Submitter : Mrs. Terri Newton **Date:** 08/29/2007

Organization : Multi-Medical

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

"SEE ATTACHMENT"

CMS-1385-P-11506-Attach-1.TXT

CMS-1385-P-11506-Attach-2.TXT

#
11506

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.

Terri Newton

Multi-Medical Specialties Billing

Submitter : **Dr. Ld Herzog** **Date: 08/29/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. John Bowman** **Date: 08/29/2007**

Organization : **Ohio University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am the Director of Sports Medicine at Ohio University. I have a Masters Degree from The University of Virginia. I have been a certified athletic trainer for 19 years. I have been licensed by the state of Ohio since 1994.

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,

John R. Bowman, MEd, ATC

Submitter : **Miss. Lynette Carlson** **Date: 08/29/2007**

Organization : **ATI Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a certified and licensed athletic trainer at ATI Physical Therapy, a private physical therapy clinic in Chicago, IL. My responsibilities include planning rehabilitation sessions and carrying these patients through the program along side physical therapists. I am a graduate of Southern Illinois University in Carbondale, where I earned my BS in Physical Education, specializing in Athletic Training. I followed my BS with a MS in Athletic Training from University of Tennessee at Chattanooga.

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,

Lynette Carlson,MS,ATC

Submitter : **Mr. Brent Leazzo** **Date: 08/29/2007**

Organization : **Joliet Junior College**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am the Head Athletic Trainer at Joliet Junior College in Joliet, Il. I have Bachlor degrees in Education and Athletic Training from Indiana University of Pennsylvania and a Master of Science in Kinesiology with a specialization in Athletic Training from The Indiana University. At JJC I provide direct medical coverage for more than 250 student athletes.

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

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

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

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

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Sincerely,

Brent I. Smith MS,ATC, LAT

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

Organization : **Dr. Brian Freeman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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 cnsure 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,
Brian Freeman, M.D.

Submitter : **Mr. Kevin Pennington** **Date: 08/29/2007**

Organization : **Delnor-Community Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Kevin Pennington and I am a certified athletic trainer that is currently the Team Leader of over 40 employees (physical therapists, physical therapist assistants, technicians, and occupational therapists). I have worked at Delnor for 15 years - 12 of which were treating patients and performing high school outreach to a local high school sports program. 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. In Illinois, we are licensed to practice just as is a physical therapist, occupational therapist and physical therapist assistant.

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,

Kevin M. Pennington, ATC, MBA
Team Leader - Outpatient Rehabilitation Services
Delnor-Community Hospital
Geneva, IL 60506
work - 630-208-5765
home - 630-896-2711

Submitter : Mr. Ricky Johns **Date:** 08/29/2007

Organization : Mr. Ricky Johns

Category : Other Health Care Provider

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing to remove Physical Therapy from the list of items that are exempt from physician self referral. I have personally seen physicians direct patients to their own clinics "to keep a close eye on them" and then refer other patients with more complicated conditions to other clinics based on the type of insurance the patient has. I have also seen patient with orders for physical therapy for 3x/week for 3 weeks to the physicians clinic, but when their insurance dictates they go elsewhere, the order gets changed to 3 visits for a home ex program. If the physician sees a possible bad outcome from surgery or other procedure, they will send the patient to other clinics, so their clinic can boast of "great outcomes". In general if a patient has poor potential or low reimbursing insurance the physician will make sure they are referred to other clinics, not their own. Patients with good potential will steered toward their own clinic despite having to pay a higher copay or deductible for out of network services, but the physician will tell the patient that their therapist know their protocols. When a therapist from out clinic calls the physicians office or their therapy clinic they will not give out the protocol or refer us to well known protocols in text books, but not THEIR protocol. If you would like to speak with me further, please call me at 423-431-6327 or cell number is 423-426-2245.

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

Organization :

Category : **Health Care Professional or Association**

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.

? 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,

Patricia Sheridan, CRNA
PO Box 1923
McKinney, TX 75070

Submitter : Mrs. Jackolin Pates-Swart, CRNA **Date:** 08/29/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

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

CMS-1385-P-11515-Attach-1.PDF

11515

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:

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- 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.
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Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : Ms. Clarissa Maynard **Date:** 08/29/2007

Organization : Ms. Clarissa Maynard

Category : Other Health Care Professional

Issue Areas/Comments

Background

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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).

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Sincerely,

Clarissa Maynard

Submitter : **Dr. Christopher Baggett** **Date: 08/29/2007**

Organization : **Dr. Christopher Baggett**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimore, Maryland 21244-8018

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Respectfully Submitted,

Dr. Christopher Baggett

Submitter : Dr. Cesar Trivino **Date:** 08/29/2007

Organization : Cesar Trivino, MD, PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

All medicare patients arc getting the best healthcare. Anesthesia payments should be increased.

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

Organization : **Dr. John Thurn**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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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.

John Thurn, M.D.

Submitter : **Mr. John Finley** **Date: 08/29/2007**

Organization : **Goldey-Beacom College**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is John Finley; I am a Certified Athletic Trainer from Delaware. I am currently employed by Goldey-Beacom College (NCAA Div II) as the Head Athletic Trainer. I am responsible for oversight of the Athletic Training Department at the college and I am responsible for the healthcare of 130 athletes in 10 varsity sports. This is my 17th year of service as a Certified Athletic Trainer and I have worked in most aspects of the profession. Over the past 17 years I have worked in the clinical setting, clinical outreach, youth sports organizations, middle school, High School, Small College (Div. II and III), Large College (Div. I), and Professional Athletics.

I am also currently the President-Elect, for the Delaware Athletic Trainers Association, and helped to shape the current laws in the state. The State of Delaware and the Delaware Physical Therapy Association have recognized the high level of education and training that Athletic Trainers possess. The current laws in Delaware allow Athletic Trainers to treat patients according to their education and training, not based on the setting in which they practice. For years we were allowed to evaluate, set up therapeutic exercise programs and make return to play decisions for Athletes in college and high school settings. However, when we entered the Physical therapy clinic we were not qualified to do anything but run errands. Does this make any sense, as soon as we enter the clinic we forget all of our education and training?

In Delaware we are now recognized for the education and training that we posses. With a physicians prescription for Athletic Training, Athletic Trainers have the ability to evaluate, treat and discharge patients. It gives the physician the ability to choose who is best qualified to treat a particular patient.

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,
John Finley MEd, ATC, LAT

Submitter : **Mr. Philip Johnson** **Date: 08/29/2007**

Organization : **American Association of Nurse Anesthetists**

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

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This increase in Medicare payment is important for several reasons.

Submitter : **Dr. Edmond Hattaway** **Date: 08/29/2007**

Organization : **ACA**

Category : **Chiropractor**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimore, Maryland 21244-8018

Re: 'TECHNICAL CORRECTIONS'

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

Edmond Hattaway, DC

Submitter : Mr. Tom Lyle **Date:** 08/29/2007

Organization : Flagstaff High School

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Dear Sir or Madam:

I am a certified athletic trainer and have worked at Flagstaff High School (AZ) for 21 years.

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

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

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

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

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

Sincerely,

Tom Lyle, M.S., ATC

Submitter : **Dr. Edward Nemergut** **Date: 08/29/2007**

Organization : **University of Virginia**

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. Barbara Morris** **Date: 08/29/2007**

Organization : **University of South Florida**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1385-P-11525-Attach-1.WPD

CMS-1385-P-11525-Attach-2.TXT

CMS-1385-P-11525-Attach-3.DOC

CMS-1385-P-11525-Attach-4.PDF

#11525

Dear Sir or Madam:

My name is Barbara Morris, I am a certified athletic trainer and strength and conditioning specialist. I currently oversee 10 certified athletic trainers placed in public school settings. In addition to that I assist in research, teach in the College of Medicine at the University of South Florida and complete other duties as assigned.

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,

Barbara J. Morris, MS, ATC/L, CSCS
Assistant Program Director,
The SMART Institute
Department of Orthopaedics and Sports Medicine
University of South Florida

Submitter : **Ms. Melynda Wallace** **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.
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,

Melynda Kaye Wallace MSN, CRNA, FAAPM
Staff Anesthetist
Cottage Hospital (A Critical Access Facility)
Woodsville, NH
603.747.9205

44 Goose Lane
Bath, NH 03740
mwallace@cottagehospital.org

City, State ZIP

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

Organization : Lewis University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a student at Lewis University graduating in May 2008. When I graduate, I plan to work as an Athletic Trainer for ATI Physical Therapy, where I am currently employed as a technician.

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,

William Sobodas II

Submitter : **Mr. John Craker** **Date: 08/29/2007**

Organization : **SAFE Anestbesia LLC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Administrator,

As a CRNA and a member of the AANA I am writing to support the Centers for Medicare and Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. As a provider of anesthesia services in rural areas I can attest to the fact that failure to elevate the conversion factor and continuing the 10% cuts proposed by Congress will have deleterious effects on the ability to retain and recruit providers in rural areas. CRNA's are the predominant providers to rural and medically underserved America. The continued availability of anesthesia services depends in part on fair Medicare payment for the CRNA's services. I applaud the agency's acknowledgement that anesthesia payments have been undervalued, and the proposal to increase the conversion factor will solidify the ability of CRNA's to provide quality anesthesia services to the rural and medically underserved areas of America.

Sincerely

John Craker MSN, CRNA, MBA
SAFE Anesthesia LLC
356 Miner Rd
Highland Hts, Ohio 44143

Submitter : **Dr. Jeff Konin** **Date: 08/29/2007**

Organization : **University of South Florida**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Dr. Jeff Konin, and I am a licensed physical therapist and certified athletic trainer at the University of South Florida. I am also the Director of the Athletic Training Education Program at USF.

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,

Jeff Konin, PhD,ATC,PT

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

Organization :

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

I am writing in strong opposition to the proposed rule dated July 12th containing an item under the technical corrections section calling for current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated.
In certain cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags" or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for futher diagnostic testing.
By limiting a Doctor of Chiropractic from referring for an X-ray study, the cost for patient care will go up significantly due to the necessity of a referral to another providor for DUPLICATIVE evaluation prior to referral to the radiologist. The patient will suffer as a result of this proposal.
I strongly urge you to table this proposal.

Submitter : **Ms. Kysha Harriell** **Date: 08/29/2007**

Organization : **University of Miami**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Scc Attachment

#11531

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Ms. Jane Steinberg** **Date: 08/29/2007**

Organization : **University of South Carolina**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS:

My name is Jane Steinberg and I am a certified athletic trainer, currently serving as the Clinical Education Coordinator for the Athletic Training Education Program at the University of South Carolina. I worked in an orthopedic clinic in Tennessee for nine years prior to this academic position.

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,

Jane Steinberg, ATC, SCAT
Clinical Education Coordinator
214 Blatt PE Center
University of South Carolina
Columbia, SC 29208

Submitter : **Ms. Pat Loe** **Date: 08/29/2007**

Organization : **San Benito Co. Board of Supervisors**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Pat Loe
San Benito Co.
Board of Supervisors
District 3
Hollister, Ca. 95023

To whom it may concern

San Benito County California is a regional neighbor and shares jurisdictional boarders with the counties of Monterey and Santa Cruz. As such we share many regional health care physicians and practices. Medicare physician fees in our geographic region are in dire need of adjustment to recognize the high cost of providing services here.

It is our belief that Option 3-revision to payment localities of the proposed rule is the most equitable and best option for California, but its calculation is faulty. If properly computed San Benito would qualify to be moved into the same locality as Monterey. The data that should be used to correctly calculate adjustments is the information unearthed by the General Accounting Office in its June Report.

Please review this data and it will be apparent that our needs in San Benito County are equally significant to our neighbor counties.

Sincerely

Pat Loe
Supervisor District 3

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

Organization : **Huntington Beach Fire Department**

Category : **Local Government**

Issue Areas/Comments

Ambulance Services

Ambulance Services

See attached

Beneficiary Signature

Beneficiary Signature

See attached

CMS-1385-P-11534-Attach-1.PDF

#11534

CITY OF HUNTINGTON BEACH

2000 MAIN STREET FIRE DEPARTMENT CALIFORNIA 92648

August 27, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

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

Dear Ms. Norwalk:

The Huntington Beach Fire Department provides emergency ambulance services to the communities which we serve. The proposed rule would have a direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. We therefore greatly appreciate this opportunity to submit comments on the proposed rule.

BENEFICIARY SIGNATURE

The Huntington Beach Fire Department commends CMS for recognizing that providers and suppliers of emergency ambulance transportation face significant hardships in seeking to comply with the beneficiary signature requirements. Ambulance services are atypical among Medicare covered services to the extent that, for a large percentage of encounters, the beneficiary is not in a condition to sign a claims authorization during the entire time the supplier is treating and/or transporting the beneficiary. Many beneficiaries are in physical distress, unconscious, or of diminished mental capacity due to age or illness. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

We believe strongly, however, that the relief being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and on the hospitals. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for ambulance services.

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

Organization : **AANA**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

August 29, 2007

Dear Administrator:

As a member of the American Association of Nurse Anesthetist, I write to support the Centers for Medicaid and Medicare Services proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor by 15% in 2008 compared with current levels. If adopted, the proposal would help to ensure that 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:
1) 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 and others have demonstrated that Medicare Part B reimburses for most services at approx 80% of private market rates, but reimburses for anesthesia services at approx 40% of private market rates.
2) 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.
3) 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.

If CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate 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,

Cissie Horton
425 Williams Drive
Apartment 637
Marietta, GA 30066

Submitter : **Ms. James Carroll** **Date: 08/29/2007**

Organization : **American Association of Nurse Anesthetists**

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.
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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.

I am an anesthesia provider in a rural hospital. Cutting reimbursement for anesthesia services, or failing to increase the valuation of those services, will compromise the access of rural Americans to quality health care, and in fact may threaten the survival of critically ill or injured patients.
Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : Dr. Lynn White **Date:** 08/29/2007

Organization : Dr. Lynn White

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11539-Attach-1.PDF

CMS-1385-P-11539-Attach-2.DOC

CMS-1385-P-11539-Attach-3.DOC

CMS-1385-P-11539-Attach-4.WPD

CMS-1385-P-11539-Attach-5.WPD

#11539

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 : **Mr. FREEBORN UKPEDE** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

http://www.aana.com/uploadedFiles/Members/Government_Relations/Federal_Issues/20070822_aana_%20memberlt_cms.pdf

Submitter : Mr. Reb Monaco **Date:** 08/29/2007

Organization : San Benito Co Board of Supervisors Dist. 4

Category : Local Government

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Reb Monaco
San Benito Co.
Board of Supervisors
District 4
Hollister, Ca. 95023

To whom it may concern

San Benito County California is a regional neighbor and shares jurisdictional boarders with the counties of Monterey and Santa Cruz. As such we share many regional health care physicians and practices. Medicare physician fees in our geographic region are in dire need of adjustment to recognize the high cost of providing services here.

It is our belief that Option 3-revision to payment localities of the proposed rule is the most equitable and best option for California, but its calculation is faulty. If properly computed San Benito would qualify to be moved into the same locality as Monterey. The data that should be used to correctly calculate adjustments is the information unearthed by the General Accounting Office in its June Report.

Please review this data and it will be apparent that our needs in San Benito County are equally significant to our neighbor counties.

Sincerely

Reb Monaco
Supervisor District 4

Submitter : **Dr. David Amar** **Date: 08/29/2007**

Organization : **Memorial Sloan-Kettering Cancer Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Anir Dhir **Date:** 08/29/2007

Organization : Dermatology Associates of Kentucky, PSC

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

This change will have a significant negative impact on the healthcare of U.S. citizens and potentially add unnecessary cost to the delivery of healthcare in this country, by reducing the cure rates for skin cancer from well over 99% to the 90-94% achievable with non-Mohs approaches and forcing more surgeries to be done in the hospital setting. Mohs micrographic surgery is the gold standard among all treatments for skin cancer, allowing the physician to examine 100% of the cancer margin to insure complete removal of the cancer with loss of as little normal skin as possible. The critical component of Mohs surgery includes meticulous removal and microscopic examination of the entire edge and deep margin of the cancer, in which the same physician serves as both surgeon and pathologist. The procedure is particularly valuable in the treatment of skin cancers in cosmetically or functionally important areas such as the face, neck, hands, feet and genitalia. It is also valuable for large, aggressive, or ill-defined cancers and for those that have recurred after other previous treatment.

In 2006, CMS reviewed the American Medical Association s Current Procedural Terminology (CPT) codes 17304 17310 (Mohs micrographic surgery) and requested that new site-specific codes be developed similar to those used for other excisional surgery. The American Academy of Dermatology, the American Society for Dermatologic Surgery, and the American College of Mohs Micrographic Surgery and Cutaneous Oncology participated in last year s review of the Mohs CPT codes, and new codes were adopted (17311-17315) addressing CMS concerns without adversely affecting the delivery of these services to patients in need. If the proposed change is enacted, we will be forced to change the way we deliver care in order to cover our costs of providing this service.

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

The exemption of the Mohs codes from the MSRR has been maintained by CMS since 1992 and was not questioned during the CMS mandated five-year review of the Mohs codes undertaken last fall or during presentation of the new Mohs codes to the AMA Relative Value Update Committee (RUC) in October, 2006. Our practice has been caring for the patients of Kentucky since 1951, and we have been successfully treating patients via Mohs surgery for 20 years. If the proposed change is enacted, patients will suffer and CMS will spend more to achieve less.

Submitter : **Mrs. Carrie Harris** **Date: 08/29/2007**

Organization : **American Association of Nurse Anesthetists**

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.

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 pproximately 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,

Carrie Harris, CRNA, MS, APNP
6626 West Ohio Avenue
Milwaukee, WI 53219

Submitter : Mr. Lewis Stanley **Date:** 08/29/2007

Organization : Mr. Lewis Stanley

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Submitter : Mr. Steve Gross **Date:** 08/29/2007

Organization : Capital High School (Randy Carlson)

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Steve Gross and I have been employed by Capital High School as an Athletic Trainer and Health Teacher for the past 17 years. I work with approximately 700 athletes, 67 Coaches who participate in 12 sports. I also have a successful relationship with the six Orthopedic Surgeons and four Physical Therapists that work directly with Helena School District #1 in Montana.

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,

Steven M Gross ATC.CSCS

Submitter : Mr. william darmody **Date:** 08/29/2007

Organization : aana

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please cosponser hr 1932 to reverse the 10% medicare cuts for anesthesia providers.

Submitter : **Dr. Ronald Albrecht** **Date: 08/29/2007**

Organization : **Dr. Ronald Albrecht**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

I STRONGLY, ...VERY STRONGLY support the inerease in ANESTHESIA unit value recommended for 2008 by the RUC.

Anesthesiology services were severely undervalued at the onset of RBRVS. This was openly acknowledged by CMS in it's comments in the FEDERAL REGISTER prior to implementation of anesthesia RBRVS. The RUC recommendations will partially correct the inequity.

As a RETIRED anestheiologist and, more importantly, a CURRENT MEDICARE BENEFICIARY I have a very strong interest in having the best medical services available to me. Please IMPLEMENT THE FULL INCREASE RECOMMENDED BY THE RUC. I want to stay alive as long as I can.

Submitter : **Dr. Kevin Anderson** **Date: 08/29/2007**

Organization : **Anesthesiology Group Associates, Inc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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.

Kevin Anderson, MD

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

Organization : **Mr. Steven Ippel**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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

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Sincerely,

Steven Ippel CRNA

1729 Andrew St. SE

Kentwood, MI 49508

Submitter : **Dr. Gretchen Schlabach** **Date: 08/29/2007**

Organization : **Northern Illinois University**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an associate professor and athletic training program director at Northern Illinois University. Furthermore, I have proudly served the National Athletic Trainers Association (NATA) as a member of the NATA Ethics Committee, NATAREF Research Committee, NATA Women in Athletic Training Committee, and NATAEC Post Certification Graduate Education Committee. Recently, I became the Chair of the NATA Ethics Committee and a member of the Ethics and Professional Standards Committee of the Commission on the Accreditation of Athletic Training Education (CAATE). My work in professional values and ethics has lead to the first text relative to Professional Ethics in Athletic Training.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
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,
Gretchen Schlabach, PhD, ATC, LAT

Submitter : **Dr. Ernesto Lombardi** **Date: 08/29/2007**

Organization : **North White Plains Chiropractic PC**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Ernesto Lombardi D.C.

