CMS-1385-P-11325

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

Organization : **Alexandria Orthopaedic Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an athletic trainer at Alexandria Orthopaedic Associates in Alexandria, MN. I provide athletic training services for Sauk Center and Osakis High Schools in MN. I recieved my Bachelor's degrees in Athletic Training and Exercise Science from Minnesota State University - Moorhead, and my Master's degree in Health, Nutrition & Execercise Science from North Dakota 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,

Jennifer Miller, MS ATC

CMS-1385-P-11327

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

Organization : **Ms. Dina Tate**

Category : **Other Health Care Professional**

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,

Dina Tate

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

Organization : **University Hospitals Case Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Deborah Brown** **Date: 08/29/2007**

Organization : **Dr. Deborah Brown**

Category : **Physician**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

MEI
August 29, 2007

Re: Technical Corrections
Attention: CMS-1385-P
Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
PO Box 8018
Baltimore, MD 21244-8018

I strongly urge you to table this proposal. 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 pathology, or to also determine a diagnosis and treatment options. X-ray 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. Seniors are a special group of people and well deserving of the best and most economical care that will result them in a quick and stronger functional capacity. If the treatment is delayed, illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as a result of this proposal.

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

In health,

Dr. Deborah Brown, D.C.

CMS-1385-P-11330-Attach-1.DOC

#11330

August 29, 2007

Re: Technical Corrections
Attention: CMS-1385-P
Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
PO Box 8018
Baltimore, MD 21244-8018

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

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

In health,

Dr. Deborah Brown, D.C.

Submitter : **Ms. Felicia Hoopingarner** **Date: 08/29/2007**

Organization : **Ms. Felicia Hoopingarner**

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,

Felicia Hoopingarner

CMS-1385-P-11332

Submitter : Mrs. Patricia Beggs **Date:** 08/29/2007

Organization : Northern Michigan Sports Medicine Center

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer that works solely in an outpatient facility. I have been providing patient care at Northern Michigan Sports Medicine Center for about 2 years now, with the emphasis on sports medicine and sports enhancement classes. I recieved my Bachelor's Degree in Sports Medicine/Athletic Training in May of 2005.

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,

Patricia Beggs, ATC

CMS-1385-P-11333

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

Organization :

Category : **Other Technician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

CMS please remove physical therapy from the "in-office ancillary services" exception to the federal physician self-referral laws.

Submitter : **Ms. Kimberly Kuman** **Date: 08/29/2007**

Organization : **National Spasmodic Dysphonia Association**

Category : **Other Association**

Issue Areas/Comments

Drug Compendia

Drug Compendia

On behalf of the National Spasmodic Dysphonia Association, we are pleased to submit these comments on the Proposed Physician Fee Schedule update for 2008 in general, and particularly on the agency's proposals concerning DRUG COMPENDIA.

The mission of the National Spasmodic Dysphonia Association is to advance medical research into the causes of and treatments for spasmodic dysphonia, promote physician and public awareness of the disorder, and provide support to those affected by spasmodic dysphonia. Spasmodic dysphonia (SD), a focal form of dystonia, is a neurological voice disorder that involves involuntary 'spasms' of the vocal cords causing interruptions of speech and affecting the voice quality. SD can cause the voice to break up or to have a tight, strained, or strangled quality. It is estimated that over 50,000 people in the United States suffers from Spasmodic Dysphonia, but researchers believe many more people are misdiagnosed or undiagnosed.

The patients we represent rely on heavily drugs to control the symptoms associated with spasmodic dysphonia. They likewise rely on rapid availability of new drugs and new uses of existing drugs to improve their treatment and quality of life.

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

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

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

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

Thank you for your consideration of our comments.

Sincerely yours,
Kimberly Kuman
Executive Director

1 Although we recognize that Medicare law refers to the compendia specifically for coverage of Part B cancer chemotherapy drugs, Medicare contractors generally refer to these compendia when making off-label determinations for all Part B drugs, including drugs and biologicals used in the treatment of patients with dystonia.

CMS-1385-P-11334-Attach-1.PDF

#11334.

NATIONAL SPASMODIC DYSPHONIA ASSOCIATION

300 PARK BOULEVARD • SUITE 415 • ITASCA, IL 60143 • 800-795-NSDA (6732)
FAX: 630-250-4505 • E-MAIL: NSDA@DYSPHONIA.ORG • WEBSITE: WWW.DYSPHONIA.ORG

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Milwaukee, WI
Michael Rolnick, Ph.D.
Wm. Beaumont Hospital
Royal Oak, MI
James Thomas, M.D.
Private Practice
Portland, OR

August 29, 2007

Via Electronic Submission to: http://www.cms.hhs.gov/eRulemaking

Kerry Weems
Administrator, Centers for Medicare and Medicaid Services-Designate
U.S. Department of Health and Human Services
Attn: CMS-1385-P
7500 Security Boulevard
Baltimore, MD 21244

Re: Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; CMS-1385-P

Dear Mr. Weems:

On behalf of *the National Spasmodic Dysphonia Association*, we are pleased to submit these comments on the Proposed Physician Fee Schedule update for 2008 in general, and particularly on the agency's proposals concerning **DRUG COMPENDIA**.

