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

Organization : RONALD S. ARONSON, MD.PC

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Please see attached comments.

CMS-1385-P-11442-Attach-1.TXT

CMS-1385-P-11442-Attach-2.TXT

#11442

Ronald S. Aronson, M.D., F.A.C.P., F.A.C.C.
Cardiovascular Disease
110 Lockwood Avenue
New Rochelle, New York 10801

Phone: 914-235-5757 Fax: 914-235-5791

September 12, 2007

Amy Bassano
Director, Division of Practitioner Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, C4-01-26
Baltimore, MD 21244

Re: CMS-1285-P: CY 2008 Physician Fee Schedule Proposed Rule Practice Expense -- Equipment Usage Percentage

Dear Ms. Bassano:

Thank you for considering this comment on the 2008 Physician Fee Schedule Proposed Rule. I am a cardiologist, and I am writing to discuss payment for Microvolt T-wave Alternans (MTWA) diagnostic test. MTWA is an important tool to determine a patient's risk of sudden cardiac death. I am concerned that Medicare payment for physicians for MTWA is based on an incorrect utilization assumption that results in a significantly lower payment. CMS should consider the actual utilization of MTWA when calculating the practice expense for MTWA.

In patients at high risk for sudden cardiac death, Medicare has expanded coverage of implantable cardioverter defibrillators (ICDs) as a preventive measure. MTWA is extremely valuable in identifying which patients will benefit most from an ICD. Published data indicates that patients with negative MTWA tests will typically receive no significant reduction in cardiac arrest-related deaths, allowing us to identify patients who are more likely to benefit from an ICD.

MTWA testing is a non-invasive procedure that takes about 45 minutes. Unfortunately, the Medicare Practice Expense formula significantly decreases physician payment for MTWA. Reimbursement for MTWA is calculated using an "equipment usage assumption" of 50 percent. The assumption that the MTWA equipment is used 50 percent of the time is inaccurate and results in an inappropriately low payment. In my practice, MTWA is typically used only for the specific high-risk patients who will benefit greatly from its analysis. On average, we use MTWA several times per week, but significantly less than 50 percent of the time.

In order for Medicare to pay appropriately for this valuable technology, and to ensure that physicians continue to use it for their patients when appropriate, CMS should use the actual usage rate when available. Please do not hesitate to contact me for this information or if I can answer any other questions about MTWA.

Thank you for your attention in this matter.

Yours truly,

Ronald S. Aronson, M.D.

Submitter : Mrs. Tracie Heimbach **Date:** 08/29/2007

Organization : Mrs. Tracie Heimbach

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Ms. Debra Burris** **Date: 08/29/2007**

Organization : **Ms. Debra Burris**

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
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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,

Debra Burris

Submitter : **Dr. Barbara Miller** **Date: 08/29/2007**

Organization : **Miller Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Do not revise thc physician fee schedule for CMS-1385-P

Submitter : **Dr. Deane Mink** **Date: 08/29/2007**

Organization : **Mink Chiropractic Center**

Category : **Chiropractor**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Not pay for Chiropractic x-rays?????? Surely you don't expect me to treat some of these elderly folks without knowing the stability of their spinal vertebra.....please, please don't try to fix what isn't broke. Leave the x-ray as it is. Thanks.....Dr. Mink

Submitter : **Ms. Erin Sullins** **Date: 08/29/2007**

Organization : **Ms. Erin Sullins**

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,

Erin Sullins

Submitter : **Dr. Jean Simonson** **Date: 08/29/2007**

Organization : **Dr. Jean Simonson**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Sincerely,

Jean A. Simonson, M.D.
924 N. 20th Avenue
Blair, NE 68008

Submitter : **Mr. Terry Wigfield** **Date: 08/29/2007**

Organization : **Clearfield E.M.S., Inc.**

Category : **Other Health Care Professional**

Issue Areas/Comments

Beneficiary Signature

Beneficiary Signature

August 29, 2007
RE: Beneficiary Signature

I would like to comment on the proposed rule on beneficiary signature requirements for Medicare services. I would like to say I appreciate the effort that Medicare is putting forth regarding beneficiary signatures. However, I believe that Medicare does not fully understand the position of the ambulance services. I would like to explain to Medicare what really happens on an emergency transport. The ambulanee crew is there for the patients medical care. At the time of an emergency transport the ambulance crews are not concerned with getting a beneficiary signature. They are concerned with the welfare of the patient. They transport to a hospital emergency room. This is where they try to obtain the beneficiary signature. The hospital emergency rooms are extremely busy and the hospital employees become very irritated with the ambulance crew for interrupting patient care, but the ambulance crew does not have time to wait at the hospital until patient care is finished. This is not the appropriate time or place to try to get a beneficiaries signature.