Submitter : **Mrs. Stephanie Macy** **Date: 08/29/2007**

Organization : **Stephanie A. Macy, CRNA, PC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
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Sincerely,

Stephanie A. Macy, CRNA

4609 Wind Hill Ct. E.

Fort Worth, TX 76179

Submitter : Mrs. Patricia Satariano-Hayden **Date:** 08/29/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11554-Attach-1.PDF

#11554

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

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Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : Dr. Christopher Scoma **Date:** 08/29/2007

Organization : Dr. Christopher Scoma

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I am against the recommendations mentioned in the CMS 1385-P.

Submitter : Dr. steve caputo **Date:** 08/29/2007

Organization : Dr. steve caputo

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.

Resource-Based PE RVUs

Resource-Based PE RVUs

Leslie V. Norwalk, Esq.
Acting Administrator
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Submitter : Dr. Kirk Bailey **Date:** 08/29/2007

Organization : Anesthesiology Group Associates, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Anesthesia Coding (Part of 5-Year Review)

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Kevin Anderson, MD

Submitter : **Dr. Peter Sarfatis** **Date: 08/29/2007**

Organization : **Dr. Peter Sarfatis**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Submitter : Mrs. Sara Byerly **Date:** 08/29/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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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,
Sara Byerly, CRNA
2546 W. Pensacola
Chicago, IL 60618

Submitter : **Dr. Robert F. Koebert** **Date: 08/29/2007**

Organization : **Dr. Robert F. Koebert**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.

Robert F. Koebert, M.D.
Milwaukee, WI

Submitter : Dr. R. Kirk Reid **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

attachment

CMS-1385-P-11561-Attach-1.PDF

#11561

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.

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Helen Sarfatis** **Date: 08/29/2007**

Organization : **Mrs. Helen Sarfatis**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Collette Jones **Date:** 08/29/2007

Organization : SJAS

Category : Physician

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

please increase medicare pay rate.

Submitter : **Mrs. Christine Oha** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

August 29th, 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,
Christine Oha__BSN SRNA_____
Name & Credential
905 Marble Drive_____
Address
Naples, FL 34104_____
City, State ZIP

Submitter : **Dr. Daniel Butler** **Date: 08/29/2007**

Organization : **Anesthesiology Group Associates, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Daniel Butler, MD

Submitter : **Ms. Melanie Schuelein** **Date: 08/29/2007**

Organization : **Ms. Melanie Schuelein**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

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

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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

Thomas Wayne Hoffman, CRNA
3116 Bradford Place
Birmingham, AL 35242

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

Organization : **AANA**

Category : **Other Practitioner**

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:
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Sincerely,

Christopher M. James CRNA
2 Lori Ln
londonderry NH 03053

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

Organization : **Anesthesiology Group Associates, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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.

John Carter, MD

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

Organization : **Mr. Robert sarfatis**

Category : **Attorney/Law Firm**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Eric Chapman** **Date: 08/29/2007**

Organization : **Anesthesiology Group Associates, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

Eric Chapman, MD

Submitter : **Mrs. Brandi Sarfatis** **Date: 08/29/2007**

Organization : **Mrs. Brandi Sarfatis**

Category : **Attorney/Law Firm**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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Thank you for your consideration of this serious matter.

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

Organization : **Anesthesiology Group Associates, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

James Fenn, MD

Submitter : Dr. W. Robert Battle **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11574-Attach-1.PDF

#11574

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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Thank you for your consideration of this serious matter.

Submitter : **Ms. Chloe Sarfatis** **Date: 08/29/2007**

Organization : **Ms. Chloe Sarfatis**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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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.

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Ronald MacKenzie** **Date: 08/29/2007**

Organization : **Dr. Ronald MacKenzie**

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 believe it is extremely important 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. This must not be allowed to happen.

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 and complete 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.

I appreciate your atention to this urgent matter.
Thank you.
Sincerely,

Ronald A. MacKenzie, D.O.
1841 Terracewood Drive, NW
Rochester, MN 55901

Submitter : **Ms. Margaret Sarfatis** **Date: 08/29/2007**

Organization : **Ms. Margaret Sarfatis**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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-11578

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

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11578-Attach-1.PDF

#11578

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

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

Organization : ACA

Category : Chiropractor

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

To restrict the reimbursement for X-rays provided by a non-provider physician taken due to referral by a chiropractic physician is inefficient and potentially dangerous. It is inefficient because if the chiropractic physician decides that X-rays are necessary to diagnose the patient's condition or to rule out pathology or to determine the need for additional studies to ascertain the potential need for referral, the patient (and Medicare) would have to undergo the additional expense of an additional office consultation as well as the payment for the radiographic study. It is potentially dangerous because it could deprive the chiropractic physician of timely information which prevent treatment, thereby leading to a worsening of the presenting condition, or delay the diagnosis of a potentially life threatening condition. It would also contravene the scope of practice laws governing the practice of Chiropractic in most of the states which are the regulating entities of the profession.

Submitter : **Mr. Randy Ashman** **Date: 08/29/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Please see attached PDF document for comments.

Randy Ashman

CMS-1385-P-11580-Attach-1.PDF

11580

August 30, 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,
Randy Ashman, CRNA
8123 SW 184th Ave
Aloha, OR 97007

Submitter : Mrs. Shawna Benner-Erickson MPT **Date:** 08/29/2007

Organization : Lake Country Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

RE: Physician owned physical therapy facilities.

Physician owned physical therapy clinics benefit the patient, physical therapist and physician in many ways. I am a physical therapist working for an orthopedic physician in Idaho and see on a daily basis the positive impact a physician owned physical therapy clinic has on all those involved. I have worked in other clinics owned and operated by a physical therapists and always felt the inability to be in close contact with my patient s physician was a hindrance in their recovery. Now I have constant interaction with my patient s physician and surgeon, which provides me with a detailed understanding of their diagnosis and condition, pre-warning of possible obstacles, immediate response to questions or concerns regarding their care and ongoing updates on medical changes.

All of our patient s have been very happy with the clinic arrangement, as they are confident I have a detailed knowledge of their surgical history and precautions prior to treating them as well as immediate updates on medial changes throughout their eare. They are also guaranteed quick answers to questions they may have regarding their care and recovery even if I don t have an answer, as I can easily check with their physician and get them the answers they need to keep them safe. These are all things patient s would expect from all physical therapists, but after working in others settings I know it is very difficult to get detailed information on a patient s condition or surgery and when questions arise it often take days to get answers, which does not only limit patient progress but could put them in danger. By attending a physician owned physical therapy clinic patients are also able to use the most state of the art equipment, which physician and therapist pick together to best fit the patient population and post surgical needs. Due to these benefits both myself and the physician have seen quicker and better overall patient recovery since the clinic opened.

In addition to benefiting our patients, I have also gained a great deal by working for a physician. First and foremost is the knowledge I have received regarding surgical procedure and recovery. This is something I would have never received working in a traditional physical therapy setting as it is not available in standard continuing education curriculums and was only briefly covered in physical therapy school. Working directly with a physician has also given me access to a extended network of healthcare information including a wide range of medical professionals, orthopedic and rehabilitation journals specific to my post surgical patients and health care databases,

allowing immediate answers to medical questions, which I never had working in a physical therapist owned clinic. I feel the additional knowledge and training I have received in the short time working for a physician has made me a more qualified and confident physical therapist and allowed me to better treat my patients.

Those physical therapists who disagree with physician owned physical therapy clinics are only looking at the financial impact on their own physical therapy businesses and not the advantages it creates for patients. They fear that physicians who own their own clinics will no longer allow patients to attend other physical therapy clinics but this is not true. Patients are always informed that they have the option to attend any physical therapy clinic and are told by the physician that he has financial interest in the elinic. With this open patient physieian relationship the patients follow up is always in their own hands. This is no different than a physician working for a hospital referring to that same hospital.
Physical therapists need to realize that they are not loosing patients to the physician, the patient is just being provided with more options in their care and recovery. Physicians should be able to own PT clinics.

Submitter : **Ms. Carmen Sarfatis** **Date: 08/29/2007**

Organization : **Ms. Carmen Sarfatis**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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To ensure that our paticnts 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 implcmenting the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. Jeremy Heitmeyer **Date:** 08/29/2007

Organization : UTHSCSA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Thank you for your consideration of this serious matter.

Submitter : Dr. D. Chan Henry **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

CMS-1385-P-11584-Attach-1.PDF

11584

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Kenneth Schuelein** **Date: 08/29/2007**

Organization : **Mr. Kenneth Schuelein**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

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

Organization : Anesthesiology Group Associates, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Nancy Neher, MD

Submitter : **Mr. Manuel Bonilla** **Date: 08/29/2007**

Organization : **Mr. Manuel Bonilla**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

Since the implementation of the fee schedule in 1992, payments for anesthesia services under Medicare have been undervalued.

This proposed rulc -- providing for an increase in anesthesia work values -- represents an important step toward correcting a longstanding inequity.

Please move forward in finalizing, as currently written, the proposed increase for anesthesia work values.

Thank you.

Submitter : **Mrs. Maxine SChuelein** **Date: 08/29/2007**

Organization : **Mrs. Maxine SChuelein**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

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

Organization : Southern Utah University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11589-Attach-1.DOC

11589

SUU SOUTHERN UTAH UNIVERSITY

Physical Education Department
(435) 586-7816

August 29, 2007

Dear Sir or Madam:

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,

Ben Davidson, MS, ATC
Athletic Training Major Program Director

351 W. University Blvd., Cedar City, UT 84720

Submitter : Dr. Robin Patty **Date:** 08/29/2007

Organization : Anesthesiology Group Associates, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Robin Patty, MD

Submitter : Dr. Jill Hester **Date:** 08/29/2007

Organization : Dr. Jill Hester

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk,
I am writing to express my full support for the proposal to increase anesthesia payments in the 2008 Physician Fee Schedule. I appreciate that CMS has acknowledged the underpayment for such services, and the Agency is taking steps to correct this tough issue.
It is imperative that the CMS follows through with this to assure expert medical anesthetic care for our growing numbers of seniors in the US. Thank you for your time and consideration.

Jill Hester MD

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

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11592-Attach-1.PDF

11592

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Ronald Robinson** **Date: 08/29/2007**

Organization : **High Plains Anesthesia Consultants**

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.

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

Organization : Anesthesiology Group Associates, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Jeffrey Pisto, MD

Submitter : **Ms. mary ann uznis** **Date: 08/29/2007**

Organization : **Uznis Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

PHYSICIAN SELF-REFERRAL ISSUES

I urge CMS to remove PT services from permitted services under the in-office ancillary exception. I am a physical therapist in Detroit, Michigan and have been practicing since 1971. We DO NOT have direct access in this state which allows physicians even greater control over physical therapy for the Medicare patient.

There is a great potential for fraud and abuse when physicians are able to refer Medicare beneficiaries to PT facilities in which they have a financial interest. Physicians who own practices that provide PT services have an inherent financial incentive to continue to refer patients and statistics have shown this overutilization.

We have received many phone calls and have treated patients that have relayed to us that their physician instructed them to ONLY ATTEND THEIR PT CLINIC- that they would not write a PT referral for another PT facility! This is restriction of trade.

Thank you for your consideration-Sincerely, Mary Ann Uznis PT

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

Organization : AANA

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11596-Attach-1.DOC

11596

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.
_ 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,
Cheryl McGinnis, CRNA, MS
350 N. Second St. #101

San Jose, CA 95112

Submitter : Dr. Peter Odland **Date:** 08/29/2007

Organization : Skin Surgery Center

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

This proposal represents a dramatic reversal of sixteen years of the Centers for Medicare and Medicaid Services (CMS) own determination that the Mohs codes are and should be exempt from the Multiple Procedure Reduction Rule (MPRR). Furthermore, because of the dual components of surgery and pathology associated with each Mohs surgery procedure, there is no gain in efficiencies when multiple, separate procedures are performed on the same date, making application of the reduction inappropriate. Third, this proposal is contrary to the Relative Value Update Committee s (RUC) own policy regarding procedures qualifying for exemption from this rule. Fourth, this proposal will negatively impact Medicare beneficiaries access to timely and quality care. Fifth, application of this proposal will not likely generate significant cost savings and may paradoxically increase costs of providing care to these patients. Finally, we are concerned that the Proposed Rule reflects an alteration in the traditional role of the RUC in CMS policy formulation.

Submitter : Dr. Melinda Prevost **Date:** 08/29/2007

Organization : Anesthesiology Group Associates, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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.

Melinda Prevost, MD

Submitter : Dr. H. Clark Ethridge **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11599-Attach-1.PDF

#11599

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Ms. Ferne Cohen** **Date: 08/29/2007**

Organization : **Ms. Ferne Cohen**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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

This increase in Medicare payment is important for several reasons.

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

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

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

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

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

Sincerely,
Ferne M. Cohen CRNA, MS,MSN
108 Whitchall Dr Voorhees NJ 08043

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

Organization : **Physical Therapy and Sports Inury Rehabilitation**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

My name is Thomas Essig and I am writing in regards to the 2008 Medicare physician fee schedule rule. I have read that CMS expressed concern that the in-office ancillary services exception to the Stark law is being misconstrued and created a thriving environment for fraud ad abuse. I have been a practicing Physical Therapist for over 32 years. I have seen over the last few years an increase in the number of physician owned physical therapy clinics. Physicians who own practices that provide physical therapy services have and inherent financial incentive to refer their patients to the practices they have invested in. Because of Medicare referral requirements, physicians have a captive referral base of physical therapy patients in their offices. I have observed that those arrangements can impact the care of patients referred to physical therapy. I have often seen physicians who own their physical therapy clinies demand that their patients can only be seen at their clinies. This limited choice of physical therapy locations and hours of operation can be very inconvenient and not in the best interest of the patient.

By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS could improve the overall care and services of physical therapy patients.

Thank you for your understanding in this matter.
Sincerely,
Thomas Essig P.T.

Submitter : **Dr. gisele wilke** **Date: 08/29/2007**

Organization : **Dr. gisele wilke**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Norman Ritchie **Date:** 08/29/2007

Organization : Anesthesiology Group Associates, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Norman Ritchie, MD

Submitter : **Dr. Barry Aden** **Date: 08/29/2007**

Organization : **Jackson Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11604-Attach-1.PDF

11604

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : Ms. Ronnie Wing, CRNA, MSN **Date:** 08/29/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a Certified Registered Nurse Anesthetist, I am asking you to finalize your proposal to increase the value of anesthesia work by 32%, and to increase the anesthesia conversion factor by up to 25% in 2008.

Submitter : Dr. Katherine Normand **Date:** 08/29/2007

Organization : UT Houston Medical School

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

This is extremelly important for teaching institutions and our ability to recruit faculty. Increasing our RVU will benefit our medical school and produce better trained residents if we can maintain faculty that deserve to be adequately reimbursed.

Submitter : Dr. Cynthia Schwartzenburg **Date:** 08/29/2007

Organization : Anesthesiology Group Associates, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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.

Cynthia Schwartzenburg, MD

Submitter : Dr. Annalisa Gorman **Date:** 08/29/2007

Organization : skin surgery center

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

This proposal represents a dramatic reversal of sixteen years of the Centers for Medicare and Medicaid Services (CMS) own determination that the Mohs codes are and should be exempt from the Multiple Procedure Reduction Rule (MPRR). Furthermore, because of the dual components of surgery and pathology associated with each Mohs surgery procedure, there is no gain in efficiencies when multiple, separate procedures are performed on the same date, making application of the reduction inappropriate. Third, this proposal is contrary to the Relative Value Update Committee s (RUC) own policy regarding procedures qualifying for exemption from this rule. Fourth, this proposal will negatively impact Medicare beneficiaries access to timely and quality care. Fifth, application of this proposal will not likely gencrate significant cost savings and may paradoxically increase costs of providing care to these patients. Finally, we are concerned that the Proposed Rule reflects an alteration in the traditional role of the RUC in CMS policy formulation.

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

Organization : Lake Country Orthopaedics and PT

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

This is a letter outlining my feelings of the proposed plan by the American Physical Therapy Association to support a bill eliminating the ownership of physical therapy and rehabilitation facilities by physicians and to prevent them from referring to those facilities that they have an interest in.

I as an orthopedic surgeon have been fully trained in rehabilitation. We spend several months and then a considerable amount of time working with the rehabilitation of injured patients in our training programs. I have a special interest in sports medicine, and after starting working as a team physician in Colorado I had the hospital develop a physical therapy program designed to help me rehabilitate my patients. There were no facilities of any kind at that time doing that. I also began working with the athletic trainers and eventually began teaching methods for physical trainers in regard to postoperative care of patients. That was in Texas at Southwest Texas University. During those years I had my own physical therapy along with my partner specifically addressing the needs of post surgical rehabilitation of the athlete. Since coming to Idaho I have been continually .frustrated with the ability to get my postoperative patients adequately rehabilitated by therapists. Therapists as a rule know little or nothing about the post surgical rehabilitation of patients and have little understanding of the operative procedures that were done.

Until last year I had tried to utilize local therapists, some of which are much better than others, but all of which lack some basic understanding of what I am trying to achieve. When the two therapists that I use primarily told me about 2 years ago that they never listened to what I asked them to do anyway, that they simply rehabilitated on their own protocols, I decided that it was time that I needed to take charge of the rehabilitation of my own patients. Several of my patients over the last few years have been irreversibly injured by the therapists, and more commonly they receive inadequate rehabilitation and have difficulty regaining their normal function ability.
Since I have owned my own therapy I have been able to teach my specific therapists exactly what I want in the postoperative courses and the reason why it needs to be done. We need to, at least 2-3 times a week, discuss a patient's progress and the
rationale and need for a specific treatment modality. This team approach and the rehabilitation,of these patients is the same technique that I used in Texas utilizing a physical therapist and an athletic trainer.
The results over the last year and a half have been dramatic. My patients achieve a much higher level of recovery of their function and are able to return to sports-specific activities which was difficult in the past. I have also had no injuries to any patient to date in part because of the procurement of state of the art rehabilitation equipment for these specific joints.
If physicians such as I who are dedicated to rehabilitation, and have been ,for 20 years, are prevented from continuing in our desire for excellent outcomes surgically then poor patient outcomes will be the result and continued frustration on the surgeons' part.

Submitter : Dr. Bill Hulett **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11610-Attach-1.PDF

11610

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : Anesthesiology Group Associates, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Mark Shoptaugh, MD

Submitter : **Dr. Herman Crowder** **Date: 08/29/2007**

Organization : **Jackson Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11612-Attach-1.PDF

#11612

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Mr. robert wood** **Date: 08/29/2007**

Organization : **aana**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Mrs. Melissa Thompson** **Date: 08/29/2007**

Organization : **Louisiana State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am a Certified Athletic Trainer employed by Louisiana State University as an instructor in the Department of Kinesiology. I earned a Masters degree from the University of Virginia and a Bachelors degree from Truman State University. I am currently working towards my Doctorate degree in the area of musculoskeletal mechanics. In my seven years of practice as a Certified Athletic Trainer I have provided services for high school and college athletes, physically active college students, military academy students, professional athletes in various sports, police, fireman, and a variety of other physically active individuals. I have also worked with several physicians to provide cost efficient athletic training services to their patients and enhance the overall quality of healthcare afforded to these 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. 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,
Melissa D Thompson, MEd, ATC, LAT
Louisiana State University
Department of Kinesiology
Baton Rouge, LA 70803

Submitter : Dr. Shepard Pryor **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11615-Attach-1.PDF

#11615

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. Marcy Julvezan **Date:** 08/29/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Dcar Administrator:
As a mcmbcr of thc American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicarc & Medicaid Scrvices (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 cnsurc that Ccrtified Rcgistcred Nursc Anesthetists (CRNAs) as Medicare Part B providers can continue to providc Mcdicarc bcncficiaries 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 scrviccs, putting at risk thc availability of anesthesia and other healthcare services for Mcdicare 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 privatc 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, thc 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 serviccs 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 rcimbursed at a ratc 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 serviccs, 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 thc valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Marcy A. Julvczan CRNA, MS

Submitter : **Ms. Carol Sauer** **Date: 08/29/2007**

Organization : **Physiotherapy Associates**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

RE: Physician Self-Referral Issues

August 29, 2007,

Dear Mr. Weems:

I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue of physician self-referral and the in-office ancillary services exception.