The mission of the National Spasmodic Dysphonia Association is to advance medical research into the causes of and treatments for spasmodic dysphonia, promote physician and public awareness of the disorder, and provide support to those affected by spasmodic dysphonia. Spasmodic dysphonia (SD), a focal form of dystonia, is a neurological voice disorder that involves involuntary "spasms" of the vocal cords causing interruptions of speech and affecting the voice quality. SD can cause the voice to break up or to have a tight, strained, or strangled quality. It is estimated that over 50,000 people in the United States suffers from Spasmodic Dysphonia, but researchers believe many more people are misdiagnosed or undiagnosed.

The patients we represent rely on heavily drugs to control the symptoms associated with spasmodic dysphonia. They likewise rely on rapid availability of new drugs and new uses of existing drugs to improve their treatment and quality of life.

Our organization is deeply concerned by the prospect of having only one compendium available, even if just for a limited period of time, on which Medicare contractors may rely to make off-label use coverage determinations.[1] We applaud CMS for sharing this concern and for responding by devising a mechanism for evaluating new compendia to serve this purpose.

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

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

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

Thank you for your consideration of our comments.

Kimberly Kuman

Kimberly Kuman
Executive Director

Submitter : **Mr. Dennis Hoopingarner** **Date: 08/29/2007**

Organization : **Mr. Dennis Hoopingarner**

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
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,

Dennis Hoopingarner

Submitter : **Mr. dennis dodd** **Date: 08/29/2007**

Organization : **American Association of Nurse Anesthetist**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

The Office of the Administrator:

Dear Administrator:

As a member of the American Association of Nurse Anesthetist,
I am writing to support CMS's proposal to boost the value of aneathesia
work by 32%. If adopted, CMS's proposal would help to insure that Certified Registered Nurse Anesthetist as Medicare Part "B" Providers
can continue to provide medicare beneficiares with access to anesthesia services.
I support the agencies acknowldgement that Anesthesia payments have been undervalued, and its proposal to increase the valuation
of Anesthesia work in a manner that boosts Anesthesia payment.

Dennis R. Dodd CRNA
Certified Registered Nurse Anesthetist
PO Box 2007
Angel Fire
New Mexico, NM 87710

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

Organization : **Michael Sime**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11337-Attach-1.DOC

#E 11337

Dear Sir or Madam:

I am a Certified Athletic Trainer who is licensed to practice Athletic Training in the State of Nevada. I completed my Bachelor of Science degree in 2000 and will be conferred my Master of Science degree at the conclusion of this semester. I have been a practicing Athletic Trainer in high school, college, and professional sport settings.

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

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

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

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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 Sime, ATC

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

Organization : Mr. Ryan Hoopingarner

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
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Thank you for your consideration of this serious matter.

Sincerely,
Ryan Hoopingarner

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

Organization : **LSU Health Sciences Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Rc: CMS-1385-P
Anesthcsia Coding (Part of 5-Year Review)

Ms. Norwalk:

I am in favor of increasing anesthesia payments under the 2008 Physician Fee Schedulc. Anesthesia services are undervalued by CMS at present. If our country is to attract bright, motivated physicians to the life-&-dcath field of anesthesiology, adequatc incentives will be important.

I can tell you from first hand experience that anesthesiologists are working much harder than in the past to try to compensate for dwindling reimbursement. This cannot go on indcfinitcly.

Thcrefore, I recommend that CMS increasc the anesthesia conversion factor as recommended by the RUC.

Thank you.

Jamcs Riopclle MD

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

Organization : **Mr. Eric Hoopingarner**

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,

Eric Hoopingarner

Submitter : **Dr. Scott Dietrich** **Date: 08/29/2007**

Organization : **East Stroudsburg University**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To whom it may concern,

I am an athletic training professor at East Stroudsburg University of Pennsylvania and I am proud to carry on the tradition of excellence, by teaching in an athletic training program with over 30 years of history. In those many years we've developed the knowledge and skill of thousands of students within the content areas under the domains of athletic training and sports medicine. Some of our students go on to become doctors and therapists but most choose to provide coverage to those who need it most: the physically active youth.

I am compelled to write you today to voice my serious concern, and STRONG opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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 ten years of education, extensive clinical experience, and passing the national athletic training 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.