Also you state about obtaining a signature on a claim form. There are no claim forms. When the government enforced the Paperwork Reduction Act, providers now have to send claims electronically. Therefore, why do we even need a beneficiary signature?

The ambulance crews are trained for the patients care and this is their responsibility. The burden of a beneficiaries signature has been place on them and is very impractical. If Medicare would really consider helping ambulance services, you would abolish getting a beneficiary signature on emergency transports.

Sincerely
Terry Wigfield
Director of Operations

Submitter : **Mr. Shawn Browne** **Date: 08/29/2007**

Organization : **Mr. Shawn Browne**

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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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,

Shawn Browne.

Submitter : **Mr. Justin Sexton** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Justin M. Sexton, CRNA
7156 Holt Run Drive
Nashville, TN 37211

Submitter : **Dr. vito cancellaro** **Date: 08/29/2007**

Organization : **greenville anesthesiology pa**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Yours truly,

Vito A. Cancellero MD

Submitter : **Dr. J. Neil Jr.** **Date: 08/29/2007**

Organization : **Eastern Maine Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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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.

On a personal note, I have left two smaller practices (<5 members) and now practice in a larger group (20 members) largely due to inadequate reimbursement from the CMS portion of the caseload covered. This illustrates the loss to CMS patients of professional service due to disparity in reimbursement described above.

Thank you for your consideration of this serious matter.

Verry Truly

J. Neil Jr., MD
Anesthesiologist, Bangor, ME

Submitter : **Ms. Jackie Fortenberry** **Date: 08/29/2007**

Organization : **MS Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I am asking that you finalize the proposal to increase the value of anesthesia work by 32% and increase the anesthesia conversion factor by up to 25% in 2008. This will help to correct the value of anesthesia services which have long been undervalued and have slipped behind inflationary adjustments. If this is not done anesthesia reimbursement will be 17% below the 2006 payment levels.

CMS-1385-P-11455

Submitter : Mrs. Dolores Pease **Date:** 08/29/2007

Organization : Mrs. Dolores Pease

Category : Health Care Professional or Association

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P
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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,

Dolores Pease.

Submitter : **Mrs. Renee Peterson** **Date: 08/29/2007**

Organization : **Mrs. Renee Peterson**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

To: Officc of the Administrator for CMS

Rc: CMS-1385-P (Background,Impact) for Anesthesia Services

Dear Administrator:

As a Certified Registered Nurse Anesthetist and a memeber of the AANA, I write to support the CMS proposal to boost the value of anesthesia work by 32%. This is important for several reasons:

1. CMS currently under reimburses for anesthesia services, putting at risk the availability of anesthesia services, especially in remote areas, like ND. Studies by Med PAC show that anesthesia is reimbursed currently at 40% less than the private market rates, in comparison to other specialities at 80%.
2. If this change is not enacted and if Congress fails to reverse the 10% sustainable growth rate cut to Medicare payment, and average 12-unit anesthesia servcie in 2008 will be reimbursed at a rate about 17% below 2006 payment levels.
3. The United State's CRNAs (36K in numbers) provide 27 million anesthetics annually and are predominantely providers to rural and medically underserved America. Medicare patients depend on our services. The availability of anesthesia providers depends on fair Medicare payment.

In closing, I FULLY SUPPORT the agency's acknowledgement that anesthesia payments have been undervalued and its proposal to increaset he valuation of anesthcisa work in a manner that boosts Medicare anestheia payment.
As a small rural hospital manager, I also see that our conversion rates are at a much lower rate that more urban areas. That further hurts rural communities, as generally, to get professional staff to relocate to remote areas, we have to pay a higher salary. Please continue your work to protect small communities access to quality health care.