I am a physical therapist and have practiced in Columbus, Ohio for 14 years. Over this time I have developed many professional relationships with area physicians as a result of a team approach in caring for patients.

Likely due to declining reimbursement for medical services many physicians have established ancillary service lines to replace income. My concern is the growing trend of physicians owning physical therapy practices. I believe physicians have changed from focus on patient care and networking with reputable ancillary providers to focus on manipulating patients to receive ancillary services exclusively within their privately owned service lines.

The patients are not given a choice about where they go for physical therapy; I have first hand knowledge of this. They are scheduled for their initial evaluation at the off-site referral for profit therapy facility while they are still in the physician office.

Patients that myself and my co-workers have treated successfully for previous conditions have not been permitted to return to see us with current conditions/injuries because the physician instructions were to go to the physician owned facility only.

Physician ownership of physical therapy facilities provides opportunity for fraud and abuse with over-utilization of referrals. In fact, private insurances have begun to investigate the over-utilization practices of physicians. Patients are aggressively pushed toward what are now out-of-office ancillary services owned by the physician, despite convenience of location or preference by the patient.

Physicians that own practices that provide physical therapy services have an inherent financial incentive to refer patients to the practices they have invested in and to over-utilize those services for financial reasons. By eliminating physical therapy as a designated health service furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse and over-utilization of physical therapy services under the Medicare program, and enhance the quality of patient care.

Thank you for your interest in this matter.

Sincerely,

Carol Sauer, PT
4605 Sawmill Road
Columbus, Ohio
43220

Submitter : Dr. Joe Golden **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11618-Attach-1.PDF

#1618

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.

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

Organization : Elizabeth Lonsdale

Category : Other Health Care Professional

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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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,

Elizabeth M. Lonsdale, CRNA
92 Colbath Rd
Poland Spring, ME 04274

Submitter : Dr. Douglas Evans **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11620-Attach-1.PDF

#11620

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : Ms. Theresa Witt-Heilman **Date:** 08/29/2007

Organization : Ozark Anesthesia Associates, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-1385-P-11621-Attach-1.TXT

11621

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.

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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,

Theresa Witt-Heilman
Claims
Ozark Anesthesia Associates, Inc.

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

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007

To Whom it May Concern:

I am an orthopedic surgeon specializing in sports medicine who would like 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.

Athletic trainers are qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. Their education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed athletic trainers to be qualified to perform these services.

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

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

Sincerely,

Michael J. Stuart MD
Professor and Vice-Chairman, Department of Orthopedics
Co-Director, Sports Medicine Center
Mayo Clinic
Chief Medical Officer, USA Hockey
Rochester, MN 55905
(507)-284-3462
stuart.michael@mayo.edu

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

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11623-Attach-1.PDF

#11623

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 : **Julie Leslie** **Date: 08/29/2007**

Organization : **bodylink**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
Hello, my name is Julie Leslie and I have worked as a certified athletic trainer since the fall of 2002. I have worn many hats as I have worked both in the clinical and secondary school settings. I have been able to use what I learn at the clinic with my athletes at the high school and I find many ways to utilize what I see and learn while at the high school with patients in the clinic. I work beside my co-workers, who are physical therapists to give the best service possible to our 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. 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,

Julie Leslie, ATC

Submitter : **Mr. Charles O'Con** **Date: 08/29/2007**

Organization : **Natchitoches Anesthesia Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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.
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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,

____Charles O Con_____
Name & Credential
____215 Celina Drive,_____
Address
____Natchitoches, LA 71457_____
City, State ZIP

Submitter : **Dr. Luis Lahud** **Date: 08/29/2007**

Organization : **American society of anesthesiologists**

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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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.

Luis Lahud, MD

Submitter : **Miss. Jessica Benoit** **Date: 08/29/2007**

Organization : **The RehabGYM, Incorporated**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11627-Attach-1.DOC

#1627

Dear Sir or Madam:

I am a recent graduate of the University of Vermont with a Bachelor's degree in Athletic Training – a CAAHEP approved program. I am currently employed at the RehabGYM, Incorporated in Williston, Vermont, awaiting Board of Certification Licensure.

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 aspiring Athletic Trainer, I will be qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam 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.

Please listen to our voices, for you are affecting thousands of careers with the decisions you make to restrict our profession further. We are qualified health care professions, and Americans are in need of our care now more than ever.

Sincerely,

Jessica L. Benoit

Submitter : Dr. Carroll McLeod **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11628-Attach-1.PDF

11628

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Joe Durfey **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11629-Attach-1.PDF

#11629

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Mrs. Katrina O'Con** **Date: 08/29/2007**

Organization : **Capital Anesthesia**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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:

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? 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,

____Katrina O Con, CRNA_____
Name & Credential
____215 Celina Drive,_____
Address
____Natchitoches, LA 71457_____
City, State ZIP

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

Organization : **Mrs. Jennifer Harenberg**

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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Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Ms. Catherine L'Heureux** **Date: 08/29/2007**

Organization : **Ms. Catherine L'Heureux**

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
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Sincerely,
Catherine L'Heureux, CRNA, MSNA
22 Kingsbury Lane
Kennebunk, ME 04043

Submitter :

Date: 08/29/2007

Organization : **OSF St. Francis Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11633-Attach-1.DOC

#1133

Dear Sir or Madam:

I am a certified athletic trainer currently employed in an outpatient hospital physical therapy center, along with high school outreach. I have a bachelor's degree in Athletic Training and a Master's degree in Sports Health Care.

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. This includes functional rehabilitation and return to activities of daily living, which are important for patients to maintain their independence. 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. Cost-effective, knowledgeable, efficient, high quality, functional care and treatment.

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,

Brandie DuPont, MS, ATC, CSCS

Submitter : **Dr. Rick Himes** **Date: 08/29/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

P.O. Box 8018
Baltimore, MD 21244-8018

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Rose Tomaro** **Date: 08/29/2007**

Organization : **Project Healthy Bones**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

I urge CMS to re-evaluate the cuts in reimbursement for DXA screening. This cut will result in more fracture rates in NJ adding greater financial burden to the state and its residents. Prevention always is less costly than the cure.

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

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Agnes Lina** **Date: 08/29/2007**

Organization : **Dr. Agnes Lina**

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
Baltimorc, MD 21244-8018

Rc: CMS-1385-P

Anesthesia Coding (Part of 5-Ycar Review)

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Jennifer Vitale** **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:

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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,
Jennifer Vitale RN,BSN,CCRN,SRNA

Submitter : Dr. G. Kline Milner **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11639-Attach-1.PDF

#11639

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.

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

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

CMS,
Please help move forward this increase for services for all anesthesia providers. Most of these patients are a far higher risk group. To cut reimbursement further does not do this group justice as well as the added providers involvement. I feel you will loose more practioners willing to take adequate care of these deserving patients.
Sincerely,

James Cleveland

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

Organization : Millennium Pharmaceuticals, Inc.

Category : Drug Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11641-Attach-1.DOC

#11641

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : Mr. C. Edward Brown **Date:** 08/29/2007

Organization : The Iowa Clinic

Category : Other Health Care Provider

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

please see attachment

CMS-1385-P-11642-Attach-1.DOC

#11642.

THE IOWA CLINIC®

August 29, 2007

Herb Kuhn, Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services

by electronic submission

Comments to **CMS--1385--P**
M. **PHYSICIAN SELF-REFERRAL PROVISIONS**

Dear Mr. Kuhn:

The Iowa Clinic is a 120 provider, physician owned, professionally managed, integrated multi-specialty clinic located in Des Moines, Iowa. We provide in-patient services at all five Des Moines area hospitals and outpatient services throughout central Iowa. The significant changes proposed to the regulations, for which comment is sought, will have a negative effect on the delivery and availability of quality health care in Iowa.

The Stark law is intended to promote competition in the healthcare marketplace. It is also the directive of CMS and the regulations to promote cooperation and partnerships among providers in order to manage utilization, improve availability, and increase efficiency. Since the adoption of the Phase I and Phase II rules we have invested considerable effort and expense to develop arrangements which meet the regulations. Some of these arrangements have allowed us to bring improved technology and service to the community in a cost effective manner. Others have allowed us to be more competitive in a market where specialists are in short supply and recruitment is challenging.

The proposed changes will require, if adopted, that we and many other physician groups evaluate our existing contracts and partnerships and potentially unwind, discontinue or restructure those arrangements. Undoing these partnerships will do nothing in Central Iowa to improve the cost effectiveness of healthcare that was one of the initial objectives.

In-Office Ancillary Services Exception:

This exception has fostered the convenience, integration and availability of health services. In-office ancillary services not only assist diagnosis and plan of treatment, but enhance the coordination of care and the convenience of care. Patients or families of patients may schedule multiple physician, diagnostic testing and therapy visits for the same time and same location. Adjustments, corrections or changes to testing and therapies are more readily accomplished and communicated when physicians are at the location.

Requiring that in-office ancillary services be limited to essentially "incident to" services is contrary to the notion of integrated, coordinated healthcare. Providing physical therapy and other treatment therapies within the clinic is effective, efficient care and service for our patients. This is of particular

Downtown Administration
1215 Pleasant Street, Suite 618 • Des Moines, IA 50309 • Phone 515-241-5785 • Fax 515-241-4415

concern to a multi-specialty group practice like The Iowa Clinic. No change to the ancillary services exception is warranted.

Unit-of-Service (Per Click) Payments in Space and Equipment Leases:

First, the legislative history protecting such arrangements under controlled conditions has not changed and should be honored by the agency.

More important is that per use arrangements recognize the economic reality of costs associated with the use or "click" of a piece of equipment. The cost of maintenance and supplies are often directly tied to the number of uses. The useful life of parts and the equipment itself will be dependent on how often it is used.

Also, a "per click" lease encourages investment in new equipment and new technology. We have been able to assist in bringing a CyberKnife to perform stereotactic radiosurgery to Des Moines and avoid sending patients to Chicago, Denver or Minneapolis. A "per click" lease was best suited for this equipment and its $4 million cost. We, and the community we serve, have relied on the ability to establish unit-of-service leases. The current protections against abuse of such arrangements are sufficient safeguards.

Again addressing the proposed changes generally, they discourage and restrict the ability of the integrated multi-specialty physician group practice to produce income from sources other than a direct fee for service. The underlying premise is that abuse through over utilization is inherent in these arrangements. Initially, the presumption of abuse is offensive to physicians who are using their best clinical judgment in determining the medical necessity for referrals and ancillary services. Secondly, there are other methods and means for monitoring over utilization and certifying standards of performance.

In an effort to control "gaming" (*see* 72 FR 133, p. 38180 (July 12, 2007)) we do not need to dismantle a healthcare infrastructure developed in reliance on the existing rules. This will be detrimental to both patients and practitioners. If integrated, available, convenient, quality healthcare is a goal, the newly proposed regulations will not achieve it. The potential unwinding of existing arrangements will have the effect of reducing service and slowing, if not stopping, the use of new technology, innovative treatments, and coordinated care with our community hospitals.

It is reasonable to allow integrated physician group practices the opportunity for a reasonable business return through arrangements that meet the current rules. These arrangements are already well regulated. We are gravely concerned that the "tightening" of the self-referral rules will, if adopted, require us and other multi-specialty clinics to move away from the infrastructure of integrated, coordinated care they have been trying to build and promote. The tightening of the rules contemplated in this section at a time when there is a lack of dependability of funding through the federal payment systems presents an even greater risk. Thank-you for your consideration.

Sincerely,

C. Edward Brown
Chief Executive Officer

Downtown Administration
1215 Pleasant Street, Suite 618 • Des Moines, IA 50309 • Phone 515-241-5785 • Fax 515-241-4415

Submitter : **Dr. Paul Carrell** **Date: 08/29/2007**

Organization : **Dr. Paul Carrell**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Paul T. Carrell, MD
3101 Toro Canyon Rd
Austin, TX 78746
paultcarrell@hotmail.com

Submitter : Dr. F. Michael West **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11644-Attach-1.PDF

#11644

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

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

Organization : **AANA**

Category : **Other Health Care Professional**

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.
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Sincerely,
Bertha Lovelace CRNA,

20775 farnsleigh rd,

shaker Hts Ohio,44122

Submitter : **Dr. Derek Marshall** **Date: 08/29/2007**

Organization : **Jackson Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

CMS-1385-P-11646-Attach-1.PDF

#11646

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. J David Netterville** **Date: 08/29/2007**

Organization : **Cardiovascular Anesthesiologists, PC**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Pascual Guerrero** **Date: 08/29/2007**

Organization : **Mr. Pascual Guerrero**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Pascual Guerrero and I am an athletic training student at the Brooklyn Campus of Long Island University. My experiences include a physical therapy clinic as well as college and professional sports.

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,

Pascual Guerrero, ATS

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

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11649-Attach-1.PDF

#11649

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : Dr. J. Edwin Dodd **Date:** 08/29/2007

Organization : Jackson Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11650-Attach-1.PDF

11650

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

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

Organization : **Chris Jurgensmeyer**

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.
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,
Chris Jurgensmeyer, CRNA
4453 Brookhaven Terrace
Clarksville, TN 37043

Submitter : **J. Mark Skaggs** **Date: 08/29/2007**

Organization : **Orthopedic Rehab Specialists**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007

To Whom It May Concern:

My name is J. Mark Skaggs, PT, CSCS, at Orthopedic Rehab Specialists in Rockford, IL. I am writing this brief note input regarding the closure of the Stark Referral for Profit loophole. An orthopedic surgeon here in Rockford, IL, referred an individual with a greater tuberosity fracture and adhesive capsulitis for treatment here at our clinic. She was an elderly individual who had problems for quite some time prior to referral to physical therapy. She was seen successfully in physical therapy here at Orthopedic Rehab Specialists for approximately 4 weeks of treatment prior to her recheck with her physician.

The physician at that time during the recheck stated that he would like to have the individual be seen in his own specific clinic for physical therapy secondary to the fact in her words He could keep an eye on her progression more specifically despite the fact that Orthopedic Rehab Specialists is no more than 1 ? to 2 miles from this physician owned physical therapy clinic. The patient was understandably upset regarding the fact that she was in her own words forced to stop coming to ORS and to go the physician owned clinic and the physician would not budge stating that he had to keep an eye on her despite her improvements at our independent physical therapy department.

Unfortunately, these occurrences with physician owned physical therapy practices are occurring much too often and independent practices of physical therapy like Orthopedic Rehab Specialists are being put at a significant disadvantage. Physical therapy services should definitely be excluded from the in-office ancillary services exception.

Sincerely,

J. Mark Skaggs, PT, CSCS

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 strongly support 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.

The RBRVS created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Now, 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 begin to 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.

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

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

Thank you for your consideration of this serious matter.

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

Organization : Gastroenterology Center of Connecticut

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The CMS comment on POD labs, if it goes forward, should be careful to differentiate "pass-through" arrangements from true in-office laboratories. Physician office laboratories in my experience are often of superior quality providing cost-effective and efficient medical care that serves the needs of community physicians far better than most hospital labs, centralized pathology groups, or large national independent labs. Pathologists in in-office laboratories have full access to patient medical information - this alone is a vast improvement over the potential service that can be provided by remote pathologists. In-office turnaround times are days to weeks better than the alternatives. Clerical error rates are lower because information systems are coordinated.
The CMS should be aware that the current campaign against so-called "pod" labs is led by a few self-interested private pathologists, some in leadership positions in our national organizations, who wish to monopolize the outpatient biopsy market. These people are using scare tactics to paint with the same brush any nontraditional pathology arrangement, without regard to any real demonstation of quality problems. I suggest that instead of focusing on the straw man of pod labs, the CMS require all providers of pathology services to demonstrate quality of service and appropriateness of utilization, as per CLIA 88, to end the ongoing abusive pathology practice that is occurring in traditional pathology groups, independent labs and academic centers.

Submitter : **Mr. Birger Baastrup** **Date: 08/29/2007**

Organization : **City Center Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Medicare Telehealth Services

Medicare Telehealth Services

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Birger Baastrup, D.C., C.C.S.P.

Submitter : Ms. judith gron **Date:** 08/29/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

see attachment

#11656

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mrs. Kristie Hoch** **Date: 08/29/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Provider**

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.
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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).
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Sincerely,
Kristie Hoch, CRNA
69 Main Road South
Hampden, ME 04444

Submitter : **Ms. Stepahnie Sibeto** **Date: 08/29/2007**

Organization : **Susquehanna Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P-11658-Attach-1.DOC

CMS-1385-P-11658-Attach-2.DOC

#11458

Dear Sir or Madam:

Hi, I am Stephanie Sibeto, athletic trainer at Sullivan County high school. I am outreached by Susquehanna Health in Williamsport, PA. I received my B.S. at Lock Haven University and received my Master of Education from Temple University. I worked 14 yrs at the collegiate level and the past 3 years have been at the high school level.

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,

Stephanie Sibeto, ATC, M.Ed.

Submitter : **Mr. Raymond Ibarra** **Date: 08/29/2007**

Organization : **Physiotherapy Associates**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Raymond Ibarra, and I am a dual credentialed physical thrapist and certified athletic trainer in Tempe, AZ. I am currently a staff therapist at Physiotherapy Associates Tempe SPORT clinic, and I hold both a Masters degree in athletic training and physical therapy.

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,

Raymond Ibarra, PT, ATC

Submitter : **Ms. Tiffany Smith** **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:
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Submitter : **Dr. Thomas Henris** **Date: 08/29/2007**

Organization : **Coffee Regional Medical Center**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

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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,

Thomas C. Henris, M.D.

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

Organization :

Category : **Chiropractor**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Removing the ability for Doctor's of Chiropractic to refer for xrays is simply wrong. As a DC providing physical medicine care for patients, I have seen many things on xrays that preclude me from treating the patient. It is simply unfair and detrimental to patient care to not allow the referral/reimbursement for medicare covered individuals for radiological services.

Instead of limiting our rights, how about letting us do our own xrays and getting paid for them.

Decreased patient safety and inconvenience will be the only noticeable difference seen with the new policy. Please consider the ramifications this rule could have before implementing such a bad policy.

Thank you.

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

Organization : **Excela Health School of Anesthesia**

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:
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Sincerely,
Debra Hamerski,RN,MSN,SRNA
CCRN
2 Marjorie Lane
Philippi, WV 26416

Submitter : **Dr. Ezekiel Wetzel** **Date: 08/29/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Joshua Greenspan** **Date: 08/29/2007**

Organization : **PainClinics Inc**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

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

Organization : **Dr. Michael Muro**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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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.

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Thank you for your consideration of this serious matter.

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

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The potential for fraud and abuse exists when physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest. The situation affecting physical therapy is compounded by Medicare s requirement of a physician referral in order for beneficiaries to receive physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons.

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

Organization : **FIU Anesthesiology Nursing Program**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

See attached letter

Sincerely,
Debra Stokes, Student Registered Nurse Anesthetist

CMS-1385-P-11668-Attach-1.PDF

#11668

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.

- 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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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,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : Mr. Rick Wade **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:
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Sincerely,
___LtCol Rick L. Wade CRNA_____
Name & Credential
__5481 Pebble Lane_____
Address
__Osage Beach MO 65065_____
City, State ZIP

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

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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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
Sincerly yours
Michael McCue, MD

Submitter : **Ms. Corinne Shurb** **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

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Sincerely,

_Corinne Shurb, CRNA_____
Name & Credential
_1195 Bruce Avenue #203_____
Address
_Windsor, Ontario Canada N9A 4Y5___
City, State ZIP

Submitter : **Dr. David Shapiro** **Date: 08/29/2007**

Organization : **Dr. David Shapiro**

Category : **Chiropractor**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

MEI - TECHNICAL CORRECTIONS

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimore, Maryland 21244-8018

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

David Shapiro, DC

Submitter : Mr. Steve Nelson **Date:** 08/29/2007

Organization : AANA

Category : Nurse Practitioner

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
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Sincerely,
_Steve Nelson CRNA_____
Name & Credential
___Elaines Way_____
Address
___Winston-Salem,NC 27127_____
City, State ZIP

Submitter : **Dr. Eddy Duncan** **Date: 08/29/2007**

Organization : **Coffee Regional Medical Center**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

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Thank you for your consideration of this serious matter.