Thank you in advance for your consideration and attention regarding this issue,

Scott R. Dietrich, EdD, ATC, CSCS
200 Prospect Street
East Stroudsburg University
570-422-0403

Submitter : **Ms. Christy Hoopingarner** **Date: 08/29/2007**

Organization : **Ms. Christy Hoopingarner**

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,

Christy Hoopingarner

Submitter : **Dr. Henry Vucetic** **Date: 08/29/2007**

Organization : **UHCMC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Ralph Salvagno** **Date: 08/29/2007**

Organization : **Center for Joint Surgery**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

This would have a significant impact on our patients. Physical therapy is not a money maker but more of a convenience for our older patients plus continuity for patient care between the doctor and therapist. Many depend on transportation, feel a sense of security with the one on one care unlike other re hab facilities that typically provide group therapy. We do not self refer patients here. They have the option to choose where they want to receive care. We also get referrals from physicians for phyical therapy outside our speciality. Please reconsider the physican self referral rule for 2008. Please feel free to contact our office if have any questions.

Submitter : **Dr. Leonard Goldberg** **Date: 08/29/2007**

Organization : **DermSurgery Associates**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

It is inappropriate to subject 17311 and 17313 to the multiple procedure reduction rule for repairs performed on the same day as the Mohs procedure or for multiple Mohs lesion excisions performed on the same day. Following are some concerns regarding the proposed changes to the Medicare 2008 Fee Schedule:

" This proposal will negatively impact Medicare beneficiaries access to timely and quality care and application of the Multiple Procedure Reduction Rule will not likely generate significant cost savings and may paradoxically increase the cost of providing care to these patients.

" By removing the exempt status of the Mohs codes, Medicare beneficiaries access to timely and quality care will be effected. Application of the proposed rule to a second tumor treated on the same day will mean that reimbursement for the second procedure does not cover the cost of providing the service. This will affect Medicare beneficiaries disproportionately, since the incidence of skin cancers peaks in Medicare-age patients, who are most likely to have multiple tumors.

" Patients who are immuno-suppressed from organ transplantation, cancer chemotherapy, infection or other diseases are at significantly higher risk for skin cancers and often have multiple tumors. Many of these patients are also Medicare beneficiaries. These immuno-suppressed patients are not only at higher risk for cancers but also at higher risk for potential metastases and possibly death from skin cancers, especially squamous cell carcinoma.

" When Mohs procedures are performed with higher-valued repairs such as flaps or grafts, application of the MPRR to the Mohs codes will result in reduced reimbursement for Mohs that doesn t cover the cost of the procedure. Likewise, for lower-valued repairs such as intermediate and complex layered closures, which are the most commonly performed repairs, reduced reimbursement will not cover the cost of the repair.

" Because of the dual components of surgery and pathology associated with each Mohs surgery procedure, there is no gain in efficiencies when multiple, separate procedures are performed on the same date, making application of the reduction inappropriate.

Submitter : **Mrs. Laura Manning** **Date: 08/29/2007**

Organization : **Tennessee Valley Health Care Systems**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

It has been my priviledge to work with veterans since graduating from the University of Southern Mississippi with a B.S. degree in Health, Recreation and Physical Education with special emphasis in Exercise Physiology in August, 1982. As a registered kinesiotherapist, I have provided therapy to veterans in acute and long term care settings including cardiopulmonary rehab, stroke rehab, drug and alcohol abuse programs, prosthetic clinics, wheelchair clinics, TBI rehab, and physical disabilities clinics.

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

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

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

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

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

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

Sincerely,

Submitter : **Ms. Elaine Weisberger** **Date: 08/29/2007**

Organization : **Baptist Sports Medicine**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please add Physical Therapy to bill prohibiting self referrals to physcian owned PT clinics.

Submitter : **Ms. W.C. Goad** **Date: 08/29/2007**

Organization : **Ms. W.C. Goad**

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,
W.C. Goad

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

Organization : **Schering-Plough Corporation**

Category : **Drug Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11350-Attach-1.PDF

#11350

Thomas J. Sabatino, Jr.
Executive Vice President
and General Counsel

Schering-Plough Corporation
2000 Galloping Hill Road
Kenilworth, NJ 07033-0530 USA
Phone +1 908 298 7367
Fax +1 908 298 7555
thomas.sabatino@spcorp.com

Schering-Plough

August 29, 2007

Herb B. Kuhn, Acting Deputy Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P: Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions.

On behalf of Schering-Plough Corporation, I appreciate this opportunity to provide comments on CMS-1385-P, *Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions*. Schering-Plough is a global science-based health care company with leading prescription, consumer and animal health products headquartered in Kenilworth, NJ. Through internal research and collaborations with partners, Schering-Plough's 30,000 employees discover, develop, manufacture and market advanced drug therapies to meet important medical needs.

Our comments focus on the following two sections of the proposed rule: (1) Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen and (2) TRHCA – Section 101(b): PQRI. Comments on each of these sections are attached.

If you have questions or if you need additional information, please contact Jenifer Levinson at 202-463-7372 or jenifer.levinson@spcorp.com.