Sincerely,
Renee P. Peterson, MS CRNA
Chief CRNA - Trinity Health, Minot ND
701-857-5124

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

Organization : **Lima Memorial Health System**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Kimberly Badertscher. I am a certified athletic trainer licensed by the state of Ohio. I currently work for Lima Memorial Health System and am also contracted to Ohio Northern University for athletic training coverage. I graduated from Ohio Northern University, which is accredited by CAATE. I did my graduate study at East Stroudsburg University in Pennsylvania. At Lima Memorial Health System, I work at the Wellness Center which provides outpatient physical therapy. I have many responsibilities, one being assisting physical therapists and physical therapist assistants in providing care to non-Medicare patients.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. The education of an athletic trainer has many similarities to that of a physical therapist, occupational therapist, PTA and OTA. Each occupation does have characteristics unique to the individual profession. I believe that athletic trainers are fully capable of working in a clinical setting and should meet CMS Standards . 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,
Kimberly Badertscher, MS, ATC, LAT

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

Organization : **Golden State Warriors**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Frank Bernard, the assistant athletic trainer of the Golden State Warriors.

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

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

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

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Sincerely,

Frank Bernard, ATC, CSCS, PES, CES

Submitter : **Mr. Chris Dane** **Date: 08/29/2007**

Organization : **Stephen F. Austin State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Chris Dane and I am currently an Assistant Athletic Trainer at Stephen F. Austin State University. I am also a current member of NATA and in good standing.

I am writing today to voice my oposition 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 hospiptal 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 medecine 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 recieve quality health care. State law and hospital medical professional have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. The lack if access and workforce shortage to fill therapy postions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, espicially those in rural areas, to further restrict their ability to receive those services.

Sincerely,

Chris Dane ATC, LAT

Submitter : **Mrs. Anita Pease** **Date: 08/29/2007**

Organization : **Mrs. Anita Pease**

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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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,

Anita Pease

CMS-1385-P-11461

Submitter : **Dr. Dewitt Bateman** **Date: 08/29/2007**

Organization : **Dr. Dewitt Bateman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1385-P-11461-Attach-1.WPD

Submitter : **Mr. Cameron Collings** **Date: 08/29/2007**

Organization : **NorthWest Physical Therapy and Spine Rehab**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,

My name is Cameron Collings and I am a certified athletic trainer. I graduated from an accredited athletic training education program with my BA in Athletic Training. I currently work as an athletic trainer in an outpatient rehabilitation setting.

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,

Cameron Collings, ATC

Submitter : **Mr. Jason Morin** **Date: 08/29/2007**

Organization : **Mr. Jason Morin**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an Athletic Training Student at Minnesota State University Mankato.

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 future athletic trainer, I will be qualified to perform physieal medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam will ensure that my patients receive quality health care. State law and hospital medical professionals have deemed ATCs 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,

Jason Morin, Athletic Training Student

Submitter : **Ms. Damon Pease, Jr** **Date: 08/29/2007**

Organization : **Ms. Damon Pease, Jr**

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,

Damon Pease, Jr.

Submitter : **Mr. Steven Burback** **Date: 08/29/2007**

Organization : **College of the Southwest**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a rural health care provider in south eastern New Mexico. I am a licensed and certified athletic trainer and CPR instructor.

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, and ten years of 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 physical therapy positions is widely known throughout the industry. It is irresponsible for CMS and the Federal government, which is supposed to be concerned with the health of all Americans, especially those in rural areas, to further restrict their ability to receive those desperately needed services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are necessary 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,except for the wants of the special interest group of physical therapists. I would strongly encourage the CMS to consider the recommendations of those doctors 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,

Steven Burback, ATC, LAT
Head Athletic Trainer
Clincal First Aid Instructor

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

Organization :

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

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

Michelle_Miller
Name & Credential
2250 State Line Road
Address
Oxford, OH 45056
City, State ZIP

Submitter : Dr. Francisco-Javier Ruiz

Date: 08/29/2007

Organization : F. Javier Ruiz, MD, PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Madam/Gentleman,
I am concern that the continued underpayment of the office base interventional pain services, will discourage many physicians from treating Medicare beneficiaries in their offices unless they are adequately paid for their practice expenses. This will shift patients back to the hospitals increasing healtcare cost to Medicare. Thank you. F Javier Ruiz MD

Submitter : **Mr. Jacobus Bogaards** **Date: 08/29/2007**

Organization : **Mr. Jacobus Bogaards**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please do not change the current rules. I love working for an orthopedic practice. It is for the patient s benefit that the orthopedic surgeon has the option to use a therapist in his office. If one would disagree then at least make it legal for a physical therapist to become a partner in a group which includes Orthopedists. The APTA has become a spokes person for a very small group of private practitioners who would like to make sure that they would obtain a monopoly. The patient has the freedom to choose to go see any private therapist they want, if they choose to stay within our office that is nice, if they opt not to that is fine too. Please take this in consideration when debating this issue. Let the current rules prevail and allow physical therapists to continue to provide quality care in a physician s office.