Sincerely,

Eddy N. Duncan, M.D.

Submitter : **Mr. John Westberg** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

_John Westberg CRNA_____
Name & Credential
_1810 Fairmount St._____
Address
_Wausau, WI 54403_____
City, State ZIP

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

Organization : **Institute for Athletic Medicine**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Date: August 29, 2007

To: Centers for Medicare and Medicaid Services

There is a huge potential for fraud and abuse of physical therapy services when physicians are able to refer Medicare beneficiaries or other patients to entities where they have a financial interest such as physician owned in-house physical therapy clinics. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce the amount of over utilization and abuse of physical therapy services under the Medicare program and enhance quality of care.

I have seen cases of patients continuing to be sent back to physical therapy when owned by the physician when they no longer are benefiting from physical therapy treatment. Often the patient has long been independent with their home program but the physician sends them back to physical therapy because he has a financial interest in keeping the physical therapists in his practice busy. Patient often require multiple physical therapy visits so it is no more convenient for them to receive these visits in their physicians office then in an independent physical therapy clinic.

Thank you for your consideration.

Tiffany Rodman, PT
Institute for Athletic Medicine, Burnsville

Submitter : **Mr. Ray Barile** **Date: 08/29/2007**

Organization : **St. Louis Blues Hockey Club**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Ray Barile. I am an Athletic Trainer for the St.Louis Blues Hockey Club of the National Hockey League. My players, coaches, staff and management all are affected by the removal of Athletic Trainers from the hospital setting.I see this revision as a step backwards in providing adequate healthcare for all americans.

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,

Raymond Barile, ATC, MS CSCS,LMT

Submitter : Mr. A. FRIELLO, CRNA **Date:** 08/29/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

To the Centers for Medicare and Medicaid Services (CMS),

I am writing in regards to the Stark Law involving the in-office ancillary services. I feel the law may be misunderstood and the practices may be misused for financial gains that may or may not be in the best interest of the patients and/or the medical community. With the referring physician being on-sight and involved in the direct financial gains of the facility, there may be instances where the physician may refer services that may otherwise not be ordered. It would seem to me that a physician is almost always refer for physical therapy services if they will be receiving direct financial gains, even though the patient may not require those particular services. These facilities seem to be under regulated and these physicians have a tendency to become abusive with their referrals, again for their own financial gains. These physicians and their facilities need to be more closely regulated, if not unable to operate under these terms where services may be abused. There is not need to have an overseeing physician in the clinic for physical therapy services.

Please take a very good look at the situation that has transpired within these clinics so that the medical community can continue to function with integrity and honesty to better services its patients.

Thank you for your time and your consideration of these comments.

Submitter : **Dr. Moirae Taylor** **Date: 08/29/2007**

Organization : **Dr. Moirae Taylor**

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.

My initial training was as a registered nurse. After a few years I went to graduate school and became a certified registered nurse anesthetist. At the age of 36 I went back to Medical School and became an anesthesiologists. I felt that I did not have all the knowledge necessary to take care of extremely ill, complicated patients as a CRNA. I have worked all over the state of Texas in various positions. I, along with the rest of my profession, have become extremely disillusioned by the stress, long hours and increasing acuity level of the patients under our care with decreasing reimbursement! It is the anesthesiologist who keeps patients alive during any procedure! It is a sad state of affairs when the automobile mechanics and the cosmetic dentists make more money per unit of time than those of us who are taking care of the elderly in this country. At the rate things are going I am afraid very few anesthesiologists will be around when I become a senior citizen.

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.

Moirae Taylor, M.D.
6704 Greyhawk Circle
Plano, Texas 75024

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

Organization : **School City of Mishawaka**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

My name is Robert Shriner. I am an athletic trainer at Mishawaka High School in Mishawaka, Indiana. I received my MS degree from Purdue University,am certified by the NATA Board of Certification and licensed by the State of Indiana.
I am opposed to the therapy standards and requirements regarding staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, and am more concerned that these proposd 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 eneourage 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 J. Shriner, Jr. MS ATC LAT

Submitter : **Dr. Sara Burke** **Date: 08/29/2007**

Organization : **North Texas Anesthesia Consultants, PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.
Thank you for your consideration of this serious matter.

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

Organization : **Dr. Jeffrey Cazier**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Jeff Cazier, MD

Submitter : **Dr. David Burdette** **Date: 08/29/2007**

Organization : **Dr. David Burdette**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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.
This increase is long overdue. I urge this increase be adopted.

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

Organization : **SRNA with AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Administrator:

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

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

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

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

Sincerely,

Katrin Pownell, SRNA
Name & Credential

818 Germain Lane
Hudson, WI 54016

Submitter : Dr. Antonio Chavez **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants, PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.
Thank you for your consideration of this serious matter.

Submitter : **Dr. Hunter Reynolds** **Date: 08/29/2007**

Organization : **Austin Anesthesiology Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

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

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Mr. Kenneth Schields **Date:** 08/29/2007

Organization : Independent Health Care Consultant / Author

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am an athletic trainer with over forty years of experience, the last twenty-two serving multiple roles (primarily administrative and business development)in outpatient and inpatient rehabilitation services.
I am writing this letter in response to the proposal Docket ID CMS-1385-P which will limit rehabilitation service providers in hospital outpatient clinics and rehabilitation facilities, specifically licensed athletic trainers.

The question is why is Medicare restricting access of Medicare recipients to degreed professionals who are licensed and/or registered in most states.

As with all other medical professionals, practice parameters for athletic trainers have been established by legislation that has led to guidelines for patient care and treatment. This alone sets the statute/legal guidelines for appropriate treatment of appropriate patients.

It is more than evident that those opposing Medicare reimbursement for athletic training services are doing so only to protect their turf and, of course, income. This is a special interest issue as opposed to a sound clinical issue. Additionally, the rhetorical issue of safety for Medicare recipients is absurd and without either merit or evidence based research.

As a soon to be Medicare recipient, I want my choice. I want the best qualified individual for my specific condition and to insure a return to a lifestyle commensurate with aging in this century, not the 1950s.

Since cost is issue (openly stated or not), please look to other areas to lower Medicare costs. Fraud and abuse remain rampant and relatively unabated. The big cases make the news. The relatively low dollar amount cases go unchecked or are simple ignored. Attack the problem of cost, fraud and abuse, not turf or unsupported issues of appropriate care or safety.

Thank you for your consideration.

Ken Schields, LAT, ATC
Author, Unmanaged Care, Ills of The American Health Care System

Submitter : Dr. William G. Davis **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants, PA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.
Thank you for your consideration of this serious matter.

Submitter : **Dr. Jay D. Gottesman** **Date: 08/29/2007**

Organization : **Dr. Jay D. Gottesman**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Jay D. Gottesman, M.D.

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

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : Dr. David Downing **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Marcus Kwan **Date:** 08/29/2007

Organization : Marcus R. Kwan, MD Inc

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

After ten years of under payment because of CMS's inaccuracy or error in holding Santa Cruz County within Locality 99 and essentially ten years of over payment to the physicians in Locality 99 with lower cost of care GCPIs; it is time for the Dept of Health and Human Services as CMS to remove Santa Cruz County from locality 99.

There has never been a justification for keeping Santa Cruz within Locality 99 except that the remaining counties would receive less money. An amount of money that the formula says that they should receive.

There are multiple other federal programs which support rural or less serveced counties, the GPCI formula should not be used for this purpose as it was designed to give everyone their fair and calculated cost return for providing the care in their particular locality.

I personally favor option 3 if it can be modified to conform to the recommendation of the GAO report, because the entire central coast of California would be corrected not just Santa Cruz.

Thank you for taking action now!

Marcus Kwan, MD

Submitter : **Ms. Andrea Nelson** **Date: 08/29/2007**

Organization : **Alexandria Orthopaedic Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am currently a Certified Athletic Trainer working in the role of a physcian extender for an orthopadic clinic. My job roles include application of casts & braces, postop care, suture removal, wound checks, and assisting the surgeons with various procedures. I feel that my Bachelors Degree in Athletic Training did a great job at preparing me for this position, and passing my national certification exam reflects that.

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,

Andrea Nelson, ATC

Submitter : Mr. Gregg Farnam **Date:** 08/29/2007

Organization : Minnesota Timberwolves

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11696-Attach-1.DOC

CMS-1385-P-11696-Attach-2.DOC

#11696

Dear Sir or Madam:

Hello, my name is Gregg Farnam and I am the Head Athletic Trainer for the Minnesota Timberwolves of the National Basketball Association (NBA). I completed my bachelor's degree at St. Cloud State University in St. Cloud, Minnesota, in the spring of 1997. I then received my master's degree in exercise science and health promotions from California University of Pennsylvania in 2004.

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

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

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Sincerely,

Gregg Farnam, ATC, CES-NASM

Submitter : **Dr. Jeff Elmore** **Date: 08/29/2007**

Organization : **North Texas Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)
Dear Ms. Norwalk:
I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.
When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.
In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.
To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.
Thank you for your consideration of this serious matter.

Submitter : Ms. Doris Schneller, CRNA, MS **Date:** 08/29/2007

Organization : Ms. Doris Schneller, CRNA, MS

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Please support this bill, all patients deserve quality anesthesia care, and all anesthesia providers deserve adequate compensation and deserve to not have to worry about giving a "too expensive" anesthetic.

Submitter : Dr. George Erdman **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Chitra Fine **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Daniel Karin **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

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

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

Organization : Mr. Dennis Conroy

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please do not degrade the level of health care any further. Pass the bill to raise the level of reimbursement to anesthesia services.

Thank you
Dennis Conroy

CMS-1385-P-11702-Attach-1.DOC

CMS-1385-P-11702-Attach-2.DOC

CMS-1385-P-11702-Attach-3.DOC

CMS-1385-P-11702-Attach-4.RTF

#11702

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,

Mr Dennis Conroy CRNA
Name & Credential
411 Montross Ct

Address

Chesapeake VA 23323

City, State ZIP

Submitter : **Dr. Michelle DeLemos** **Date: 08/29/2007**

Organization : **Stony Brook Univerosty Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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,

Michelle DeLemos, MD.
Assistant Professor
Stony Brook University Medical Center
Stony Brook, NY 11794

Submitter : Dr. Chinubhai Patel **Date:** 08/29/2007

Organization : Prefered Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Elon Mehr **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Paul Morrow **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

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

Submitter : Dr. Joshua Greenspan **Date:** 08/29/2007

Organization : PainClinics Inc

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

To whom it may concern.

I am a fellowship trained, board certified Pain specialist. I was previously a Program Director of a ACGME Accredited Pain Management Fellowship so I know the difference proper training makes. Lumping me and my similarly trained colleagues into the same category as others who lack our training and expertise is not fair. My practice offers a comprehensive approach to chronic pain which includes injections, medications, physical therapy, acupuncture, nutrition, massage therapy, and psychotherapy. As such the overhead for my practice is higher than someone who calls themselves a "Pain Doctor" who performs injection procedures in someone else's facility. These "wannabe's" just don't meet the quality of care and expertise someone like myself offers.

Your proposal of lumping everyone who performs these procedures is unrealistic. This whole thing is being driven by the economics. The American population is ageing and with age comes chronic pain. Pain Management is a bonafide subspecialty in medicine. It's not the kind of work you take a weekend course in and go out there and hang up your shingle.

I want to be recognized as "09" as an acknowledgement of the extra training and expertise I have acquired that separates me from the wannabe's. My overhead is higher and so I need to be compensated more for my services. If you continue to reduce my reimbursement for my services, I'll be forced to stop offering them to your beneficiaries. Others like myself across America are already following suit.

I understand your wanting to save money. But forcing your beneficiaries to receive inferior care from inferiorly trained wannabe's is penny-wise and pound-foolish. The United States is a first world nation, not a third world nation.

Thank you for your attention.

Sincerely,

Joshua Greenspan M.D.
Medical Director, PainClinics Inc.

Submitter : Dr. Frank Schabel **Date:** 08/29/2007

Organization : Roper Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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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.

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Thank you for your consideration of this serious matter.

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

Organization : **North Texas Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Submitter : Dr. Chance Juenger **Date:** 08/29/2007

Organization : ASA

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk

I am writin to strongly support the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I feel we have long been under valued in our services and yet we have been held hostage by hospitals and surgeons who demand we accept medicare patients. These other parties have found medicare reimbursment profitable while anesthesia fees frequently don't cover the cost of a crna. This has meant the we care for and take responsability for medicare patients without any compensation.

Thank you for your consideration in this matter.

Sincerly
Chance Juenger M.D.

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

Organization : **The Dalton School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Meg Schneider and I am a certified Athletic Trainer for the Dalton School in New York, NY. I have a bachelor's degree in sports medicine and I have a master's degree in exercise physiology. I cover the medical coverage for all high school athletes at my school and work very closely with other ATC's who work for high schools through hospitals. My school is fortunate enough to afford an ATC directly through the school. Other schools may not have that luxury and hire ATC's through a hospital or clinical setting. If these ATC's were not available, this would be a great disservice to all high school athletes.

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

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

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

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,

Megan Schneider, MS, ATC

Submitter : Dr. Edward Santos **Date:** 08/29/2007

Organization : Galesburg Pathology Group, S.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

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

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

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

Submitter : **Dr. William Van De Graaf** **Date: 08/29/2007**

Organization : **Capitol Anesthesiology Association**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

William C. Van De Graaf, MD

Capitol Anesthesiology Association
3705 Medical Parkway, Suite 570
Austin, Texas 78705

Submitter : **Mr. Fikre Wondafrash** **Date: 08/29/2007**

Organization : **Intermountain Health Care**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Fikre Wondafrash and I am a certified athletic trainer, employed by the Intermountain Healthcare Hospital in state of Utah. I provide athletic training services for the US Speedskating National Team.

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

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

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Sincerely,

Fikre Wondafrash MS,ATC

Head Athletic Trainer
US Speedskating Sprint National Team

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

Organization : **North Texas Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Organization : **North Texas Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P
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Submitter : Dr. Shanon Schwimmer **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

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

Organization : **North Texas Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

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Submitter : Mr. Tony Walther **Date:** 08/29/2007

Organization : Corban College

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Tony Walther and I am the Assistant Athletic Trainer at Corban College. I graduated from George Fox University in 2005 with my undergraduate degree in Athletic Training, after which I sat for my certification exam. I became certified in the summer of 2005 and subsequently began working at Corban College in the fall. 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,

Tony Walther, ATC, BS
Corban College
Assisant Athletic Trainer

Submitter : Dr. Shawn Slyka **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Judy Wood** **Date: 08/29/2007**

Organization : **North Texas Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

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

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

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

Organization : **DuPage Medical Group**

Category : **Physician**

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

To Whom It May Concern:

I am writing on behalf of DuPage Medical Group, Ltd a 250 physician-owned multi-specialty group with 34 office sites in DuPage, Will and Kane Counties in Illinois. Currently we care for about 25% of all DuPage County residents. We provide over one million patient visits on an annual basis.

Recently we began our implementation of an electronic medical record and fully intend to implement an e prescribing solution. While we support the mandate to make electronic prescriptions the standard for the country, we believe that the January 2009 date is too soon. This date would place an undue hardship on providers like us who are still planning for and implementing an EMR system with all of its functionality. Additionally since the facsimile solution would not be a viable interim solution for us, it would further delay our ability to provide our patients with the convenience of electronically delivered prescriptions, since we would have to wait until our e-prescribing functionality was fully operational. We are also concerned that the elimination of the facsimile solution means that it cannot be used as a back-up in the event that the e-prescribing system is not functioning. We believe that computer-generated faxing should still be allowed, even after the final ePrescribing requirement date, in the event of a system failure.

Thank you for your consideration of these comments. Please feel free to contact me if you have any questions regarding this matter. I can be reached at 630-942-7962. My email address is mark.daniels@dupagemd.com

Sincerely,

Mark Daniels, MD
President, DuPage Medical Group

Submitter : Dr. Hebert Story **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : Dr. George Murakawa **Date:** 08/29/2007

Organization : Somerset Skin Centre

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

See attached Word document with Dr. Murakawa's comment letter.

CMS-1385-P-11725-Attach-1.DOC

11725

SOMERSET SKIN CENTRE

August 28, 2007

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

RE: Resource-based PE RVUs for photopheresis (CPT 36522)

For my treatment-refractory cutaneous T-cell lymphoma patients with serious debilitating skin manifestations, extracorporeal photopheresis therapy is highly effective, and enables the patient to return to a more normal, productive life.

Unfortunately, because of the current and proposed reimbursement rates, I continue to be unable to treat these patients in my office, despite the fact that it is more convenient and poses less risk for infection than in a hospital setting. The direct cost for disposable supplies and drugs used for each procedure is more than $1,200; the cost of the procedural kit alone is $1,100. Add to this the cost for a nurse specialist to administer this 3 ½- to 4-hour procedure, and I am faced with the fact that that the current practice expense reimbursement of about $1,320 scarcely covers my direct cost only. There is no compensation for any overhead costs, which include not only office overhead but equipment service costs and the requirement to purchase a back-up photopheresis machine. At the proposed 37 RVUs for practice expense, I could provide this service only at a substantial loss.

Currently, there are only two hospitals that offer photopheresis therapy that I can refer my patients to; both of these hospitals are in the city of Detroit, a minimum of 20 miles for those patients in the closer surrounding suburbs. This creates a significant added burden for patients who require periodic scheduled treatments, who must travel many miles, especially older patients not familiar with the area.

By encouraging physicians to provide photopheresis in their offices, not only would the quality of the patient experience be greatly improved, I assume that Medicare expenses would very likely be reduced as opposed to the hospital-based treatment setting. Therefore, CMS needs to significantly increase the valuation or reimbursement of photopheresis to make it feasible to offer this important treatment in a physician office or clinic.

If you have any questions regarding this important subject, please do not hesitate to contact me.

Sincerely,

George J. Murakawa, M.D., Ph.D.

George J. Murakawa, MD, PhD
255 Kirts Blvd, Suite 100 • Troy, MI 48084
Office (248) 244-8448 • Fax (248) 244-8766
www.somersetskincentre.com

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

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Erin Sendelweck Temple** **Date: 08/29/2007**

Organization : **Dr. Erin Sendelweck Temple**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Sincerely,
Erin Sendelweck Temple, M.D.

Submitter : **Dr. Jonathon Steubing** **Date: 08/29/2007**

Organization : **North Texas Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Organization : **North Texas Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

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Submitter : Dr. Leslie Wayne **Date:** 08/29/2007

Organization : North Texas Anesthesia Consultants

Category : Physician

Issue Areas/Comments

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Submitter : **Dr. Roald Shamaskin** **Date: 08/29/2007**

Organization : **West End Anesthesia Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
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Thank you for your consideration of this serious matter.

Ronald Shamaskin, MD, DDS

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

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

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.
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,
MAJ Robert Ladd CRNA
108 Daneswood Ct
Radcliff, KY 40160

Submitter : Mr. Garrel Kinzler **Date:** 08/29/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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

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Sincerely,
Garrel C. Kinzler SRNA
906 N 5th St.
Grand Forks, ND 58203

Submitter : **Dr. Roald Shamaskin** **Date: 08/29/2007**

Organization : **West End Anesthesia Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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.

Ronald Shamaskin, MD, DDS

Submitter : **Dr. David Reeder** **Date: 08/29/2007**

Organization : **Wenatchee Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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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.

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Thank you for your consideration of this serious matter.

David Reeder, M.D.
Wenatchee Anesthesia Associates
Wenatchee, Washington, 98801

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

Organization : Mr. Steven Swanson

Category : Nurse Practitioner

Issue Areas/Comments

Background

Background

Dear Administrator-

As a CRNA working in a small rural hospital serving the 2 poorest counties in Colorado- I write urging you to support the CMS proposal to boost the value of anesthesia work by 32%(72 FR 38122,7/12/2007)
It's passage will enable us as medicare part B providers to recruit and sustain anesthesia services for many of rural Colorado's poorest and underserved patients. Thanks in advance for your consideration of this issue of utmost importance to the patients of rural underserved America. We will be contacting our hometown sons Senator Salazar and his brother Representative Salazar seeking their continued support with this issue as well. Again Sincere Thanks- Steven Swanson CRNA Monte Vista CO

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

Organization : jerold blatt

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

How can you expect a doctor of chiropractic to properly assess a patient's spine, especially if elderly, without adequate x-rays. If an orthopedist saw a patient with low back pain and did not x-ray the patient, he would be accused of malpractice. This policy of not honoring x-rays taken or ordered by a Chiropractor who has been well-trained in x-ray taking and reading is blatant discrimination!! The ones to suffer by it are the unsuspecting patients. Disgraceful. What bozo introduced this bill?