Sincerely,

Thomas J. Sabatino, Jr.
Executive Vice President and General Counsel

SCHERING-PLOUGH CORPORATION
COMMENTS ON CMS-1385-P

DRUG COMPENDIA

Schering-Plough commends CMS for creating a process to review the list of drug compendia that support medically appropriate coverage of off-label uses of anti-cancer drugs and biologicals. Since the compendia list was established in statute in 1994, the science surrounding cancer treatment has developed dramatically. As the clinical information regarding cancer treatment has progressed, new compendia have been introduced or are in development, which reflect the state-of-the-art in terms of new uses of cancer drugs. Creating a process for adding new compendia will help ensure that Medicare beneficiaries with cancer have access to the best care supported by science. Our comments focus on ensuring that the compendia review process provides a mechanism for Medicare beneficiaries to receive the most clinically appropriate cancer care, according to the parameters established in statute.

Existing Compendia

Both of the compendia currently recognized in statute, the American Hospital Formulary Service-Drug Information (AHFS-DI) and Thomson DrugPoints (the successor publication to the United States Pharmacopoeia-Drug Information (USP-DI)), continue to provide current and credible information regarding off-label uses of anti-cancer drugs. The recent amendment to the 1994 compendia provision mandated in the Deficit Reduction Act (DRA), which added "or its successor publications" after the reference to USP-DI reaffirms in statute that Thomson DrugPoints remain a recognized compendium for purposes of Medicare coverage of off-label uses of anti-cancer drugs. Furthermore, both Thomson DrugPoints and AHFS-DI continue to meet the highest priority characteristics identified by the CMS Medicare Evidence Development and Coverage Advisory Committee (MedCAC)[1] at the March 30, 2006 meeting. For these reasons, Schering-Plough urges CMS to continue to recognize both Thomson DrugPoints and AHFS-DI as approved compendia.

In the proposed rule, CMS specifically seeks input regarding a process for eliminating currently listed compendia. The statute clearly defines the Secretary's authority to add compendia and to recognize a successor compendium to one of the listed compendia. However, nowhere does the statute create an authority for the Secretary to eliminate a currently listed compendium. In addition to the lack of statutory authority for removing listed compendia, there is no substantive reason for CMS to do so. The two existing listed compendia, Thomson DrugPoints and AHFS-DI, meet the most important characteristics of compendia specified by the MedCAC.

Moreover, delisting of an existing compendium could create clinically damaging disruptions in the care of cancer patients. A number of medically appropriate off-label uses of cancer drugs are listed in only one of the two approved compendia. Therefore, eliminating either of the existing compendia could lead to access problems for cancer patients. Although Medicare Administrative Contractors (MACs) and Part B Carriers can permit coverage of off-label uses of anti-cancer drugs based on the peer-reviewed literature, coverage is only guaranteed if the off-label indications are included in a listed compendium. Therefore, to the extent that CMS is

[1] Formerly the Medicare Coverage Advisory Committee (MCAC).

provided with statutory authority to remove listed compendia in the future, CMS should not rely on the peer-reviewed literature as a safety net for indications that would no longer be covered due to de-listing of one of the compendia. Instead, CMS should create a process to ensure that there is no loss in Medicare coverage for medically appropriate off-label indications of cancer drugs when a compendium is de-listed.

<u>Process for Adding New Compendia</u>

We commend CMS for creating a transparent process by which new compendia can be recognized for the purpose of Medicare coverage of off-label indications of anti-cancer drugs. However, the approach proposed by CMS may unnecessarily delay recognition of additional, high quality compendia.

To support the goals of timely access to high-quality cancer care, we recommend the following modifications to the process proposed by CMS:

- *The process should be based on rolling review cycle rather than an annual review cycle.* Medicare has operated without the benefit of the full complement of statutorily recognized compendia for several years. During this time, the reduced number of recognized compendia, as well as Medicare contractors' denial of coverage for medically appropriate off-label uses supported by peer-reviewed literature, has restricted beneficiary access to medically appropriate off-label uses of cancer drugs. Therefore, rather than only reviewing additional compendia once each year, we recommend that CMS employ a rolling review process, similar to the existing process for national coverage decisions. Creating a rolling review cycle rather than an annual cycle would enable CMS to recognize the *NCCN Drugs and Biologics Compendium*™ as soon as possible. This compendium has been under consideration by CMS since 2006. Sponsored by the National Comprehensive Cancer Network, the *NCCN Drug and Biologics Compendium*™ is an authoritative, evidence-based listing of on-label and off-label cancer drug uses. Because there are a limited number of drug compendia available for consideration, CMS likely would receive only a small number of requests for compendia changes, particular in later years when existing authoritative compendia had already been considered. Thus, a rolling process would not impose undue administrative burdens on CMS.