Jaap Bogaards PT, APTA member

Submitter : **Mr. Gregory Nicotra** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Please see attached document.

CMS-1385-P-11469-Attach-1.TXT

#11469

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS-1385-P (BACKGROUND, IMPACT)
Baltimore, MD 21244-8018 ANESTHESIA SERVICES

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

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

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

America's 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting
requiring anesthesia services, and are the predominant anesthesia providers to rural and medically

underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The
availability of anesthesia services depends in part on fair Medicare payment for them. I support the
agency's acknowledgement that anesthesia payments have been undervalued, and its proposal to increase
the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Gregory Nicotra, CRNA
315 West 35th Street
Apt 23E
New York, NY 10001

Submitter : **Ms. KAREN AMERMAN** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Scrviees (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
___KAREN AMERMAN, CRNA______________________________
Name & Credential
___5341 PAGEWOOD_________________________________
Address
__HOUSTON, TEXAS 77056_________________________________
City, State ZIP

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

Organization : **Mr. James Tazelaar**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

CRNA reimbursement must not be cut as we are already paid at a smaller rate than MDA's. A further erosion of reimbursement will lead to less care alternatives to lower and middle class patients which are disporportionately served by mid level providers. This will also hurt rural and inner city patients and push care toward large teaching facilities. All of these effects move in the wrong direction away from affordable health care and towards high overhead, inflexible and large organizations. Please do not starve those of us on the front lines.

Submitter : **Mr. Scott Anderson** **Date: 08/29/2007**

Organization : **University of Oklahoma**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am the Head Athletic Trainer for the University of Oklahoma Department of Intercollegiate Athletics.

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,

Scott Anderson, ATC

Submitter : **Mrs. Zena Tipton** **Date: 08/29/2007**

Organization : **Mrs. Zena Tipton**

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,

Zena Tipton

Submitter : **Ms. Diane Vermaelen** **Date: 08/29/2007**

Organization : **Ms. Diane Vermaelen**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a working wife and mother of 5 and work contract as a Certified Athletic Trainer and Physical Therapist Assistant in various health care environments. I hold two BS degrees, am NATA Certified, and licensed as a PTA under the LAPTA here in Louisiana.

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. Since I am also licensed as a Physical Therapist Assistant, I am well aware of not only the differences of my licenses, but also of the unique compliment they have with eachother in my work envirnoments. 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,

Diane Scotti Vermaelen, ATC, PTA, LAT, FIS

Submitter : **Mr. Miguel Tipton** **Date: 08/29/2007**

Organization : **Mr. Miguel Tipton**

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,

Miguel Tipton

Submitter : Ms. Heather Wilson

Date: 08/29/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

29 August 2007

Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Administrator:

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

First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.

Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.

Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Heather Wilson, CRNA, MS
2916 Terrace Avenue
Alhambra, CA 91803

Submitter : **Mrs. Jessica Braun** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
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ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Jessica Braun
Name & Credential
21850 Hartford Way
Address
Macomb, MI 48042
City, State ZIP

Submitter : **Mrs. Lori Chancellor** **Date: 08/29/2007**

Organization : **Mrs. Lori Chancellor**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

I am a member of the American Association of Nurse Anesthetists (AANA). I write to support the CMS proposal to boost the value of anesthesia work by 32%. If adopted, the proposal will ensure that nurse anesthetist(CRNA)providers can continue to provide Medicare beneficiaries with access to anesthesia services.

Medicare currently under-reimbuses anesthesia services to such a great degree that it risks the availablility of CRNA services to Medicare beneficiaries. Medicare currently reimburses anesthesia services at a rate that is 40% of the private market rate compared to reimbursing most other services at a rate of 80%.
Most part B sevices have already been reviewed and adjusted for 2007. Anesthesia services have not. This proposal will allow for changes to begin in 2008, a full year after most other services.
This proposal will help correct the value of anesthesia services which have long been severly undervalued.