Submitter : **Mr. Raymond Alonge** **Date: 08/29/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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

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Sincerely,

Raymond Alonge, C.R.N.A., M.S.N

5933 Riley Road
Ooltewah, TN 37363

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

Organization : **Dr. Thomas Gunning**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

My Subaru dealership charges me more per hour to work on an inanimate car than Medicare pays me (an anesthesiologist) to care for live (and often very ill) people. THAT'S NOT RIGHT.

Following is a joke circulating the internet. I think the explanation is clear:

--- Original Message -----
Subject: Funny, but how true

Two patients limp into two different medical clinics with the same complaint. Both have trouble walking and appear to require a hip replacement.

The first patient is examined within the hour, is x-rayed the same day and has a time booked for surgery the following week.

The second sees his family doctor after waiting a week for an appointment, then waits eight weeks to see a specialist, then gets an x-ray, which isn't reviewed for another week, and finally has his surgery scheduled for six weeks from then.

Why the different treatment for the two patients?

The first is a Golden Retriever.

The second is a Senior Citizen.

Submitter : Roy Karle CRNA MS **Date:** 08/29/2007

Organization : Roy Karle CRNA MS

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

Baltimore, MD 21244 8018

Dear Administrator:

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Sincerely,
Roy Karle CRNA MS
28807 Cromwell Dr
Chesterfield< MI 48047

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

Organization : Lori Faulkner

Category : Other Health Care Professional

Issue Areas/Comments

Background

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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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Submitter : **Ms. Genia Corum** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 28, 2007 RE: CMS-1385-P (Backgound, Impact)
Anesthesia Services

Dear Administrator at Centers for Medicare & Medicaid Services:

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: 1. 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. 2. 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. 3. 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.

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Sincerely,

Genia E. Corum CRNA
P.O. Box 670
Courtland, AL 35618

Submitter : **Mr. Keith Macksoud** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007

Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), and an assistant program director in a Nurse Anesthesia program, 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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Sincerely,

Keith E. Macksoud, CRNA, MA
LTC(ret), AN, USAR
Assistant Program Director
Memorial Hospital of Rhode Island
School of Nurse Anesthesia

Submitter : **Mr. Jon Dix** **Date: 08/29/2007**

Organization : **Mr. Jon Dix**

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:

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Sincerely,

Jon Dix, CRNA

Submitter : Dr. rajiv kwatra **Date:** 08/29/2007

Organization : Dr. rajiv kwatra

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am writing this letter to express my deep my concern regarding the proposed removal of the Mohs Surgery codes from the MPPR exemption list. I believe this proposed rule change would adversely affect the healthcare of U.S. citizens while increasing costs at the same time

Mohs micrographic surgery is the gold standard (cure rate of 98-99%) among treatments for skin cancer. As a brief review, these are steps involved in the process to treat each skin cancer. The Mohs surgeon removes the obvious skin cancer and the tissue is processed in the lab that is at the office. After it is processed in the lab, the Mohs surgeon examines 100% of the cancer margin. If there is any cancer left, it is carefully mapped and more tissue is removed only where there is still cancer present. This process is repeated until all the cancer has been removed. Once the removal is complete, the area is reconstructed (stitched) or allowed to heal naturally. There is very little overlap between any of the procedures we perform on a single patient. If I treat two skin cancers, it only requires a little extra time if these are located on two different patients. If they are located on the same patient, some time is saved in checking in and checking out the patient but the work required to remove each cancer is more or less the same. Each has to be evaluated and removed in the manner that is best suited for which type of skin cancer it is and where it is located. The Pathology portion of the process has absolutely no overlap at all as each has to be processed and evaluated independently. I allow a very high percentage of areas to heal by secondary intention (heal naturally) because that is the best option for the patient. It also happens to be extremely cost effective. If a reconstruction is performed, it requires the evaluation of the defect as to which way is best, discussing this with the patient., prepping the site for reconstructive surgery, and the setting up of a whole new sterile surgery tray. Frankly, if I referred the patient out to a plastic surgeon for the reconstruction, it would require roughly the same time for them to do all this. However, it would cost at least 3 to 4 times as much as plastic surgeons usually do their reconstructions in the outpatient OR while we do it in the office. The Outpatient OR is a costly environment. There is a plastic surgeon, an anesthesiologist, and the facility which all will submit their claim.

This rule change will result in many patients having their skin cancers treated one at a time as the reduction will make it prohibitive to treat multiple sites on a single patient. More patients will be referred to plastic surgeons for reconstruction as the reduction will make this prohibitive to do in the office in many patients.

There is little work overlap in treating each skin cancer or reconstructing a site after the skin cancer is removed. It will inevitably result in unintended increased costs to the healthcare system. Worst of all, it will have the greatest adverse impact on patients who are the most vulnerable in society seniors with multiple skin cancers with transportation difficulties and transplant patients with multiple aggressive skin cancers.

I realize that we live in a time where reducing healthcare costs is critical. However, Mohs Surgery is part of the solution, not the problem. Not only is the cure rate higher with Mohs surgery, It cost approximately 70-75% less to treat a skin cancer at a Mohs Surgeon s office than it does if the patient is treated by a physician in the outpatient OR. Leaving apart the fact that the proposed rule change conflicts with the well known requirements for exemption, this change if allowed to occur will result in decreased quality of care while increasing the costs at the same time. Thank you for taking time to consider my concerns. Sincerely, Rajiv Kwatra M.D. 1331 North 7th street, suite 290, Phoenix, AZ, 85006, Phone 6022306744

Submitter : **Ms. Lyn Jansen** **Date: 08/29/2007**

Organization : **Northern Physical Therapy Services**

Category : **Occupational Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I have practiced Occupational Therapy in a variety of settings for over 20 years. I believe that the July 12 proposed 2008 fee schedule rule poses great potential for fraud, and would diminish quality therapy services to Medicare beneficiaries.

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

Organization : **Karen Coulson**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007

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

Dear Administrator:
As an associate 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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Sincerely,
Karen Coulson
Nurse Anesthesia Student and Associate AANA Member

Submitter : **Dr. Brent Moody** **Date: 08/29/2007**

Organization : **Skin Cancer and Surgery Center**

Category : **Physician**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am in opposition to the proposed application of the Multiple Procedure Payment Reduction for Mohs Micrographic Surgery (CPT codes 17311 through 17315).

In the practice of Mohs Surgery, there is little efficiency gained when performing more than one Mohs procedure on the same patient in the same day.

Greater than 80% of the work is duplicated for a second procedure. Aspects of the procedure that do not gain efficiency with multiple procedures are:

1. Pre-service positioning. In many instances, the anatomic location of the tumors requires patient re-positioning for each tumor.
2. Pre-Service scrub, dress and wait time. Each lesion must be separately identified, marked and scrubbed. For lesions on separate anatomic locations, the sterile field created for the first procedure must be broken down and then a new field created for the second cancer.
3. Intra-Service work. Each tumor is dealt with as a distinct entity. Each tumor must be separately anesthetized, and excised. Once the tumor enters the pathology portion of the procedure, there is no efficiency gained in performing multiple procedures. Each tumor must be processed and prepared independently. The interpretation of the tissue for residual cancer and tumor mapping are also independent events for each tumor. For two cancers, this portion of the physician work and practice expense is doubled. As this intra-service work comprises approximately 80% of the total amount of work and resources for the procedure, applying a reduction to the code will significantly undervalue the code. Moreover, of the total intra-service time, the laboratory/pathology proportion consumes the majority of the time and resources of the procedure.

The Mohs procedure may also be accompanied by a reconstructive effort by the same surgeon on the same day of service. The reconstruction is covered under a separate code from the Mohs surgery series of codes. When a reconstruction is performed after the Mohs procedure, there is little efficiency gained. The reconstruction stands on its own as a separate surgical procedure. As the patient has been waiting in the waiting room, the Mohs defect reconstruction contains all of the elements of a stand alone procedure.

1. Pre-Service evaluation. Prior to the reconstruction, the patient must be evaluated to determine optimal wound management. The nature of the wound cannot be known until the completion of the Mohs procedure, thus, there is no substantial reduction in the pre-service evaluation of the reconstruction.
2. Pre-service positioning. Given the long time of the Mohs intra-service work, the patient is removed from the operating table and waits in the waiting room during the Mohs intra-service work. Once the Mohs procedure is complete, the patient must be repositioned for reconstruction.
3. Pre-service scrub, dress and wait time. Given the long time of the Mohs intra-service work, the area must be scrubbed and prepared as if it where a new surgical procedure.
4. Intra-service time. The intra-service time and resources for the reconstruction is not reduced by the prior Mohs procedure. The area must be re-anesthetized as any anesthesia from the Mohs procedure is inadequate for the reconstruction. Additionally, separate and additional instrumentation is required for the reconstruction.
5. Post service time. The post service time is not reduced by the Mohs procedure as the post service work is now dictated by the reconstruction.

In summary, given the significant duplication of work and resource utilization when a subsequent procedure is performed in conjunction with Mohs surgery, applying the Multiple Procedure Payment Reduction for Mohs Surgery (CPT 17311- 17315) will significantly undervalue the codes.

I would ask that you reconsider removal of the Mohs Surgery codes from the exempt list and retain their longstanding exemption from the multiple procedure payment reduction.
Sincerely,
Brent Moody, MD

Submitter : **Dr. Barry Bergquist** **Date: 08/29/2007**

Organization : **Mountain West Anesthesia, LLC**

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 Utah this has definitely been a big problem for the southern end of the state.

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.

Respectfully submitted,

Barry Bergquist, M.D.
LDS Hospital Dept of Anesthesia
8th Avenue and C St, SLC UT 84143

Submitter : **Ms. Amanda Little** **Date: 08/29/2007**

Organization : **AthletiCO**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My Name is Amanda Little and i am a certified athletic trainer (ATC). I graduated with a bachelors of science from Eastern Illinois University. I have been licensed as an ATC since 2003. I currently work for AthletiCo as an outreach ATC.

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,

Amanda Little, ATC (and/or other credentials)

Submitter : **Dr. Larry Presley** **Date: 08/29/2007**

Organization : **Dr. Larry Presley**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **American Association of Nurse Anesthetists**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

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

Name & Credential
Charles R. Sharbel, CRNA
Address
1225 Temple Ridge Drive Nashville, TN 37221
City, State ZIP

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

Organization : **Oklahoma Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Sincerely,
James Walker, M.D.

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

Organization : **MTSA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007

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

Dear Ms. Norwalk:

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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,

Shannon Sexton SRNA_____
Name & Credential
170 B Lelawood Circle_____
Address
Nashville TN 37209_____
City, State ZIP

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

Organization : **American Association of Nurse Anesthetists**

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:
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Sincerely,
Christopher Loeffel SRNA
Name & Credential
1009 Whitney Springs Ct
Holly Springs, NC 27540

Submitter : **Mr. Daniel Golden** **Date: 08/29/2007**

Organization : **AthletiCo**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Daniel Golden and I am an Athletic Training graduate from Western Illinois University. I am currently working as an Intern for AthletiCo while I await the results of my NATABOC exam.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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

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

Sincerely,

Daniel Golden, ATS

Submitter : **Ms. Donna Sledge** **Date: 08/29/2007**

Organization : **Rehabilitation Services of Tifton**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Donna Kay Sledge. I am a nationally board certified, state licensed Athletic Trainer; I am currently employed by Rehabilitation Services of Tifton and Abraham Baldwin Agricultural College. I provide coaches and athletes with researched based principles and I practice these researched based principles in my practice of injury prevention, recognition and rehabilitation. I provide on the field emergency care of injuries and off the field rehabilitation (structured, planned, monitored and modified exercise programs which are scientifically based for recovery of injury pre and post operative) for athletes. I have earned two Baccalaureate degrees and a Masters degree.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
DONNA KAY SLEDGE MS, ATC/L

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

Organization : **Community Rehab Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Physician Self-Referral Issues

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

I would like to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception.

I am a practicing physical therapist in Sioux City Iowa. I recently opened a private practice in an area that was underserved, 8 months ago. I had been working in another city approximately 40 miles from Sioux City for 12 years, during which a large orthopedic group in Sioux City, referred me patients. While there I established a good working relationship with these doctors. Once opening my clinic in Sioux City, this same group which owns there own in house PT facility no longer referred patients to me. They also ended up putting another PT/ortho doctor clinic approximately 3 miles from my clinic 5 months after I opened. It has been quite difficult establishing patients. I continually market the family practice physicians, and other physicians not affiliated with this group to build new relationships and establish patients.
I am not afraid of competition but I would like an equal playing field. I believe it is in the patients best interest for them to recieve care where they want and they are given the opportunity to choose whom and where they are seen. With the current arrangements of the "in-office ancillary services" the patients are not given that option readily without being swayed to stay "in-house."

The "in-office ancillary services" exception is defined so broadly in the regulations that it facilitates the creation of abusive referral arrangements that have affected me directly.
I believe it is in the best interest for the patient that PT services should not be permitted under the in-office ancillary exception.

Thank you Administrator-Designate for your time in this very important issue.

Sincerely,
Blake D. Wagner,PT
Community Rehab Physical Therapy
3111 Gordon Drive
Sioux City, IA 51106
(712)277-0507
bwagner@communityrehabpt.com

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

Organization : **Arrowhead Regional Medical Center**

Category : **Other Health Care Provider**

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:
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Sincerely,
_Eric J. Weed, RN BS SRNA_____
Name & Credential
4001 View Point Dr._____
Address
_Granbury, TX 76048_____
City, State ZIP

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

Organization : Alabama Orthopaedic Clinic

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a physical therapist employed in a Physician owned practice for the last 10 years I can honestly say that therapy services should remain in the In Office Ancillary Services Exemption under the 'Stark' regulations. To remove physical therapy would deprive patients of services that are provided with the highest level of coordination between surgeon and therapist. This direct line of communication and teamwork provides the most comprehensive treatment program the client can receive. The specialization of the therapists coupled with the Board Certifications of the Physicians can not be found in other arenas.

The letter campaign by the American Physical Therapy Association (APTA) is not representative of the entire membership. I am a member in good standing of the APTA I cannot agree with their wishes. I urge you to preserve the current process.

Submitter : **Mr. Alex Oliu** **Date: 08/29/2007**

Organization : **Mr. Alex Oliu**

Category : **Health Care Professional or Association**

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:

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Sincerely,
Alexande J. Oliu, CRNA, MSc
9946 N.W. 32 Street
Doral, Florida 33172

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

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

August 27, 2007

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

Re: CMS-1385-P

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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.

John Neeld

Submitter : **Dr. Yolanda Harold** **Date: 08/29/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Spencer Curtis** **Date: 08/29/2007**

Organization : **Dr. Spencer Curtis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Sincerely

Spencer Curtis, MD

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

Organization : Mark Hopp

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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.

Submitter : **Mr. Duane Fuerst** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Please consider the proposed increase in payments for Anesthesia charges and pass this amendment

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As it stands this practice appears not only unethical due to financial gains involved, but also a contributing fator to the increasing health care costs which often leads to uninsured Americans. Insurance companies increase costs by hiring staff to police the abuse that is occurring and therefore past the cost to the consumer. This, coupled with the rising number ofcliams, leads to unaffordable insurance premiums for many. There are no checks and balances regarding physicians who profit from owning thier own therapy facilities. Due to the lack of checks and balances, corruption is promoted and the MD in essence owns the entire chain of medical care. This is indeed the case when the physician is able to own the MRI, pharmacy, x-ray and lab. The entire health care market share is being monoploized. How is it that a MD can no accept lunch or dinner paid for by drug reps, but can make millions of dollars on PT which was ordered by the owner of the therapy clinic?

We would like to think that the oath that all physicians take upon getting licensed would promote quality patient care, strong ethical pratice and the desire to compassionately serve humankind. As we have seen over in England in recent events, where 5 doctots attempted to blow up cars, potentially taking the human lives they vowed to save, some MD's are swayed by elicit behavior. This is obviously an extreme, however can not be disregarded when viewing the deviaiatons that can occur from the oath of conduct taken by phsycians.
Is the system being abused when a doc directs care and gives the uneducated consumer no choice? The fact is that the consumer does not even realize they do have a choice for care when given a PT order by a MD who refers to his own practice.
Being an owner of an outpatient therapy clinic I have seen first hand the gross over utilization of therapy over the past several years. Patients will consistently recieve thearpy whether it is medicall necessary or not. Current and past patients have expressed the displeasure the referring physician has when it is discovered they are not going to their clinic. At times, no further orders have been given dispite my recommendation to continue.
Complaints about increased malpractise, rising and unaffordable health care costs and the inereasing number of uninsured Americans will only continue to rise at this rapid rate as the abuse continues. A check and balanee system must be put in place to address this crisis. By eliminating in office ancillary services is only one way to create such a system.

CMS-1385-P-11767-Attach-1.DOC

Submitter : **Mrs. Linda Mazzoli** **Date: 08/29/2007**

Organization : **Cooper university Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

sec attachment

CMS-1385-P-11768-Attach-1.WPD

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

Organization : Dr. James Leibsohn

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Dear sirs: The T wave alternans study is a complex text that requires about 45 min. to 75 min. of my time to perform. It involves reviewing a pt's entire cardiac hx, controlling the treadmill (or infusion) to maintain a narrow range of heart rate, and then making a complex determination from multiple data sets as to whether the test is negative or not, and whether the data is valid, and then using that data to make a potential life saving decision whether or not to place an ICD. The test often must be repeated one or two times in order to achieve a valid study, and even then, results are often reviewed with colleagues before a final determination is made. The test is performed in a very limited number of patients, I anticipate performing it no more than 4 or five times a month. The test allows us to identify those patients at most risk for sudden death, and serves as a strong negative indicator for ICD implant when negative, thus saving unnecessary ICD implantations, in turn saving a great deal of money. Please consider adjusting reimbursement to reflect the time the test eonsumes, the complexity of its performance and interpretation, and the profound impact it has on patient management. Thanks.

Submitter : **Mr. Richard Beall** **Date: 08/29/2007**

Organization : **Mr. Richard Beall**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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

Organization : **Elaine Chong**

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 support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am impressed that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is poised to taking steps towards address this issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, primarily due to the 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.

The RUC has 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 attention.

Elaine Chong, MD

Submitter : **Dr. cherian oommen** **Date: 08/29/2007**

Organization : **Milford Anesthesia**

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.

Sincerely,

Cherian S. Oommen, MD

Submitter : **Mr. Donald Fontenot** **Date: 08/29/2007**

Organization : **Mr. Donald Fontenot**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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.

Submitter : **Mr. Brian Treston** **Date: 08/29/2007**

Organization : **Practicing Nurse Anesthetist**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

Dear Administrator:

As a practicing Nurse Anesthetist I support the Centers for Medicare and Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. This boost would increase our present conversion factor by 15% in 2008.

This increase will give our profession the ability offset cost to provide anesthesia services to the uninsured or underinsured patients. In addition, it will increase the relative anesthesia value of anesthesia that was taken away in 2007.

If this proposal is not enacted Congess will make furthers cut to our reimbursement to conversion factors that were seen in 1992. Is that fair!

In closing I wanted to thank the CMS's acknowledgement that CRNA anesthesia services are undervalued and its proposal to increase the valuation of anesthesia work in a manner that increases Medicare anesthesia payment

Sincerely,

Brian R. Treston CRNA MS
16 East Brookhaven Road
Wallingford, PA 19086

Submitter : Dr. Ellen Gawrisch **Date:** 08/29/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Please consider an increase for physician services as the elderly are high risk with expertise in anesthesia care required.