- *Timelines for decisions should be shortened and clarified.* We suggest that CMS consider reducing the 120-day post-comment period proposed for agency review. In evaluating Medicare national coverage issues, CMS publishes a final decision memo no later than 60 days after close of public comments. We also recommend that CMS clarify the precise sequence of steps intended in connection with the 30- and 45-day periods identified for acceptance and review of external requests for compendia changes.

Measures of appropriate medication for chronic conditions have been included in PQRI (e.g., pharmacologic therapy for asthma, bronchodilator therapy for COPD, etc.). We support continued inclusion of the measures in place and recommend that CMS look to expand measures focused on chronic illness management in 2008 and beyond. In particular, CMS should pay close attention to updating these measures as guidelines evolve over time. For example, the National Heart Lung and Blood Institute (NHLBI) will soon be releasing new guidelines for asthma and COPD, and new HEDIS measures for asthma and COPD are planned in 2008. (Additional comments regarding the update process are provided below.)

However, to date, the PQRI has not included any measures of medication adherence, and we recommend that CMS review available metrics from sources such as NQF, and NCQA to identify measures that can fill this gap. At this time, an appropriate measure for inclusion in PQRI in 2008 is *annual monitoring of patients on persistent medications*, which is a current HEDIS measure and which CMS recently proposed as a performance measure for MA plans. Moving forward, CMS should consider adding adherence measures to the PQRI measure set that are developed as part of NQF's ongoing *National Voluntary Consensus Standards for the Reporting of Therapeutic Drug Management Quality* project. While these standards will likely not be available in time for inclusion in the 2008 PQRI measure set, they should be available for consideration in 2009.

Consensus-Based Organizations

Division B of the Tax Relief and Health Care Act of 2006 – Medicare Improvements and Extension Act of 2006 (MIEA-TRHCA) states that any measures selected for inclusion in PQRI in 2008 must have been adopted or endorsed by a consensus-based organization. In the proposed rule, CMS defines a voluntary, consensus-based organization based on the criteria outlined in the National Technology Transfer and Advancement Act (NTTAA) and the Office of Management and Budget (OMB) Circular A-119.

Schering-Plough supports the reliance on measures adopted or endorsed by consensus-based organizations, including the two organizations, NQF and AQA, identified by CMS in the proposed rule. Schering-Plough is an active member of the NQF. The NQF plays a unique and invaluable role as an endorser of quality measures, and we agree that NQF endorsement is an appropriate threshold for inclusion of quality measures in the PQRI. We further support CMS' use of measures adopted by the AQA, even though AQA does not meet all of the attributes described in the NTTAA and OMB Circular A-119. As currently structured, the AQA meets many of the most important attributes of a voluntary, consensus-based organization, including openness, balance of interest, and consensus. However, AQA is currently in the process of considering changes to its structure and operation. Should those changes move AQA away from the attributes of openness, balance of interest, or consensus, CMS should re-evaluate AQA's role in determining which measures may be considered for inclusion in PQRI.

While we support the use of measures endorsed by the NQF and adopted by the AQA, these two groups alone do not offer input from all of the key stakeholders on medication management

issues. As described above, physicians play a central role in prescribing decisions, and medication management has been widely identified as an important quality measure. In order to ensure that appropriate medication measures, including adherence and management of medications for chronic conditions, can be incorporated into the PQRI, we recommend that CMS also consider measures developed by the PQA (formerly the Pharmacy Quality Alliance).

The PQA also meets many of the attributes of a voluntary, consensus-based organization as defined by NTTAA and OMB Circular A-119. Similar to the AQA, the PQA is a voluntary organization and is structured in a similar manner, with wide stakeholder voting participation, a consensus-based process, and meets the criteria for openness, balance of interest, and consensus as outlined in the NTTAA and OMB Circular.

While the PQA is focused on pharmacy-related quality measures, there are a number of measures developed by PQA that are appropriate for consideration as quality measures for physicians, given the central role that physicians play in prescribing decisions. For example, PQA is considering a number of measures for adherence and appropriate therapy for chronic conditions that could serve as important gauges of physician quality. Given that the PQA meets many of the attributes of a voluntary, consensus-based organization outlined in the NTTAA and OMB Circular A-119, we believe that the sub-set of measures adopted by the PQA that are also appropriate measures of physician quality given physicians' role in the prescribing process should also be open for consideration as future PQRI measures.

Update Process

Quality measures are based on best practices in health care, reflecting the best available clinical evidence. Clinical science is continually evolving. Quality measures must be consistently re-evaluated and updated to ensure that they continue to reflect the best available scientific evidence and do not reinforce outdated standards of care. All measures included in the PQRI – and all measure development/endorsement organizations from which CMS derives the PQRI measure set – should be required to have a maintenance process established to review and update quality measures. The process should be transparent so that anyone wishing to supply data on new scientific evidence or new technologies can do so. As CMS considers further measure updates in 2009 and beyond, it should give preference to measures developed by organizations that have established sound measure maintenance and update procedures.