CRNA providers are 36,000 strong and provide 27 million anesthetics in the U.S. annually. The availability of their services depends in part on fair Medicare payment for them. I support the agency's acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

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

Organization : Harris-Stowe State University

Category : Individual

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Christa Ikard. I am a Certified Athletic Trainer working in the Saint Louis Area. I have had the privilege to work in quite a few physical therapy clinics in Missouri and Colorado. I intend on receiving my Doctorate in Physical Therapy and working as a PT/ATC. Therefore, the therapy standards and requirements in regards to the staffing provision for rehabilitation in hospitals and facilities proposed in 1385-P are causing me some concern.

While I am troubled 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,

Christa Ikard, ATC

CMS-1385-P-11481

Submitter : Dr. Gerald Augustin **Date:** 08/29/2007

Organization : Dr. Gerald Augustin

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I want to give my support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.When the RBRVS was instituted,a huge disparity in payment for anesthesia care was created because anesthesia work was undervaluated.Medicare payment for anesthesia is only $16.16 per unit.This amount does not cover the cost of caring for our senior citizens.The RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation.That would result in an increase of $4.oo per unit,which would correct the long-standing undervaluation of anesthesia services.I am pleased that the Agency accepted this recommendation in its proposed rule,and I support full implamentation of the updated payment. Thank you for your consideration of this serious matter.

Submitter : **Mrs. Wanda Benefee, Sr.** **Date: 08/29/2007**

Organization : **Mrs. Wanda Benefee, Sr.**

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,

Wanda Benefee, Sr

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

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To the powers that be in determination of medicare funding decisions:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely -Robert LaGrone MD

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

Organization : **Loretta Krahn**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for
Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and
others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments. Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation). America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Loretta Krahn, CRNA
1320 Boxelder Street
Mountain Lake, MN 56159

Submitter : **Mrs. Megan Taylor** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

You should also feel free to share the letter with your colleagues whom you believe might share your interest such as your fellow CRNAs, nurse anesthesia students, practice administrators, anesthesiologists, or hospital administration for them to write the Medicare agency. Urging the agency to provide appropriate Medicare reimbursement increases the economic value of the anesthesia services to your local healthcare practice.

Submitter : Dr. vernice robinson **Date:** 08/29/2007

Organization : prime coummunity health group

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

This bill(CMS-1385-P) shouldn't be allowed to pass. This would hindered the medicare patient diagnostics care as well as cost the patient to occurred more medical expense---having to be referred out for x-rays. Chiropractors are doctors and should continue to request the best diagnosics for patient care.

Submitter : Dr. Arash Kimyai-Asadi **Date: 08/29/2007**

Organization : Dr. Arash Kimyai-Asadi

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am a Mohs surgeon and I routinely operate on patients from the countryside with multiple skin cancers traveling hours to come see me. If Mohs surgery will get paid in half for second tumors, it will not be cost effective for me to perform surgery on more than one tumor on a patient in one day. For patients with numerous tumors on their ears, noses, eyelids, and lips or with multiple large tumors, this would mean many many visits. Most likely, a lot of patients will end up delaying their care for their second tumors, resulting in drastically larger and more invasive tumors, that will cost Medicare a lot more to treat and will be functionally and cosmetically devastating to patients.

There is no overlap in work between one and multiple Mohs procedures. A large portion of the work is the pathology component, and two tumors on one patient is the exact same amount of work for the histotechnologist and the physician as two patients with one tumor each. Moreover, the numbing and the excising share no overlap. Perhaps, the only overlap is in the brief discussion of the procedure preoperatively. There is no post-operative work for Mohs surgery and the global period is 0 days.

Especially for large tumors requiring complex reconstruction, I may be forced to perform the repairs on a day other than the day of Mohs surgery. It is not cost-effective to provide either the first stage of Mohs surgery or the reconstruction for half of the allowable fee.

Moreover, I also perform Mohs surgery on hospitalized patients. If a patient requires reconstruction or has multiple tumors, the stage 1 of Mohs that is paid in half would be reimbursed at such a low level that it would pay more to treat the tumors with a destruction instead of a complex procedure such as Mohs surgery.

For many of the complex reconstructions I perform, the multiple procedure reduction would make performing Mohs surgery and reconstruction on the same visit cost-prohibitive. I would have to refer many patients to other specialists, such as plastic surgeons and oculoplastic surgeons, who will end up utilizing operating room and general anesthesia services, increasing the cost from a few hundred dollars to thousand of dollars for Medicare.