Submitter : **Dr. Ian Gilmour** **Date: 08/29/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Ms. Dona Maria Oliveira, CRNA, MSN** **Date: 08/29/2007**

Organization : **Ms. Dona Maria Oliveira, CRNA, MSN**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 30, 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 : Ms. ANN MYERS **Date:** 08/29/2007

Organization : AANA

Category : Other Practitioner

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 the anesthesia services.

This increase in Medicare payment in important for several reasons:

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Sincerely,
Ann Myers, SRNA
1493 Iron Bridge Road
Columbia, PA 17512

Submitter : **Dr. Roman Schumann** **Date: 08/29/2007**

Organization : **Dr. Roman Schumann**

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:

Thank you for allowing me to let you know that I strongly support the proposal to increase payments for anesthesiology services under the 2008 Physician Fee Schedule. Fortunately and rightly so, CMS has recognized the gross undervaluation of anesthesiology services, and the Agency is addressing this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesiology care, not recognizing the equal value of anesthesiologists services compared to our peers work in other medical specialties. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services has now reached a level ($16.19 per unit), that no longer covers the cost of anesthesiology care for seniors. This creates an unsustainable system forcing anesthesiologists away from areas with a disproportionately high Medicare population.

The RUC recommended that CMS increase the anesthesia conversion factor to rectify a calculated 32 percent work undervaluation a move that would be a major step forward in correcting this long-standing undervaluation of anesthesiology 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 continue to have access to expert anesthesiology medical care, I ask 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.

Roman Schumann, M.D.

Submitter : **Mr. Bryant Peterson** **Date: 08/29/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Provider**

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
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Sincerely,
_Bryant Peterson, SRNA_____
Name & Credential
_P.O. Box 1056_____
Address
_Scottsbluff, NE 69363_____
City, State ZIP

Submitter : Mr. Jeff DesJardine **Date:** 08/29/2007

Organization : Self

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I have been a physical therapist for 14 years. I would like to add my opinion that I think this is creating a very big challenge for the profession of physical therapy by allowing the physician to self refer. This is creating difficulty for the profession to gain independenee for the referral based system and is allowing possible questionablc sclf referring practises for physicians. Please consider this objection to this proposed system. Thank you. Jeff DesJardine PT.

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

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

Robert Allison

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

Organization : **Mr. Eric Armstrong**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Eric Armstrong. I recently graduated from King's College in Wilkes-Barre, PA with a degree in Athletic Training. I am currently a NATABOC certified Athletic Trainer.

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,

Eric Armstrong, ATC

Submitter : Ms. Amy Streitman **Date: 08/29/2007**

Organization : American Association of Nurse Anesthetists

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

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

Dear Administrator:

As a member of the American Association of Nurse Anesthetists(AANA), I am writing to support the Centers for Medicare & Medicaid Services(CMS) proposal to boost the value of anesthesia work by 32%.

Under CMS's proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008. (72 FR 38122, 7/12/2007) If adopted, CMS's 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 reported 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 HEALTH CARE 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 of the other Part B providers's services were reviewed and adjusted in previous years, and those adjustments took effect in January of 2007.

Third, CMS's proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which has fallen far short of inflationary adjustments. Additionally, if CMS's 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 ONE-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 CMS'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,

Amy Streitman, CRNA, MS

Submitter : Dr. D. Heck **Date:** 08/29/2007

Organization : SJAS

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.

D. Heck, MD

Submitter : Mr. Brian Duncan **Date:** 08/29/2007

Organization : Harris County Hospital District

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Unfortunately, the current loopholes in the Stark Laws provide an economic incentive that facilitates increased healthcare utilization while, at the same time, sacrificing positive patient outcomes. While in-house physical therapy services seems like a cost-efficient collaborative effort that would provide convenient patient care with improved outcomes. However, the Office of the Inspector General found widespread abuse (millions of dollars in appropriately billed) with no sign of improved outcomes.

Physical therapy is a profession in and of itself and cannot be "ancillary" to another provider. When put in this position due to the current healthcare environment, patient care becomes more expensive because physical therapists are not allowed the autonomy necessary to effectively treat the patient in an efficient manner. Cost-efficient care actually hurts the business in this case by reducing the amount billed and the amounted collected. Furthermore, "ancillary" services are inherently subservient in nature and do not allow for proper collaboration between professions.

Physician-owned physical therapy sevices are create anti-trust issues by not allowing a competitive market within physical therapy. The patient will simply be directed to another part of the office or down the hall instead of being given a referral that could be taken to any licensed physical therapist. Physician-owned physical therapy services create a closed system that actually restricts patient choice and does not allow the patient to take ownership of their healthcare needs.

From a practical standpoint, the physical therapists who work at in-house physician owned physical therapy services do not typically hold board certifieations or prominent positions within the profession. As you can see, this set-up is truly referral for profit and not at all beneficial to the patient.

Physician-owned physical therapy services create a revenue stream coming and going. The patient is referred to the physical therapist which drives physician profit. Then, if the patient does not get better, the physician will make money on the surgery. Following the surgery, the physician will further his/her economic gain with a referral back to physical therapy for post-operative rehabilitation. As you can see, this does not facilitate efficient patient care. It facilitates expensive patient care at the detriment to the patient.

Not only do these set-ups drive up the cost of physical therapy services by placing them in a subservient role and rewarding poor patient outcomes with surgery and more physical therapy, it also increases physician surgical rates. Instead of an independent physical therapist earning a reputation by achieving positive outcomes with conservative care via unbiased critical thinking and true collaboration, the "ancillary service" will treat as directed without true autonomy and feed the orthopedic surgeons surgical juggernaut.

At Harris County Hospital District we are implementing a system to integrate physical therapists into our community health centers. The US Military, Veterans Administration in Salt Lake City, Kaiser Permanente, and the british healthcare system have learned that integrating the physical therapist onto the primary care team as an autonomous practitioner actually improves outcomes and decreases costs. As you can see, this puts the physical therapist in a role to achieve quality patient outcomes and reduce costs. Unfortunately, the current Stark Law facilitate poor patient care and increased healthcare utilization.

I thank you for your time and support in eliminating this loophole and ELIMINATING physical therapy a designated health service (DHS) furnished under the in-office ancillary expeception. Please support legislation that encourages quality patient outcomes in a cost-effective manner. Remember, collaboration results in quality care, but subservient systems with overt economic gain cannot be allowed.

CMS-1385-P-11786-Attach-1.PDF

CMS-1385-P-11786-Attach-2.PDF

Submitter : Dr. Hector Lozano **Date:** 08/29/2007

Organization : Dr. Hector Lozano

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I wish to express my support for the increase in anesthesia fees under the proposed 2008 Physician Fee Schedule.

Submitter : **Miss. Amanda Youse** **Date: 08/29/2007**

Organization : **Onsite Innovations**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Amanda Youse, and I am a certified athletic trainer currently employed in the occupational setting. I am both a nationally certified ATC and a Pennsylvania State Licensed athletic trainer.

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,

Amanda P. Youse, ATC

Submitter : **Dr. donald lane** **Date: 08/29/2007**

Organization : **DML Mobile Anesthesia LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

My impression is that if anesthesia reimbursement is not addressed, anesthesia providers will have a difficult time continuing service. Because we have no control over patient selection, the long term for anesthesia residencies will be adversely affected. There are multiple other career opportunities available to the best students and call, nights, and weekends/holidays are not necessary. I did not go into anesthesia for money. I thoroughly enjoy what I do. But the long term provision of medical services will be significantly and adversely affected if the anesthesia disparity is not realistically addressed. Thank you for correcting this disservice. Sincerely, Donald M. Lane M.D.

Submitter : **Mr. Terence Burrows** **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.
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,
Terence J Burrows CRNA, MSN
Name & Credential
1425 NE 7th Ave #133
Address
Portland, OR 97232

Submitter : Mr. Joseph Abruzzo **Date:** 08/29/2007

Organization : One on One Physical Therapy

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Joseph Abruzzo I am a certified athletic trainer, curently working for One on One Physical Therapy and Sports Rehabilitation. I am nationally certified as well as state certified. I have a BS/MS degree in Athletic Training from Long Island University, Brooklyn Campus. Please review the following comments as it affects not only me but many of my colleagues as well.

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,

Joseph Abruzzo, MS,ATC

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

Organization : **Mr. William Christman**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

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

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

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

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

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

Sincerely,
William L. Christman II, ATC

Submitter : Dr. THOMAS HARRISON **Date:** 08/29/2007

Organization : VERMONT ANESTHESIA CONSORTIUM

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 paymcnts 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.

Thomas Harrison MD

Submitter : **Mr. Paul Malloy** **Date: 08/29/2007**

Organization : **Vanderbilt University Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 28, 2007

Dear Sir or Madam:
My name is Paul Malloy and I work at the Vanderbilt Orthopaedic Institute in Nashville, TN where I along with 18 other Certified Athletic Trainers work with outpatient therapy. We are all individuals with Master s Degrees, NATA certification and state licensure. Our rehabilitation model is one of the most efficient in the country and provides the patient the best care available as Athletic Trainers are utilized as a team member with our physical therapists. The extensive training and education that we as athletic trainers have in the area of orthopaedics is a perfect fit in outpatient therapy and far surpasses that of a PTA or PT tech.

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

Paul Malloy, MS, ATC
Head Athletic Trainer
Belmont University Athletics
Assistant Manager
Vanderbilt Sports Medicine /Vanderbilt Orthopaedic Institute

Submitter : **Mr. Howard MacFadden** **Date: 08/29/2007**

Organization : **Medcenter Anesthesia, Inc.**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

Administrator
CMS/HHS
P.O.B 8018
Baltimore, MD 21244-8018

Dear Administrator:

Please support the proposal CMS-1385-P (Background, Impact) for Anesthesia Services.

The proposal would increase (for the first time since 1992!) the work value for anesthesia providers by 32% and increase the anesthesia Conversion Factor by 15% for CRNAs in 2008.

CRNAs provide on the order of 27 million anesthetics per year in the USA in every type of anesthesia setting. And we provide the majority of anesthetics in rural and underserved areas of our nation.

It is very important this proposal be passed so CRNAs can continue to provide the same high quality anesthesia care Americans have benefitted from in the past, and which they continue to expect and deserve.

Thank you for your attention to this vital issue.

And thank you for serving our nation in your vital position.

Howard MacFadden, CRNA
1200 Pincridge Dr
Marion, OH 43302
740.361.7157
hmacfadden@yahoo.com

Submitter : **Dr. Gary Richman** **Date: 08/29/2007**

Organization : **Anesthesia Associates, PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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 : Mr. Timothy Giel **Date:** 08/29/2007

Organization : Shady Side Academy

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Tim Giel and I am a Certified Athletic Trainer at Shady Side Academy in Pittsburgh, PA. I have been at Shady Side for the past 25 years after graduating from the University of Pittsburgh in 1981.

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,

Timothy K. Giel M.S., AT, C

Submitter : **Dr. Tamara Housman** **Date: 08/29/2007**

Organization : **Providence Dermatologic Surgery**

Category : **Physician**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

As a Mohs micrographic surgeon in Portland, Oregon, I am writing to express my deep concern regarding the planned change in Medicare reimbursement policy that will adversely impact my ability to provide care for my Medicare patients. Mohs micrographic surgery is a common way of treating some of these cancers and is considered the gold standard among treatments for skin cancer, allowing the physician to examine 100% of the cancer margin to insure complete removal of the cancer with loss of as little normal skin as possible. Mohs surgery is an outpatient procedure that utilizes onsite laboratory analysis of excised tissue while the patient waits for the results. The critical component of Mohs surgery includes meticulous removal and microscopic examination of the entire edge and deep margin of the cancer, in which the same physician serves as both surgeon and pathologist. The exemption of the Mohs codes from the MSRR has been maintained by CMS since 1992 and was not questioned during the CMS mandated five-year review of the Mohs codes undertaken last fall or during presentation of the new Mohs codes to the AMA RUC in October, 2006.

I was notified of a planned change in payment policy that in my opinion has the potential to negatively impact the care of my patients and could add significant cost to an already stressed healthcare budget. This planned change would remove Mohs surgery from a long-standing exemption from the multiple surgery reduction rule (MSRR, indicated by CPT modifier -51). The change proposed would eliminate the exemption and decrease reimbursement by 50% for either the Mohs excision or for the associated repair, and for Mohs excision of any additional cancers treated on the same day; such a decrease in reimbursement would not cover the cost of providing the service. If this proposed change is enacted, I will no longer be able to provide the same kind of high-quality, cost-effective services for my patients in need. I will be forced to change the way I deliver care in order to cover our costs of providing this service.

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

I am asking that you reconsider the proposed rule that would no longer exempt the Mohs procedure codes, 17311 and 17313, from the multiple surgical reduction rule. I am concerned primarily about being able to continue to provide the most optimal, cost-effective care for my patients; if this unexpected change is allowed to take effect, that will no longer be possible.

Submitter : Mrs. Teresa Ross **Date:** 08/29/2007

Organization : American Physical Therapy Association

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Physical Therapy should be excluded from the in-office ancillary service exception. Physical Therapy services should only be provided by licensed Physical Therapists and Physical Therapist Assistants, who receive and poccess the education qualifications to carry out these activities. If Physical Therapy is not excluded, then this opens the door for unqualified personell to provide these services which in turn can cause increase in medically induced injuries.

Submitter : **Dr. Phil Cooper** **Date: 08/29/2007**

Organization : **Dr. Phil Cooper**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

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. Finally, CMS has recognized the gross undervaluation of anesthesia services, and it is about time 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.

Philippe Cooper, MD

Submitter : **Dr. Stephen Brotherton** **Date: 08/29/2007**

Organization : **private practice**

Category : **Physician**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Reference the proposed restriction on CERTIFIED ATHLETIC TRAINERS providing care in CLINICS: it has been our experience that using AT's as well as physical therapists reduces utilization and saves money. Athletic trainers use treatment paradigms that emphasize rapid turnaround to home exercise programs and time goals. Physical therapists benefit from a mixed provider group in the clinic setting. In our experience, PT-only clinics have longer treatment plans and slower conversion to self-directed care

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

Organization :

Category : **Individual**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Individual,

I am an Athletic Training Student from Marietta College in southeast Ohio. I am working towards my Bachelors in Athletic Training and Health Science. I am senior here and hope to go on to further schooling to sharpen my skills.

I am writing you tonight to tell you that I oppose the therapy standards and requirements for the staffing provsions for rehabilitation in hospitals and all facilites proposed by 1385-P.

Not only is this burdening me in my later profession, but my future patients. What am I working towards if one day I can not work at all.

Within the next year I will be a certified, and licensed athletic trainer. My schooling for four+ years will give me that right. I understand that their are other professions that I could have chosen, but not with this spectrum of care. With the new rules you have set in place, my services are being put on the back burner for individuals you have less experience, schooling, and qualifications that I have worked hard for and earned.

So looking into my future at this point in time it seems like a bleak outlook to fulfill my life goals and work with patients in a health care setting, because of you rules and regulations. I would love to request that you revoke these new rules and reinstate either a revised version or and old version that would give me the future that I deserve.

Thanks for you time,
Jessica Moss Athletic Training Student Marietta College

Submitter : Dr. David Hanley **Date:** 08/29/2007

Organization : WCGME

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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 : **Mr. John Keith** **Date: 08/29/2007**

Organization : **North Ohio Heart Center**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P; Proposed Physician Fee Schedule and Other Part B Payment Policies for CY2008
Coding Additional Codes from 5-Year Review

Dear Mr. Kuhn:

I am an echocardiographer/vascular technologist working in a clinical practice in northern Ohio. We provide exams for many Medicare patients, as well as the general population. I am writing this letter to state my objections concerning CMS s proposal to discontinue separate payment for the use of color flow Doppler in our cardiac exams.

Color flow Doppler is an important part of many of our procedures, but not all of our procedures. Pericardial effusion studies, stress echocardiography, and pacemaker synchronization exams often do not incorporate color flow Doppler. But, it is an important part of many of our other examinations. Color flow Doppler requires additional expense for equipment and supplies, as well as additional training for physicians and sonographers. Use of color Doppler adds to the time and complexity of exams.

For these reasons, I ask you to refrain from approving the proposed bundling of color flow Doppler into other echocardiography procedures.

Sincerely,

John B. Keith, BS, RVT, RDMS, RT
North Ohio Heart Center
Lorain, Ohio

Submitter : **Dr. Marlon Pereira** **Date: 08/29/2007**

Organization : **Dr. Marlon Pereira**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern,
I am a physical therapist and co-owner of a private practice with another physical therapist. We have had our doors open for nearly 3 years and have had to struggle immensely with physician-owned PT practices. Our office is located in Miami, FL and in my area I only know of 1 out of ~30-40 Ortho MD's that doesn't have their own PT practiee. This not only affects my office but it doesn't allow the patient to make their own decisions on where they are to receive their PT services. Most of the time they are told that if they don't go the physician's in-house PT practice then they cannot guarantee the results they will receive. Of course the patient doesn't want to upset their doctor and therefore end up in-house. There have been many studies by the AMA and CMS that demonstrate the OVER-UTILIZATION and INCORRECT CODING of PT services in physician-owned PT offices versus private practices. This makes it difficult for me to understand as to WHY this self-referral is allowed to go on. In addition, many MD offices will use unlicensed individuals to perform these services. This whole pracice of self-referrals and unlicensed activity needs to STOP, not only to save Medicare money but also to allow patients to make the best desicions regarding their PT care. Thank you

Submitter : **Dr. Edward Park** **Date: 08/29/2007**

Organization : **Newton-Wellesley Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
P.O. Box 8018
Baltimore, MD 21244

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

Dcar Ms. Norwalk,

I am writing to urge your consideration and support of the proposal to inerease anesthesia payments under the 2008 Physician Fee Schedule. When the RBRVS was institutcd, it created a huge payment disparity for anesthesia services, primarily because of a gross undervaluation of anesthesia work relative to other physician services. Today, Medicare payment for anesthesia care stands at just $16.19 per unit. This does not cover the cost of caring for our nation's seniors and forees anesthesiologists to move away from areas and hospitals with disproportionately high Medicare populations.

In an effort to right this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation. This would increase the payment by almost $4 per anesthesia unit and help greatly in correcting the long-standing inequity in anesthesia payment compared to other specialties. I am grateful that the Agency has accepted this recommendation in its proposed rule and I hope you will support full implementation of the RUC's proposal.

It is vital to ensure our senior citizens have access to expert anesthesia care by implementing the increase in the anesthesia conversion factor recommended by the RUC. This proposal recognizes the importance of our specialty in the overall health care of our seniors. It also helps to recognize and respect the tremendous advances our specialty has made in improving the safety of anesthesia for an ever aging population undergoing more complex procedures all the time.

Thank you for your consideration of this critically important matter.

Submitter : Mr. joseph schweitzer **Date:** 08/29/2007

Organization : aana

Category : Other Practitioner

Issue Areas/Comments

Background

Background

as a member of the anesthesia profession, i support the proposal to boost the value of anesthesia work by 32%.

sincerely,

joe schweitzer

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

Organization :

Category : **Hospital**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Pls don't allow Medicare to add add'l fees for surgical patients needing anesthesia...Patients forego treatment needed because they can't afford to make add'l payments for meds etc. This will be an additional burden on our already over burdened aging population. Our senior population needs our help to insure they get proper & pain free care.

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

Organization : **Anesthesia Medical Alliance of East Tennessee**

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
Baltimorc, MD 21244-8018

Re: CMS-1385-P

Ancsthesia 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 cnsure 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.

Brian R. Conroy M.D.
Knoxville, TN

Submitter : Mrs. Orlando Rodriguez **Date:** 08/29/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

In support of AANA.

Submitter : **Dr. Joshua Meezan** **Date: 08/29/2007**

Organization : **Medical Anesthesia Consultants**

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

Anesthcsia 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.

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Joshua Meezan, M.D.

Submitter : **Dr. Ricardo Gotay** **Date: 08/29/2007**

Organization : **Brevard Anesthesia Services**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

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

Thank you for your consideration of this serious matter.