CMS-1385-P-11351

Submitter : Dr. Rochelle Davis **Date:** 08/29/2007

Organization : Dr. Rochelle Davis

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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.

FOR IMMEDIATE RELEASE: July 31, 2007; American Chiropractic Association

********CMS Proposes Changes to Chiropractic X-Ray Reimbursement********

ACA to Submit Comments, Asks DCs to also Contact Agency

The Centers for Medicare and Medicaid Services (CMS), on July 12, published a proposed rule in the Federal Register that would eliminate patient reimbursement for X-rays taken by a radiologist or other non-treating physician and then used by a doctor of chiropractic. If approved, this proposal would reverse a long-standing policy originally obtained by ACA and could severely hamper the chiropractic profession's ability to care for many Medicare patients.

"X-rays, when needed, are integral to the overall chiropractic treatment plan of Medicare patients, and unfortunately in the end, it is the beneficiary who will be negatively affected by this proposed change in coverage. The current X-ray Medicare protocol has served patients well, and there is no clinical reason for this proposed change," said ACA President Richard Brassard, DC. "If doctors of chiropractic are unable to refer patients directly to a radiologist, patients may be required to make additional and unnecessary visits to their primary care providers, significantly driving up the costs of patient care."

The proposed change would specifically eliminate Medicare reimbursement in connection with the referral of a patient by a doctor of chiropractic to a radiologist or other non-treating physician for X-rays; however, doctors of chiropractic will still be able to refer patients back to any treating physician, such as a primary care provider, for needed X-rays.

ACA plans to submit comments on this proposal to CMS prior to the August 31 deadline.

While subluxation need not always be detected by X-ray, it is very often the case that a patient requires an X-ray to rule out any contraindications to chiropractic

care or to determine appropriate treatment options. X-rays may also be required to help determine the need for further diagnostic testing, such as an MRI, or for a referral to an appropriate health care specialist

CMS-1385-P-11352

Submitter : **Mr. Jim Brand** **Date: 08/29/2007**

Organization : **Mr. Jim Brand**

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,

Jim Brand.

CMS-1385-P-11353

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

Organization : **Ms. Marilyn Clark**

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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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 Clark

Submitter : **Dr. Randy Moze** **Date: 08/29/2007**

Organization : **Dr. Randy Moze**

Category : **Chiropractor**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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 often 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. I personally have found abdominal aneurisms in 7 patients this year that were it not for X-rays they might have been seriously injured and because of my referral to their local MD their lives may not have been saved. Last month I referred a patient for an MRI, based on my X-ray findings, which revealed a 2 inch tumor. He is in surgery today! X-rays should 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. Chiropractors take 4 years of X-ray preparation in some respect in school, It would be a great injustice, to the patients, to not include this in their evaluation.

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, financially as well as in health, should this proposal become standing regulation.

Sincerely,
Randy C. Moze

CMS-1385-P-11355

Submitter : Mr. Brandon Rader **Date:** 08/29/2007

Organization : Mr. Brandon Rader

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,

Brandon Rader

CMS-1385-P-11356

Submitter : **Dr. stephen maloon** **Date: 08/29/2007**

Organization : **Dr. stephen maloon**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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Thank you for your consideration of this serious matter.
Stephen A. Maloon, M.D.

CMS-1385-P-11357

Submitter : Dr. david sheinbein **Date:** 08/29/2007

Organization : Univeristy of arizona college of medicine

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.

David Sheinbein M.D.

CMS-1385-P-11358

Submitter : Ms. Bonnie Unruh **Date:** 08/29/2007

Organization : Ms. Bonnie Unruh

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Aeting 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.

Bonnie B. Unruh

CMS-1385-P-11359

Submitter : Ms. Christen Rader **Date:** 08/29/2007

Organization : Ms. Christen Rader

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,

Christen Rader

CMS-1385-P-11360

Submitter : **Mrs. Margaret Frens** **Date: 08/29/2007**

Organization : **Hope College**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Athletic trainers continue to amaze me in their diligence on this issue. Bravo!! If insurance companies continue to think they can "rule the roost" in this manner I fear for all of us! The 275 pages that I just skimmed over just proves that someone has too much time on their hands and is probably making too much money off of my grandparents.