Another problem is that the multiple procedure reduction punishes only Mohs surgeons who provide their patients with efficient care, taking care of multiple tumors on one day and reconstructing them during the same visit. By applying this multiple procedure reduction rule to Mohs surgery, these Mohs surgeons will be forced to alter their practices, thus penalizing patients who have skin cancer by requiring them to make multiple visits, requiring time off from work, arranging transportation, long-term wound care, etc.

I implore you to do everything possible to maintain the current status of the Mohs surgery codes as being exempt from the multiple procedure reduction rule. The consequences of altering this are grave for many patients with skin cancer.

Submitter : **Mr. Don Benefee, Jr** **Date: 08/29/2007**

Organization : **Mr. Don Benefee, Jr**

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,

Don Benefee, Jr.

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

Organization : **Union University**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

August 29, 2007

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

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

" ? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.

" ? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007.However, the value of anesthesia work was not adjusted by this process until this proposed rule.

" ? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

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

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

Sincerely,

Mary Millen Pena, RN, BSN, SRNA

9155 Gillie Cove

Bartlett, TN 38133

Submitter : **Dr. Donald Cappadona** **Date: 08/29/2007**

Organization : **Southcoast Cardiac Anesthesthesia Assoc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-11491

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a Physical therapist practicing for 20 years I would like to speak out against physician owned Physical therapy practices.Please remove physical therapy from the " in -office ancillary services"exception to the federal physician self referral laws,

Submitter : **Mr. William McLaughlin** **Date: 08/29/2007**

Organization : **Athletic Trainers' Society of New Jersey (ATSNJ)**

Category : **Other Health Care Professional**

Issue Areas/Comments

Impact

Impact

Dear Sir or Madam,

I am an NATA certified Athletic Trainer working in the Gloucester City School District in Gloucester City, NJ.
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,

Bill McLaughlin, M.A., A.T.,C.

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

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely ,

Alexandru Sculciu MD

Submitter : **Ms. Christie Crook** **Date: 08/29/2007**

Organization : **Ms. Christie Crook**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Sincerely,

Christie Crook

Submitter : Ms. Annette Owens **Date: 08/29/2007**

Organization : Ms. Annette Owens

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,

Annette Owens

Submitter : **Mr. Ben Chancey** **Date: 08/29/2007**

Organization : **LC VAMC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

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

I, Ben Chancey, am a Kinesiotherapist at the LC VAMC. I have been serving our veterans for 22 years.

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 eare 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,
Ben Chancey, RKT

Submitter : **Dr. Eric Smith**

Organization : **Summit Urology**

Category : **Physician**

Date: 08/29/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1385-P-11497-Attach-1.DOC

#11497.

SUMMIT UROLOGY
S P E C I A L I S T S
Brian J. Logue, M.D.
Eric M. Smith, M.D.
Gregory T. Walker, M.D.
Bryan D. Hoff, M.D.
David R. Elkins P.A.
Cheryl D. Pittsford, P.A.
Treatment & Surgery

August 27, 2007

Herb Kuhn, Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn: CMS-1385-P
P. O. Box 8018
Baltimore, MD 21244-8018

Dear Mr. Kuhn:

I am writing to you regarding the proposed change in physician fee schedule rules that was published on July 12, 2007 regarding rules and how they will impact our practice.

The changes proposed in these rules will have a negative impact on the care I can provide in my office and may lead to a decrease in the quality of medical care. With respect to the in-office ancillary services exemption, I feel the definition should not be limited. We provide in office computed tomography (CT), which is critical to the care of patients who present with acute pain from problems such as kidney stone, appendicitis, etc. Furthermore, because we have CT we are able to adjust our studies needed for the appropriate condition and avoid needless additional studies.

We also provide pathology services in our office and it is important for us to be able to provide this service. The proposed changes will make it impossible for us to continue to provide pathology services which are presently provided by part-time pathologists. We often consult with these pathologist and review tissue samples with them regarding the diagnoses made. This is not always possible with traditional pathology services. In addition, our turn around time is much faster that it would be otherwise and we are able to inform patients of significant problems, such as cancer, more quickly and thus provide care more quickly.