Ricardo M. Gotay, MD

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

Organization : **Jeff Holweger**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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

Organization : Select Medical

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Tony Benz and I work in Concord, NC as the director of athletic training in Cabarrus County for NOVACARE rehabilitation. I have been in the field of athletic training for 20 years and have worked in many venues of the field ranging from the coverage of middle and high school sports, the coverage of college athletics and the Olympic Games. I have also worked with and for both Orthopedic Surgeons and Physical Therapists and have earned a Masters degree in Health 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,
Tony M. Benz, ATC, MHs

Submitter : **Dr. Antoinette Austin-Glass** **Date: 08/29/2007**

Organization : **Dr. Antoinette Austin-Glass**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Antoinette Austin-Glass, MD, Indianapolis, Indiana

Submitter : **Dr. Pamela Stark** **Date: 08/29/2007**

Organization : **Dr. Pamela Stark**

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-385-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's 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 PartB 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's 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's 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,

Dr. Pamela Stark, ND, CRNA
7617 Astoria Place
Raleigh, NC 27612

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

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to SUPPORT the Centers for Medicare & Medicaid Services (CMS) proposal to BOOST the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can CONTINUE to provide Medicare beneficiaries with access to anesthesia services.
This INCREASE in MEDICARE PAYMENT is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare CURRENTLY UNDER-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but REIMBURSES for ANESTHESIA SERVICES at APPROXIMATELY 40% of private market rates. JUST 40%!
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,
Mark Padrnos CRNA
Mount Vernon, WA 98274

Submitter : Dr. Juliet Hanson **Date:** 08/29/2007

Organization : MSA, ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

There is an urgent need for Medicare to increase its payments for Anesthesia Services. For too long Anesthesiologists have provided expert and vigilant service to all patients regardless of how much insurances and Medicare pay as little as possible. Insurance companies and HMOs use Medicare policies to be a guideline for what they will pay.

Submitter : **Mr. Chad Achord** **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:
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Sincerely,

Chad Joseph Achord, CRNA
12527 North Lakeshore Dr.
Walker, LA 70785

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

Organization : **American Association of Nurse Anesthetists**

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 thc 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 ancsthesia 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. JUST 40%! 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, Mark Padrnos CRNA Mount Vernon, WA 98274

Submitter : Mrs. Sara Gutierrez **Date:** 08/29/2007

Organization : Mrs. Sara Gutierrez

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer licensed in the state of FL. I have two bachlors in science degrees and have practiced as an athletic trainer since 2000. I currently have had to redirect my carcer due to changes in legislation which have made holding a job as an athletic trainer difficult, and see that this revision may put more certified athletic trainers out of work.

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,

Sara Gutierrez, ATC, LATC

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

Organization : **Albert Dentz**

Category : **Individual**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **Anesthesia Medical Group**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

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

Submitter : **Dr. joseph skibba** **Date: 08/29/2007**

Organization : **UNM Dept of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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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.
This proposal takes on greater importance when one recognizes that there continues to be an ever increasing elderly on medicare. Many in this aged population will require surgery at some time and they are best served with the availability of expert anesthesiology care. (I will be in that group next year.)

Thank you for your consideration of this serious matter.

Joseph L. Skibba, MD, PHD
Associate Professor of Anesthesiology

Submitter : **Dr. Charlie Beckenstein** **Date: 08/29/2007**

Organization : **American Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Cynthia Cappello **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
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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.
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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 Ameriea. 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.

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

Organization : Urology Associates

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a urologist who practices in a group setting in a small town, Kalispell, MT. I am writing to comment on the proposed changes to the physician fee schedule rules that were published concerning the Stark self-referral rule and the reassignement and purchased diagnostic test rules.
The changes propesed in these rules will have a serious impact on the way I practice and medicine as it will prohibit the provision of laser for prostate surgery. It is important for us to be able to provide pateints with the most up to date treatment choices, including laser prostatectomy. The service, wtihout a joint venture between the physicians and the providing laser company may not have been possible to bring to a community our size. Please do not limit the services we can provide to our patients and decrease the quality of care we are delivering. These rules go beyond what is necessary to prevent fraud in the Medicare program.

Respectfully,

Amy McKerrow,MD

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

Organization : **Parkway Neuroscience and Spine Institute**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Thomas M. Larkin, M.D.
3633 Everett St. NW
Washington, DC 20008

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 (the Proposed Rule) published in the Federal Register on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.
There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the all physicians crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as interventional pain physicians for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

***

Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

Thomas M. Larkin, M.D.
3633 Everett St. NW
Washington, DC 20008

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

Organization : **Beth Israel Deaconess Medical Center**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

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

Thank you for your consideration of this serious matter.

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

Organization : **University of Texas Medical School Houston**

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
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Thank you for your consideration of this serious matter.

Submitter : **Dr. Thomas Marks-Strauss** **Date: 08/29/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

As a practicing anesthesiologist my most difficult surgical cases are taking care of older sick medicare patients. They frequently are in the poorest baseline health and are having the most invasive medical procedures, therefore making them the riskiest patients to anesthetize. Currently, Medicare undervalues anesthesia services by an estimated 32 percent. Please rectify this by supporting the RUC's reccommendation to boost the anesthesia conversion factor. Thank you for your time and consideration in this most important issue.

Sincerely,

Thomas A. Marks-Strauss, M.D.
8731 Admirals Woods Circle
Indianapolis, IN 46236

Submitter : **Ms. Shauna Grady** **Date: 08/29/2007**

Organization : **Santa Monica High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I graduated from Merrimack College, North Andover, MA in 2005 with a Bachelor of Science degree in Sports Medicine. I am a Massachusetts licensed Athletic Trainer who recently relocated to California and currently work as the Head Athletic Trainer at Santa Monica High School.

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

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

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

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,

Shauna Grady, ATC

Submitter : Ms. Patricia Jackson **Date:** 08/29/2007

Organization : Home Care

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

You must stop the very high possibility of fraud in physicians offices by excluding physical therapy as an in office ancillary. Doctors will bill for physical therapy while having unskilled employees perform meanial activities and bill them as physical therapy. Patients who have never had PT will be suffering because they are not getting the health care they deserve and medicare will be receiving very high bills for services not performed.

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

Organization : self

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

I am writing in regards to the error of holding Santa Cruz, California in locality 99. Due to the high cost of living and doing business in Santa Cruz, there is no justification in designating it locality 99. It is very difficult at this time to find enough physicians to service our elderly population because they go to other locations which reimburse better and it has caused significant hardship to many of the medicare patients.
I favor option 3 if it can be modified to conform to the recommendation of the GAO report, because the entire central coast of California would be corrected not just Santa Cruz. Thank you for taking action now!
Sincerely
James Engelman

Submitter : **Miss. Jill Falbey** **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
Baltimore, MD 21244 8018

RE: CMS 1385 P (BACKGROUND, IMPACT)
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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,

_Jill Falbey, CRNA_____
Name & Credential
_4133 W. Northampton Pl._____
Address
__Houston, TX 77098_____
City, State ZIP

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

Organization : **Priviously employed with the State of Washington**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am a Certified Athletic Trainer and previously worked in the university setting practicing sports injury assessment and physical therapy. I will be seeking a position in a physicians office or hospital in outpatient therapy. My undergrad degree is in Exercise Science specializing in sportsmedicine and my master's degree is in Education, specifically adult education.

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Sincerely,
Linda Bergen, M Ed, ATC

Submitter :

Date: 08/29/2007

Organization :

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See Attachment

CMS-1385-P-11837-Attach-1.DOC

#11837

08/28/2007

Mr. Kerry N. Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: DMS-1385-P
P.O.Box 8028
Baltimore, MD 21244-8018

Dear Mr. Weems:

I am a practicing physical therapist with over 30 years of clinical experience. I have had the opportunity to practice in the states of Indiana, Kentucky, Virginia and Michigan. I have a wide variety of work experiences within the field of physical therapy, including working in management. Clinically, I have been fortunate to work in various areas of my profession, including rehabilitation with spinal cord, multi-trauma, head trauma, and CVA (stroke) clients, outpatient therapy, orthopedics, manual medicine, inpatient therapy, and home health care. I have always been proud of and appreciated the opportunities and challenges that physical therapy has provided for me. I am especially grateful for the ability to directly affect the quality of life for many of the individuals I have been fortunate enough to work with. Most recently, I am working in a well equipped and comprehensive private practice clinic staffed by 9 qualified and experienced physical therapists and 7 ancillary/support staff employees.

I am writing to you with concerns regarding the Medicare Program: Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule. I am writing to urge you to support that Physical Therapy services be removed from the permitted services under the in-office ancillary exception. I believe this exception has created a legal "loophole" that has resulted in significant abuse, which has resulted in the expansion of physician owned physical therapy services.

I can site an example of what recently occurred in our clinic. One of our therapists had a new client who was referred by an orthopedic specialist for a routine orthopedic diagnosis. This client was thoroughly evaluated by our therapist in a timely manner (we have been able to schedule most of our new client evaluations within 48 hours of receiving a referral). The client was set up for an appointment to begin actual physical therapy/rehabilitation within a short time following his initial evaluation. However, this client returned for a follow up re-evaluation to his orthopedist's office before his next appointment in our clinic. This orthopedic specialist has a physician owned physical therapy practice adjacent to his office. The physician proceeded to tell the client he "wasn't making progress fast enough in physical therapy" and needed to come to his physician owned clinic in order to receive the proper therapy. The client subsequently called our therapist, explaining what the physician had said. Our therapist contacted the physician's practice and explained that the client had only attended one session for an evaluation and

that he was scheduled to begin his actual physical therapy within the next couple of days. The response from the physician's office was that they wanted the client there in their practice. This client subsequently had to travel approximately 30 miles each way to the physician owned practice rather than 10 minutes to a well-qualified physical therapist who had already evaluated him, set up an appropriate & comprehensive treatment program, and was familiar with his case. In my opinion, there was no logical or appropriate reason for this client to have to travel to the physician owned practice. It did not benefit the client in any way---but I am certain it financially benefited the physician. (An interesting aside question---was this client's insurance charged for both evaluations? How appropriate & cost effective was that?)

Unfortunately, incidences like this are becoming increasingly common as more physicians open physical therapy practices. In talking with clients who are being referred by physicians who own a physical therapy practice, most of them indicate that the physicians encourage them to come first of all to their self-owned practice-even if it requires significant travel time and inconvenience to the patient. It seems that only when the clients ask these physicians for a closer, qualified practice or specifically state that they already know of a qualified physical therapy clinic, do their physicians refer them to a clinic outside of the ones that they own. It seems as if there is a large captive referral base for these physician owned PT clinics. I feel this is an abuse of the system and of no significant benefit to the client. One can only assume that this is being done primarily for financial gain.

Physical therapy services are not routinely needed at the time of the patients visit to a physician. In fact, most PT services are scheduled after the initial physician visit-even at physician owned PT clinics. Physical therapists do not assist the physician in his/her diagnosing process and we are not a needed on-site "emergency" service.

We are licensed professionals, most with Master's or Doctorate level degrees, who do not require or need direct physician supervision to provide qualified physical therapy services. Our expertise & practice is outside the scope of a physician's supervision. We are independent professionals and should remain so.

First and foremost, our primary motivation & concern should be to provide professionally excellent & beneficial physical therapy to our clients in a supportive & convenient manner. There is something terribly wrong in the system when the first & foremost reason & motivation for referral is for financial gain. I again urge you to support that Physical Therapy be removed from the in-office ancillary services exception.

Thank you very much for your consideration in this matter.

Sincerely,

L.E.D., PT
Grand Rapids, MI 49504

Submitter : **Mrs. Erica Perez** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007
Office of thc Administrator
Centers for Medicarc & Mcdicaid 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 Nursc Anesthetists (AANA), I write to support the Centers for Medicarc & Medicaid Services (CMS) proposal to boost the valuc 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 ensurc that Certificd Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to providc Mcdicare beneficiaries with access to ancsthesia services.
This increasc in Medicarc payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for ancsthcsia serviccs, putting at risk thc availability of ancsthesia and other healthcare services for Mcdicarc bcncficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and othcrs 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) eut to Mediеare 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 anesthcsia services depends in part on fair Medicare payment for thcm. 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,
Erica Perez, CRNA_____
Name & Credential
6808 Wellington Valley Court_____
Address
Fairview Heights, IL 62208_____
City, State ZIP

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

Organization : **Oregon Anesthesiology Group, P.C.**

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,
Neil J. Axel, M.D.
Attending Anesthesiologist,
Portland, Oregon

Submitter : Dr. spencer mellum **Date:** 08/29/2007

Organization : Dr. spencer mellum

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please consider the medicare reimbursement increase for anesthesiologists. The complexity and high acuity in caring for our parents, at a minimum, would warrent this token increase.

Submitter : **Mr. Kai Kline** **Date: 08/29/2007**

Organization : **CORA Rehabilitation Services**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Kai Kline and I am the Certified and Licensed Athletic Trainer at Clearwater Central Catholic High School and therapist at CORA Rehabilitation Services. I am a recent graduate of the University of Florida's Graduate Athletic Training Program and four year member of the National Athletic Trainer's Association.

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,

Mr. Kai J Kline, MS, ATC, LAT

Submitter : Dr. Neil Medalie **Date:** 08/29/2007

Organization : Acupath, DBAPathology Associates of Indian River

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007
Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Vero Beach, Florida as a solo practitioner operating an independent laboratory.

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

Other physician groups have seen these arrangements and are actively pursuing similar ones. They believe that because they are generating the revenue stream they then have the opportunity to capture the revenue stream with no risk to them or their practice, in the same way their colleagues have.

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

Opponcnts to thcse proposed changes assert that their captive pathology arrangements enhance patient care. This argument is fallacious, because in reality, in the vast majority of these cases, the execution of pathology services by these physician groups is motivated by profit only and not quality. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Submitter : Dr. Casey Chaney **Date:** 08/29/2007

Organization : Western University of Health Sciences

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician Self-Referral to physical therapy or occupational therapy may be ethically practiced by a few, but for too many it is nothing more than referral for profit. As a health care professional and an educator of future health care professionals, I am very opposed to physician self-referral because, too often, it results in a lack of quality care and over billing to Medicare for unnecessary procedures. Being intimately involved in the education of DPTs in California, I know the depth and breadth of the education physical therapists receive. As an active member of the APTA and the CPTA, I know that physical therapists are practicing evidence-based practice to provide each and every patient with the best-quality of care known, as well as continued research to expand this knowledge. Additionally, physical therapy interventions are critical to restore function and quality of life, as well as to save the patients and the Medicare system from more costly interventions.

I urge you to remove physician self-referral provisions in order to provide the highest quality of care without unnecessary costs depleting the funds and depriving those that really need our assistance.

Respectfully,
Casey Chaney, PhD, PT, OCS, CSCS
Associate Professor of Physical Therapy Education
Board Certified Orthopedic Clinical Specialist

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

Organization : Leann Peters

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As a soon to be "medicare" patient our physicians in the community should be reimbursed at a level that there years of training require. The stigma and decreasing amount of doctors who want to serve medicare patients will continue to decrease.

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

Organization : **Dr. John Bethea**

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 strong support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. There are multiple factors that make this issue so important. The fact that since RBRVS was implemented anesthesiologists have been significantly underpaid compared with the rest of the medical doctors as well as getting hit with what amounts to cost-of-living penalties. Even the minimum wage has gone up by a larger percentage.

With the rising number of surgical procedures that can be done to help people that are ever sicker, it seems sad that when doctors -anesthesiologists - are being penalized financially when we take care of the older and sicker people.

My children hear me talk with there mother about this situation and they have asked me why people (the government) would treat doctors this way. I have not been able to give them an answer they will accept. I believe they are learning from seeing and hearing this go on. I wonder what choices they will make in the future. I wonder if they will choose medicine (especially anesthesiology) or if they will become dentists or choose some other job.
I hope that I will be able to tell my children (and wife) that this increase went through and that we are appreciated. Therefore, I ask you to please enact this provision to increase the anesthesia conversion factor increase as recommended by the RUC.

Thank you for reading this comment and for supporting the future of anesthesiology in the United States.

Sincerely,

John Bethea

Submitter : Dr. Ryan Brandt **Date:** 08/29/2007

Organization : Santa Cruz Medical Clinic

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

I would strongly urge CMS to update physician localities to resolve the unfair issues related to area 99. Santa Cruz, CA is currently considered area 99 for physician payment and is not a rural area. The discrepancy between San Jose and Santa Cruz is signficant in physician payment--yet the cost of practicing is the same. We have tried for years to convince CMS/Congress/patients that this is grossly unfair--and as a result we have been underpaid for years. Please equalize the playing field and bring Santa Cruz and other misappropriated communities up to the urban payment schedules that they deserve. Thank you

Submitter : **Mrs. Jaime Tessier** **Date: 08/29/2007**

Organization : **American Association of Nurse Anesthetist**

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.

_ 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,

Jaime Tessier, CRNA
3019 Ironwood Circle
Jeannette, PA 15644

Submitter : **Dr. Steven Saul** **Date: 08/29/2007**

Organization : **The Saul Clinic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimore, Maryland 21244-8018

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Submitter : **Dr. Gregory White** **Date: 08/29/2007**

Organization : **SMMC**

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

Rc: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dcar 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. 1 am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. Christine Mackey **Date:** 08/29/2007

Organization : AANA

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

Dcar Administrator:
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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 Medicarc 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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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 thc valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

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

Organization : **SMMC**

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 inerease as recommended by the RUC.

Thank you for your consideration of this serious matter.

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

Organization : Davis Wright Tremaine LLP

Category : Attorney/Law Firm

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached document for comments.

CMS-1385-P-11852-Attach-1.PDF

#11852

Comment on File Code CMS-1385-P, due by 5 p.m. Friday August 31, 2007

Submit electronically to: http://www.cms.hhs.gov/eRulemaking

Issue Identifier: PHYSICIAN SELF-REFERRAL PROVISIONS

We represent a number of clients potentially affected by the amended definition of "entity" in the Medicare Physician Fee Schedule (MPFS) Proposed Rule at Section II.M.22. ("Services Furnished 'Under Arrangements'"), 72 Fed. Reg. 38122, 38186-87, 38224 (July 12, 2007). We urge CMS not to adopt this proposed amendment because it is both overbroad and ambiguous. It will lead to an unnecessary increase in hospital costs, disruption of a number of beneficial arrangements, and increased inefficiency in the delivery system and will create a legion of what appear to be unintended consequences.

A. The Proposed Amendment Fails to Recognize the Benefits of Under Arrangements Relationships.

In the commentary to the MPFS Proposed Rule, the agency expressed concern that certain "under arrangements" relationships between physicians and hospitals may lead to over-utilization and abuse. While there may be instances where such concern is warranted, amending the definition of entity in the manner suggested is not the solution.

CMS has historically recognized that "under arrangements" service agreements between hospitals and other providers lower costs, increase access and serve a number of legitimate goals. CMS's sweeping revision of the definition of "entity" under the Stark Law at 42 C.F.R. 411.351 to include both the person or entity that bills for a Designated Health Service ("DHS") and the person or entity that either performs the service or "causes a claim to be presented for Medicare benefits for the DHS" greatly limits the ability of hospitals to obtain services under arrangements. All "under arrangements" service providers would become "entities" under the Stark Law, and all physician owners of such entities would appear to have prohibited ownership interests. This revision would effectively throw out the baby with the bathwater.

In the MPFS Preamble on "Services Furnished 'Under Arrangements,'" CMS fails to discuss or even acknowledge the benefits of the various physician-owned "under arrangements" providers. The agency should investigate the impact of its proposed amendment in terms of the disruption of care, increase in cost and restrictions on access before taking action. Moreover, it seems more appropriate for the agency to consider whether the perceived problem with under arrangements service agreements could be better addressed with a more limited approach or through changes to other CMS regulations such as those governing a hospital's ability to bill for services provided under arrangements.

B. The Proposed Amendment Creates Unnecessary Complexity and Uncertainty.

The existing definition of an "entity" that is considered to be furnishing DHS under the Stark Law is generally limited to "the person or entity to which CMS makes payment for the DHS." 42 C.F.R. §411.351. Under the proposed revision, an "entity" that is considered to be

furnishing DHS would also include a person or entity that has "performed the DHS" or that has "caused a claim to be presented for Medicare benefits for the DHS." 72 Fed. Reg. 38224 (July 12, 2007). While this new three-part definition of "entity" may result in full employment for health lawyers, it is difficult to see how any perceived benefit would outweigh the increase in confusion and complexity in the application of the Stark Law. For instance, under the proposed definition of "entity," a single DHS referral may cascade into three or more separate referrals to "entities," each of which must be separately analyzed. A provider must consider (or more likely pay a lawyer to analyze) the financial relationships between the involved physicians and the entity billing the DHS, the entity performing the DHS, and anyone who plays any role that could somehow be construed as causing the DHS claim to be submitted.