CMS-1385-P-11361

Submitter : Mrs. Kari Rader **Date:** 08/29/2007

Organization : Mrs. Kari Rader

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
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,

Kari Rader

CMS-1385-P-11362

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I own physical therapy (PT) clinics and my direct competitors are physician-owned PT practices. I am writing to encourage CMS to close the loophole that allows physicians to own PT practices unethically using the designated health service (DHS) aspect of the in-office ancillary exception.
When physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest there is a natural conflict of interest that exists and we see this in physician owned PT clinics. By eliminating PT as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutlization of PT services under the Medicare program, and enhance the quality of patient care.
The office of the Inspector General in a report dated May 1st, 2006 showed serious issues with physician owned PT practices and their billing and documentation practices: http://www.oig.hhs.gov/oei/reports/oei-09-02-00200.pdf
In the study examining costs and rates of use in the California Workers Compensation system, Swedlow et al reported that physical therapy was initiated 2.3 times more often by the physicians in self-referral relationships than by those referring to independent practices. Johnson and Swedlow noted that physical therapy accounted for an estimated $575 million per year in California workers compensation costs. Furthermore, they concluded that the phenomenon of self-referral or POPTS generates approximately $233 million per year in services delivered for economic rather than clinical reasons.
In a study appearing in the Journal of the American Medical Association, Mitchell and Scott documented higher utilization rates and higher costs associated with services provided in POPTS (referred to as joint venture clinics) in the state of Florida. The study revealed greater utilization of physical therapy services by the joint venture clinics, rendering on average about 50 percent more visits per year. It also concluded that visits per physical therapy patient were 39 percent higher in joint venture clinics. Joint venture clinics generated almost 32 percent more net revenue per patient than their counterparts. (References are available in the APTA White Paper at: http://www.mopt.org/pdf/POPTS.pdf)

These findings refute many of the points the Orthopedic Surgeons attempt to outline in their position statement.
(http://www.aaos.org/about/papers/position/1166.asp) They say there is a loss of access to PT Services unless they own them this is absurd as these PT s would find employment with independent practices overnight. In fact I now PT s who have had to either close or sell their PT businesses because of physicians opening their own practice.

My personal experience is that patients are directed by the physician to their own clinic without the patient being given a choice of where to get their PT care. Patients many times are not told what their options are and/or are not informed that the physician has a financial interest in the clinic they are being told to go to. Patients, due to the authoritative relationship they have with the physician, put total trust in what the physician recommends as what is best for them. This is not in fact why they are being directed to the physician s clinic but rather for financial reason if not fully, at least in part. This is a clear conflict of interest. Other physicians that refer to our clinic have questioned the ethics of this arrangement as have some patients.
In one case the facility is a long distance from the physician s office and it is in serious doubt that the physicians see patients there are they are supposed to according to the latest Stark Laws.
I appreciate the opportunity to comment on this important issue that negatively affects millions of Medicare beneficiaries. I designate these comments for your consideration.

CMS-1385-P-11363

Submitter : Mrs. Irene Unruh **Date:** 08/29/2007

Organization : Mrs. Irene Unruh

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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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.

Irene Unruh

CMS-1385-P-11364

Submitter : **Mrs. Becy Rader** **Date: 08/29/2007**

Organization : **Mrs. Becy Rader**

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,

Becky Rader.

CMS-1385-P-11365

Submitter : Mrs. jayme wright **Date:** 08/29/2007

Organization : Utah Pain and Rehab

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jayme Wright, I currently work at Utah Pain and Rehab in Ogden, Ut. I recieved a Bachelors Degree in Athletic Training and a Masters Degree in Exercise Physiology. I am the primary provider of physical therapy under doctor supervision in a multi-discipine clinic. I have been here for 4.5 years. Over this time, I have establish a rapport with area physicans and my patients to triple the size of this practice in my time here. It is hard in small clinic settings, that might not have the revenue of larger clinics, or the big hospital affiliations (Intermountain Health) to find cost effective, appropriate care for their patients. I know I am qualified to do my job, and I respect the boundries between the differences among Physical Therapist and Athletic Trainers. I sincerely hope tbat the CMS takes in consideration that Athletic Trainers are qualified and have the education and the exerience to provide rehab services in their domain.

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,

Jayme Wright M.S. A.T.C/L

Submitter : **Mr. Charles McDonald** **Date: 08/29/2007**

Organization : **Mr. Charles McDonald**

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,

Charles McDonald

CMS-1385-P-11367

Submitter : **Dr. john kim** **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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Thank you for your consideration of this serious matter.

Thank you,

John P. Kim MD

CMS-1385-P-11368

Submitter : Ms. Alta McDonald **Date:** 08/29/2007

Organization : Ms. Alta McDonald

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,

Alta McDonald

CMS-1385-P-11369

Submitter : **Mr. Brandon Meuse** **Date: 08/29/2007**

Organization : **Lawrence**

Category : **Hospital**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear CMS:
Hello, I work for Lawrence Memorial Hospital in Connecticut. I am a manager of our sports medicine program. We employ 7 full time licensed athletic trainers. I have worked in the hospital setting as an Athletic Trainer (LAT) for 6 years.

I am very concerned about the verbiage used in the provision for rehabilitation in hospital facilities proposed in 1385

I see the complete avoidance of use of Licensed Athletic Trainer In the writing of competent people that perform rehabilitation.