There are other aspects of the proposal which are concerning to me. The prohibition of payments for space and equipment rentals does not affect us directly at this time, however, with the constantly changing practice of medicine and the introduction of new technology this may adversely impact our ability to offer services to patients in this area if these rules

2907 McIntire Drive
Bloomington, IN 47403
(812) 332-8765
Fax (812) 336-3425

SUMMIT UROLOGY
SPECIALISTS
Brian J. Logue, M.D.
Eric M. Smith, M.D.
Gregory T. Walker, M.D.
Bryan D. Hoff, M.D.
David R. Elkins P.A.
Cheryl D. Pittsford, P.A.
Treatment & Surgery

go into effect. I feel this is burdensome not only to the physicians but more importantly to the patients we care for.

Thanks you for your consideration.

Sincerely,

Eric M. Smith, M. D.

2907 McIntire Drive
Bloomington, IN 47403
(812) 332-8765
Fax (812) 336-3425

CMS-1385-P-11498

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

Organization : **Winter Park High School Orange County, FL**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Elaine M. Judy, ATc and I am the Head Athletic Trainer for Winter Park High School in Orange County, FL. I am responsible for over 1,300 athletes and their care at the school. I received my degree from the University of Florida. I am Nationally certified as well as State licensed.

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,

Elaine M. Judy, ATC

Submitter : **Mrs. Christiane Jernigan** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

Christiane Jernigan, SRNA
1808 Lakemont Lane
Knoxville, TN 37922

11500

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College of Health Sciences
Department of Exercise & Sports Science
Athletic Training Education Program
www.athletictrining.eku.edu
Email: eric.fuchs@eku.edu

Address Here
521 Lancaster Avenue
Richmond, Kentucky 40475-3102
OFF: (859) 622-8173
FAX: (859) 622-1254

Dear Sir or Madam:

My name is Dr. Eric J. Fuchs, ATC, NREMT-B; currently I am an Assistant Professor and Clinical Coordinator for the Athletic Training Education Program, where I teach, General Medical Conditions, Pharmacology, Therapeutic Modalities and several other courses. As an educator I know that Athletic Trainers are qualified through education and the national certification exam which no individual may sit for without first graduating from an accredited Athletic Training Education Program. These entry-level programs are found either as a four-year Bachelor's degree or through a 2 year Master's Degree program, all programs are accredited by CAATE (Commission on Accreditation of Athletic Training Education). I am also concerned that these proposed changes will limit the career and job opportunities for the many graduates of athletic training education programs across the country.

I have been a certified athletic trainer for 15 years, additionally why would I as an ATC be limited to provide these services when as an ATC I do have and was able to acquire a NPI (National Provider Identifier) number as a health care provider I have an NPI number an my own evaluation and treatment CPT codes additionally to provide these services.

Again, 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,

Dr. Eric J. Fuchs, ATC, NREMT-B
Asst Professor & Clinical Coordinator
Athletic Training Education Program
Eastern Kentucky University
Eric.fuchs@eku.edu
OFF: 859 622 8173
FAX: 859 622 1254

Submitter : **Dr. Eric Fuchs, ATC, NREMT-B** **Date: 08/29/2007**

Organization : **Eastern Kentucky University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See My Attachment

CMS-1385-P-11500-Attach-1.PDF

Submitter : Dr. Joel Radney **Date:** 08/29/2007

Organization : Radney Chiropractic Clinic P. C.

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Thc proposed dated July 12, 2007 under technical corrcctions section whereas a beneficiary not be reimbursed by medicare for an x-ray taken by a non treating providcr and uscd by a Chiropractor.

I AM IN STRONG OPPOSITION TO THE NEW RULE. It needs much debate before implimentation.

Sinccrely,

Jocl E. Radncyi D.C.

CMS-1385-P-11502

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

Organization : **Stillwater Medical Center, Total Health**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

August 29th, 2007

Dear Sir or Madam:
I am a certified athletic trainer and currently work in the fitness setting for a hospital. I also am an adjunct instructor for Oklahoma State University in the Athletic Training program and I provide services to a local high school. I have worked in the past in several settings including industrial, semi-professional sports, high school, college and clinical. Both my Master s degree and Bachelor s degree are in Health and Human Performance with an emphasis on Applied Exercise Science.

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,
Robert A Woods, M.S., ATC, LAT
Medical Fitness Supervisor
Stillwater Medical Center

Submitter : **Dr. Nancy Loeffler** **Date: 08/29/2007**

Organization : **Anesthesiology Associates of Tallahassee**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Ms. janice follmer** **Date: 08/29/2007**

Organization : **Ms. janice follmer**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

Submitter :

Date: 08/29/2007

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
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Sincerely, Keri Ortega MSN, CRNA