schools for 44 years.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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

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

Sincerely,

Dan Rasor, ATC

CMS-1385-P-11313

Submitter : Miss. Jan Lauer **Date:** 08/29/2007

Organization : TRI-REHAB, INC.

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

Scc attachmcnt

Submitter : **Ms. April Campbell** **Date: 08/29/2007**

Organization : **NovaCare Rehabilitation**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is April Campbell and I am a Certified Athletic Trainer in a secondary school setting. And I am concerned about some recent proposals.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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Sincerely,

April Campbell, ATC

Submitter : **Mrs. Lacey Langerak** **Date: 08/29/2007**

Organization : **Alexandria Orthopaedic Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Lacey Langerak. I am a Certified Athletic Trainer, Orthopaedic Technologist, and Physician Extender at Alexandria Orthopaedic Associates. I also do outreach athletic training services to a local high school. Alexandria Orthopaedic Associates employees ten Athletic Trainers in west central Minnesota. As an AT with multiple job duties I am able to utilize my education, training, and skills in several playing fields including athletic event coverage, cast and brace fitting, post op checks, therapy services, and assisting in the operating room.

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,

Lacey Langerak, MS, ATC, OTC

Submitter : **Miss. Kelly Livingston** **Date: 08/29/2007**

Organization : **Miss. Kelly Livingston**

Category : **Physician Assistant**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Kelly Livingston

Submitter : **Mr. Colin Gillerman** **Date: 08/29/2007**

Organization : **Mr. Colin Gillerman**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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. Colin Gillerman

Submitter : **Dr. peter glass** **Date: 08/29/2007**

Organization : **SUNY Stony Brook**

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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CMS-1385-P-11319

Submitter : **Mr. Ian Gillerman** **Date: 08/29/2007**

Organization : **Mr. Ian Gillerman**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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

Submitter : **Dr. Catherine Scholl** **Date: 08/29/2007**

Organization : **American Society of Anesthesiologist**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Nadia Jensen** **Date: 08/29/2007**

Organization : **Ms. Nadia Jensen**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing as a physical therapist employed at a physical therapist-owned practice to argue against physician owned PT facilities. The doctors who run the only orthopedic clinic in the area also own their own on-site physical therapy facility. They refer their patients to their own clinic and I have spoken to numerous patients who don't realize that they have a choice as to where they receive care. In a profession that relies heavily on physician referrals this is an unfair business practice and does not provide the patient with the highest quality or convenient care.It's too possible that the physicians are referring patients solely for profit. This practice is exactly what the Stark laws are supposed to prevent.

Submitter : **Mr. Gary Tate** **Date: 08/29/2007**

Organization : **Mr. Gary Tate**

Category : **Health Care Professional or Association**

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
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Thank you for your consideration of this serious matter.

Very truly yours,

Gary Tate

Submitter : **Mr. David Morrison** **Date: 08/29/2007**

Organization : **Artesia Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I am a physical therapist and a partner of a small private practice clinic. We serve a rural community with a fairly high Medicare population. Data has shown that the therapy caps impact Medicare beneficiaries who need rehabilitation services the most. Congress has recognized the potential harm in this policy and has passed moratoriums on its enforcement three times. Twice, Congress passed legislation allowing for exceptions for beneficiaries needing care above the financial limit to apply for additional medically necessary care but this expires January 1, 2008. I urge you to take action to provide a long term policy solution and encourage legislation to remove the therapy cap and prevent harm to Medicare beneficiaries needing rehabilitation services.

The profession's ability to treat Medicare patients will also be severely limited if these cuts in payments under the 2008 Medicare physician fee schedule to go into effect as scheduled on January 1. The past two years Congress has blocked payment cuts determined by the flawed "sustainable growth rate" formula. While Congress froze 2006 and 2007 payments to prevent the cuts, the cost of providing patient care has increased. Now providers are again faced with the possibility of another 10% cut in 2008. The combined impact of these policies has hamstrung the ability of the profession to provide patient care to Medicare beneficiaries without going out of business.

I understand the need for change to the system, but allowing the exception process to the cap expire (further limiting patient access to needed care) and making serious cuts to provider reimbursement does not seem like a reasonable solution.
Thank you for your consideration.

David Morrison, PT, OCS