Licensed athletic trainers have a bachelor s degree from an accredited institution, have finished an extensive internship program, and taken a national board exam. Recently this past year our profession was recognized by state licensure. The words written in the provision for rehabilitation in hospital facilities seem to imply that we cannot perform rehabilitation. It is apparent that my profession was not included and my impression was that this is a grave mistake or oversight.

I am sure when the CMS evaluates the credibility of Licensed Athletic Training further you will see that the Athletic Training license is a credible licensure. Not adding Licensed Athletic Training to a pool of qualified individual that perform physical medicine and give rehabilitation services will leave the community that is all ready served without the quality care that they have been receiving. We will also be seeing a loss of employment in these setting.

The profession of athletic Training has also been shown to be a lower costing service line
when compared to other medical practitioners.

It is very concerning that our profession has been avoided and seems to have no worth. I feel like a very competent individual and the profession is highly regarded in our community and amongst the patients served.

Brandon Meuse LAT
Administrative Manager
Therapeutic Fitness & Sports Medicine
Lawrence & Memorial Hospital
860-388-5881

CMS-1385-P-11370

Submitter : Dr. Craig Selinger **Date:** 08/29/2007

Organization : Selinger Chiropractic and Acupuncture

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

Please allow coverage for chiropractors to take x-rays on medicare patients. Most medicare patients have degenrative conditions and we need to take films, to treat the patient. Many patients do have the extra money to pay for x-rays, this makes it hard for patients to have access.

Thank You.

CMS-1385-P-11371

Submitter : Mrs. Mary Butch

Date: 08/29/2007

Organization : Physical Rehabiliation Services, Inc.

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11372

Submitter : **Mr. kerry wimberly** **Date: 08/29/2007**

Organization : **sports**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam,

My name is Kerry Wimberly and I am a Texas Licensed and Nationally Certified Athletic Trainer employed in a rehabilitaiton center.

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

While I am concerned that these proposed changes to the hospital Conditions of Participation have not recieved 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. May 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 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 hospistals 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,

Kerry Wimberly ATC, LAT

CMS-1385-P-11373

Submitter : Mr. Boyd Cabie **Date:** 08/29/2007

Organization : Mr. Boyd Cabie

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,

Boyd Cabie

Submitter : **Ms. Cheryl Cable** **Date: 08/29/2007**

Organization : **Ms. Cheryl Cable**

Category : **Individual**

Issue Areas/Comments

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Thank you for your consideration of this serious matter.

Sincerely,

Cheryl Cable

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

Organization : **James Tobin**

Category : **Physician**

Issue Areas/Comments

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Thank you for your consideration of this serious matter.

Submitter : Mr. Jay Yeich

Organization : Mr. Jay Yeich

Category : Individual

Date: 08/29/2007

Issue Areas/Comments

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Thank you for your consideration of this serious matter.

Sincerely,

Jay Yeich

CMS-1385-P-11377

Submitter : Dr. Jeffrey Harrison **Date:** 08/29/2007

Organization : Dr. Jeffrey Harrison

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

In order to provide a beneficiary with a "Standard of Care", A doctor must evaluate and determine a proper course of action for that beneficiary. Although x-rays are not needed to determine if a subluxation is present, they may be warranted in some cases to determine any "red flag" issues are present, to determine if referral is warranted or if further diagnostic imaging is needed.

You have already limited our treatment of patients to manipulation as it is as you do not allow for examination, physiotherapy, radiography or DME. To further limit the Doctor of Chiropractic by eliminating referral for X-ray studies will only increase the costs for the beneficiary and for CMS as well as it will require duplicate evaluation prior to referal. With fixed incomes and limited recourses, seniors may choose to forgo these casts and thus needed treatment. When treatment is delayed, illnesses that could be life threatening may not be discovered. Costs for treatment then will be increased.

As it stands now, CMS is causing itself greater costs than if you allowed Doctors of Chiropractic to provided benificiaries with evaluation and radiographs. A typical AP and Lateral lumbar radiograph, if taken by the Doctor of Chiropractic, is reimbursed at roughly $70.00. If refered out(or if the beneficiary seeks medical evaluation only), the typical medical scenario involves more films and reading by a radiologist and therefor increased cost to CMS.

It seems to me, the more you try to limit reimbursement, the more it costs you in real dollars. Think of this as well, as a chiropractor, elimination of this regulation has no finacial benefit to me.

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.

CMS-1385-P-11378

Submitter : Ms. Les Yeich **Date:** 08/29/2007

Organization : Ms. Les Yeich

Category : Individual

Issue Areas/Comments

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Thank you for your consideration of this serious matter.

Sincerely,

Les Yeich

CMS-1385-P-11379

Submitter : **Ms. Dorothy McGinnis** **Date: 08/29/2007**

Organization : **Ms. Dorothy McGinnis**

Category : **Individual**

Issue Areas/Comments

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Sincerely,

Dorothy McGinnis