By including the entity that performs the DHS in the definition of entity, the proposed amendment not only eliminates the possibility of any physician ownership in "under arrangement" providers, but it also raises a host of ambiguities as to the circumstances under which a person is deemed to have provided a DHS. For example, if a service is only a DHS by virtue of being billed as a hospital service, is a person that provides such a service in a non-hospital setting an "entity" under the proposed definition? Is a person who provides a component part (i.e., perfusion services) of a service billed by a hospital as an outpatient or inpatient service an "entity" under the proposed definition?

Perhaps the most ambiguous and potentially disruptive aspect of the proposed amendment to the definition of entity is the inclusion of all persons who *cause a claim for DHS to be presented.* Neither the proposed text of the regulation nor the commentary offer a clue as the intended scope of this provision. It could be interpreted to expand the Stark prohibition far beyond anything that Congress envisioned. If so interpreted, the agency lacks the authority to amend the statutory prohibition in a manner inconsistent with Congressional intent. At a minimum, the "caused to be submitted" standard will add complexity to a statute that already has more than its share. Will all vendors of equipment, supplies, devices, drugs and software be deemed to have "caused a claim for DHS to be submitted" by selling goods or services to a hospital which then uses the goods or services in the delivery of inpatient or outpatient hospital services? If simply selling a good or service to a hospital is not enough to "cause a claim for DHS to be submitted," what is the standard? Will all persons who provide a component part of a service billed by a hospital under a prospective inpatient or outpatient payment rate be deemed to have caused the hospital to submit a claim for DHS? If not, what criteria should one use to determine when a component provider might cause a hospital to submit a DHS claim?

The 2001 Stark II Phase I Final Rule adopted a bright line test for the definition of entity: the entity that bills the Program is the entity furnishing the DHS. Now, six years later, after the industry has relied upon the definition in structuring a legion of financial arrangements, CMS has proposed a new definition that fundamentally alters the analysis of the law and raises far more questions than it answers to boot. The proposed definition should be abandoned because it is ambiguous, unworkable and will cause significant disruption in the health care delivery system.

C. MedPAC Proposal is Flawed.

CMS also solicits comments regarding the Medicare Payment Advisory Commission (MedPAC) March 2005 Report to Congress, which recommended that the Secretary "expand the definition of physician ownership in the physician self-referral law to include interests in an entity that derives a substantial proportion of its revenue from a provider of [DHS]." While the MedPAC Report was published after the close of the Stark II Phase II comment period, CMS notes that certain arrangements structured such that referring physicians own leasing, staffing, and similar entities furnish DHS without submitting claims are already prohibited by Stark Law. We generally agree that revising the definition of "entity," as problematic as that is, is more straightforward than MedPAC's recommendation. Expanding the definition of physician ownership to include interests in entities that derive a "substantial proportion of revenue derived from providing DHS" would disrupt many existing, valid relationships that benefit hospitals and the public, including management services joint ventures that manage physician practices or hospital service lines and joint venture building or equipment leasing companies. Simply put, if the proposed revision to the definition of "entity" would disrupt many valid relationships, the MedPAC recommendation would have an even more pernicious effect on the health care delivery system.

Thank you for your consideration of our comments.

Sincerely,

Davis Wright Tremaine LLP

/s/ Robert G. Homchick

Submitter : **Dr. Chad Weare** **Date: 08/29/2007**

Organization : **SMMC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **SMMC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Alan Buchwald **Date:** 08/29/2007

Organization : Dr. Alan Buchwald

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/ and or Madame: Regarding GCPIs and Locality 99, it is time for the Dept of Health and Human Services as CMS to remove Santa Cruz County from locality 99.

There has never been any further justification for keeping Santa Cruz within Locality 99 except that the remaining counties would receive less money.

There are multiple other federal programs which support rural or less serviced counties, the GPCI formula should not be used for this purpose, as it was designed to give everyone their fair and ealculated cost return for providing the care in their partieular locality.

I personally favor option 3 since it is my belief that Option 3 sets forth a reasonable change for localities in California but that CMS miscalculated the designation of the new payment localities. It appears that Option 3 of the CMS proposed rule - if correctly calculated - would result in the tri-county area (Santa Cruz, Monterey and San Benito) all being bumped up into a new, fairer payment locality.

Sincerely, Alan Buchwald, M.D., Past President, Santa Cruz County Medical Society, Santa Cruz, California 8/29/07

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

Organization : Mr. Thomas Bartrum

Category : Attorney/Law Firm

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

With respect to the proposed changes to the set in advance requirement relative to percentage compensation arrangements, the proposal to limit such arrangements to "revenues directly resulting from personally performed physicians services" is too restrictive and will cause hospitals and other DHS entities to waste resources restrueturing numerous, legitimate arrangements. First, there are other legitimate percentage compensation arrangements that use a basis other than a percentage of revenuc, sueh as percentage of charges, percentage of collections, percentage of costs, percentage of third party fee schedules, etc. For instance, this change would eliminate the ability of hospitals to bill globally for a service and pay the physician a percent of its charges. Likewise, hospitals could not pay physicians in gain sharing arrangements based upon a percentage of cost savings. Second, limiting the revenues to "physician services" would eliminate a number of legitimate arrangements whereby DHS entities and physicians are trying to align their financial interest. For instance, even if CMS expands the allowable basis of percentage compensation arrangements to more than revenue, such arrangement would still not be allowed because the physician is being compensated for something other than physician services. Likewise, percentage compensation arrangements for administrative tasks such as management services or medical directorships are often used to minimize the potential outlay by the DHS entity in the event that the physician (or group practice) does not perform at the level anticipated. A flat compensation basis puts the DHS entity at risk for paying more for services than such services are often worth (that is, even if there is a front end fair market value, if the assumptions on which the fair market value was based do not bear out over the term of the agreement the physicians may be get paid more than their effort merits or more than the value of the service to the DHS entity (e.g., if a hospital pays physicians to help develop a spine center and despite the best efforts of the parties the spine eenter is not utilized by patients). Third, if CMS' concern is percentage compensation in equipment and space rental situations, a more effective solution would be to prohibit pereentage compensation arrangements under those speeific exceptions. Personally, I have seen very few percentage lease or space rental agreements and when discussed with clients, they usually agree that these arrangements are too risky from an Anti-Kiekback Statute (AKS) perspeetive. On this note, I would also add that many of the proposed changes to the Stark law seem to be in response to either a lack of enforcement of the AKS or a failure of parties to health care transactions to adequately consider the AKS risks. Although some in the health care industry may applaud CMS' efforts to fill sueh gaps, they are typically motivated to do so in an effort to proteet their own historic turfs given the overall disruption of service locations and providers/suppliers of services in the market and, from a pure policy perspective, given the delineation of ageneies with enforcement responsibility, I would caution against blurring the lines between the two statutory authorities and resist the temptation to turn the Stark law into a cure all for bad actors in the health care industry. The health care industry is in a state of evolution and evolution naturally attracts bad actors; however, regulating to the level of bad actors, will likely stifle innovation which is necessary as health care delivery evolves. With some tweaking the current exceptions provide a good floor upon which good actors can experiment, over regulation will stifle such. AKS enforcement activities and guidance will eventually weed out the bad actors (e.g., 04-17 was the beginning of the demise of pod labs).

These comments are personal and do not reflect the opinion of my firm or any client.

Submitter : Dr. Heather Smith-Fernandez **Date:** 08/29/2007

Organization : University of Florida

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

As a Pain Management Specialist, I would like to have the specialty designation code of 09.

Submitter : Mrs. kyle benedetto **Date:** 08/29/2007

Organization : CCMC/Villanova University

Category : Other Health Care Professional

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 ean continue to provide Medicare beneficiaries with access the anesthesia services.

This increase in Medicare payment in 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 the 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, in 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,

Kyle C. Benedetto, RN, BSN, SRNA
Gilbertsville, PA 19525

Submitter : **Dr. Ray Engstrom** **Date: 08/29/2007**

Organization : **Private Practice Physician**

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 reetify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a ealculated 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.

Dr Ray Engstrom
Alamo, CA 94507

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

Organization : **AANA**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

Dear Administrator,

I write to encourage you to support CMS-1385-P. Certified Registered Nurse Anesthetists (CRNAs) are an integral part of America's health care system providing approximately 27 million anesthetics annually. This group of anesthesia practicioners continues to provide Americans with an extremely safe and reliable service.

If adopted, CMS' proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare type B providers could continue to provide Medicare beneficiaries with access to safe and readily available anesthesia services.

Unfortunately, reimbursements have fallen below inflationary adjustments for sometime. If this trend continues it will become ever difficult to ensure that these highly skilled practicioners are available to provide the 27 million safe anesthetics annually.

I urge you to support CMS-1385-P.

Thank you for your attention to this situation,

Mike Carpenter, CRNA

Submitter : **Mrs. Ellen Balsizer** **Date: 08/29/2007**

Organization : **Millennium Anesthesia Care**

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 : Dr. Douglas Doty **Date:** 08/29/2007

Organization : SMMC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Jamal Fakhoury** **Date: 08/29/2007**

Organization : **Fakhoury Chiropractic Clinic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr Jamal Fakhoury Bsc, DC, FACO, PA

Submitter : Mr. Kenneth Call **Date:** 08/29/2007

Organization : Therapeutic Associates West Kennewick PT

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-11864-Attach-1.DOC

#11864

CMS-1835-P
Physician Self-Referral Issues.

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

Submitter: Kenneth S. Call, PT, DPT

Mr. Kerry N. Weems
Administrator – Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Dear Mr. Weems,

I would like to share with you how my practice has been affected from the problem of physician self-referral. I opened my outpatient physical therapy practice in 1997 in Kennewick, Washington. During this time I have treated many patients and developed many friendships with patients and the community. Often times when these former patients have an injury they return for care.

In the past few years we have had a few physician groups open physical therapy practices in which they have a financial interest. While this was of concern to me I know I have a good reputation in the community and believe that I will be able to continue providing excellent care to the community.

What surprised me was when I was treating the spouse of a former patient and she told me her husband would be having surgery and coming back in for therapy. Following the surgery I did see that this former patient scheduled to come in for therapy and then his name was removed from the schedule. When I asked if he was ok she related to me the fact that the physician had called this patient at home and told them that if they did not go to his therapist he would revoke the referral and discharge the individual as a patient with no further care provided.

While this is just one example of the abusive nature of physician referral for profit I have had several of the other local physical therapists contact me and ask what we can do to fight this problem as they have seen their referrals reduces as well. I have encouraged them to educate their patients that they do have a choice as to where they receive therapy and to continue providing the excellent care they know how as well as to contact CMS with how they have been affected by this same practice by physicians.

It is my hope that CMS will address the physician self-referral law and reduce or eliminate this practice.

Thank you for your time,

Kenneth S. Call, PT, DPT
Therapeutic Associates, Inc.
West Kennewick Physical Therapy

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

Organization : Mr. Rhett Scott

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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' propsal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Mediare 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 service, 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% sustainsable 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.

Submitter : Mrs. heather hawley **Date:** 08/29/2007

Organization : Mrs. heather hawley

Category : Nurse

Issue Areas/Comments

Background

Background

Dear Administrator:
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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).
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Sincerely, Heather Hawley RN, BSN

Submitter : **Dr. Jedidiah Smith** **Date: 08/29/2007**

Organization : **Anchorage Spinal Care Center**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Dear Sir or Madam,
This is a technical correction for file code CMS-1385-P.
It has come to my attention that certain lawmakers have proposed to cut Medicare reimbursement of x-rays taken at a radiological facility, when ordered by a doctor of chiropractic.
Although the intent of this proposed rule is unknown, I can assure you that the outcome will be very unfavorable to the senior citizens of this country. I am a third generation chiropractor, and can relate some of the history of this issue with you. Doctors of chiropractic have always been considered "gatekeeper status health care providers from the time of the earliest formation of the state licensing boards of chiropractic to today. The three licensed primary care providers are medical doctors (M.D.), osteopaths (D.O.), and chiropractors (D.C.). All doctorate level programs are similar in duration, course of study, and clinical knowledge. To discriminate against one or prefer one of these groups over another is a personal issue based on philosophy of health, rather than science.
Please consider that you are dealing with doctorate level, gatekeeper status health care providers when creating and/or changing laws that pertain to the profession.
The proposed decision to stop reimbursing Medicare patients for x-rays will not directly affect the doctors of chiropractic - however, it will directly affect the senior citizens on a limited income, and this is why: Chiropractors are not currently reimbursed from Medicare for x-rays taken at our office.
However, it has been our right, (and I maintain that it will always be our right) as licensed primary care providers to refer a Medicare patient for x-rays when needed, and that Medicare will reimburse the radiological clinic for those services.
Any change to cut this policy would only serve to take more money out of seniors' low, fixed incomes, and demonstrate a lack of understanding of the status of doctors of chiropractic as laid out by the state licensing boards of this country.
Thank you for your time and consideration in this matter.
Sincerely,
Dr. Jedidiah T. Smith
Anchorage, Alaska

Submitter : **Miss. Elizabeth Couture** **Date: 08/29/2007**

Organization : **Beaumont Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Please see attached letter regarding my support for the increase in reimbursement for anesthesia services from Medicare and Medicaid.

CMS-1385-P-11868-Attach-1.DOC

11868

August 20, 2007

Ms. Leslie Norwalk, JD
Acting 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 Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Dr. Leslie Gearhart** **Date: 08/29/2007**

Organization : **Redding Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

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

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

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

Submitter : **Dr. Dai Lu** **Date: 08/29/2007**

Organization : **North Houston Anesthesiologists**

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 inerease 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 arcas 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.

Dai Lu, Ph.D., M.D.
Norhth Houston Anesthesioloists
Houston, TX 77345

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

Organization :

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Fran and I am a physical therapy student in NY. I have just recently started school but have worked for the past two years in a physician owned out-patient orthopedic physical therapy clinic as an athletic trainer. My undergraduate degree was in Kinesiology but my focus was in athletic training which led me to my certification four years ago. Unfortunately I feel that the profession of athletic training is in jeopardy and am uncertain about the future of its practice. I take great pride in being an athletic trainer and want it to be known that they are a great addition to the medical profession and need to be secured within the health care realm.

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

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

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 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,
Fran

Submitter : **Dr. Douglas Jensen** **Date: 08/29/2007**

Organization : **American Society of Anesthesiologists**

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.

Douglas R. Jensen, M.D.

Submitter : Mr. charles zueck **Date:** 08/29/2007

Organization : american association of nurse anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

please approve CMS proposed changes in increasing anesthesia reimbursement. Anesthesia payments have fallen behind inflation and the public deserves better.

Submitter : **Ms. Heidi Ritchie** **Date: 08/29/2007**

Organization : **Fairbanks Memorial Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear sir or Madam:

I am a Certified Athletic Trainer employed by Fairbanks Memorial Hospital. I have a bachelor's degree from North Dakota State Universtiy,an accredited institution.I havc worked in our outpatient rehabilitation clinic for eleven years. In addition to treating patients in the outpatient setting our staff of ATC's provide scrvices to threc of the local high schools, a junior A hockey team and assist the sports medicine staff at the University of Alaska Fairbanks.

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.

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Sincerely,

Heidi J. Ritchie ATC

Submitter : **Dr. Yar LUan Yeap** **Date: 08/29/2007**

Organization : **Indiana University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Carmencita Castro** **Date: 08/29/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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Thank you for your consideration of this serious matter.

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

Organization : **AANA**

Category : **Other Health Care Professional**

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.

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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,

Gene Tyler McDonald, CRNA

Submitter : **Mr. Abraham Hancock** **Date: 08/29/2007**

Organization : **University of Southern Mississippi**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Hi, my name is Abraham Hancock. I am a recent graduate of the Kinesiotherapy program at USM. I am currently working toward an MS in Exercise Science.

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist who has been practicing for over 20 years and I have been a business owner of an orthopedic PT clinic for over 10 years. Quality patient care has always been my primary goal and minimizing costs to patients is part of that goal. Within the last 4 years we have had a physician-owned practice open 2 offices within 10 miles of my clinic. We have encouraged our patients to chose where they wanted to attend PT, just as they can chose what pharmacist to fill their medical prescriptions.

Scenario 1 - We had a patient who was very happy with our services but she knew she was going to need surgery to repair her dysfunction. She knew she could return to our clinic after surgery. When she went to the surgeon, who owns a physician-owned PT practice, he told her he would not do the surgery if she returned to our clinic. She was forced [blackmailed] into attending PT at his facility is she wanted to have her surgery done. She was not able to return to our office.

Scenario 2 - we had a patient that we had seen in the past, who had been very pleased with our services. The patient went to the orthopedic surgeon who had a physician-owned PT practice, who recommended continued PT. The MD wanted the patient to attend PT at his facility 'so he could keep better control on what gets done'. Per MD advice, the patient did begin at his PT facility. After 1 month, upon recheck with the MD, the MD ordered continued PT. The patient told him he wanted to return to our facility [the patient preferred the quality at our facility versus the MDs]. The MD told the patient that if he were going to attend PT at our facility, he would discontinue PT. If the patient wanted to continue at his office, he could.

We have seen NUMEROUS cases where the MD [owner of a physician-owned PT practice] strong-armed the patient into attending PT at his facility. The patient was not given a choice. This is certainly not in the financial interest of the patient or any insurance company. We have also had patients return to our facility for the quality care. Despite my being a business owner, I am a physical therapist first and appropriate care is always the most cost-effective. It is ALWAYS less expensive to do the job right the first time than to have to correct mistakes later, whether the mistake is made by a PT, MD or the patient.

There is not a doubt in my mind that you have seen an increase in PT charges since the number of physician-owned PT practices has increased. I certainly hope that you have or will track charges in physician-owned practices versus PT-owned and take action accordingly. Most of these physicians are not looking out for the interest of their patients, but rather the interest of their bank accounts.

Submitter : Dr. Sharon Tiefenbrunn **Date:** 08/29/2007

Organization : Sharon F. Tiefenbrunn, M.D.

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

The exemption of Mohs Surgery from the MMPR has resulted in the evolution of skin cancer care from an inpatient procedure with general anesthesia to an outpatient procedure done in physicians offices under local anesthesia. Cure rates are excellent, and functional and cosmetic outcomes have improved with this exemption . Fairness, when looking at the separate nature of Mohs for more than one lesions, or of Mohs and a repair, would dictate that this exemption should continue.

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

Organization : Indiana University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P
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.
CMS-1385-P

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please take this email seriously. Our livlihood and our ability to continue helping people on a daily basis is in grave danger. Physical Therapists and Physical Therapists ONLY should own and operate PT clinics. Physicians should not have ownership or have the ability to employee PT's just as we should not own physician practices! If the physician truly 'wants the best care for their patients' then all they have to do is create a relationship with a great PT in their area to refer to. It's that easy. Instead they open PT clinics or employ PT's to work for them. They don't attempt to find the best PT to deliver great care, they hire the most inexperienced and most importantly the cheapest PT they can find. Then, they have them see as many patients as possible in a day. This is the best combination for the physican to make money. This ability to allow physicians to own PT's and make money off them gives them unlimited opportunity for patient abuse. Suddenly, most, if not all of their patients need PT. Just because everyone in medicine is experiencing cut backs in reimbursements, why should PT's provide more income to the physician? The physician is already making an income that the PT can't even dream about. I have been a private PT practice owner since 1985. We have gone through many bouts of physician owned practices that have detrimentally effected us. We work very hard to do the best for our patients and keep our physicans who refer to us happy with our care. It is hard work and rewarding. Many years ago we had a thriving practice, very dedicated PT's and were helping many patients. Overnight, a handful of our physicians who referred to us openned their own PT clinic. We lost 40% of our patients in a matter of days. We lost a clinic, a business and in the end, it was the patients who lost the most. It wasn't that we all of a sudden gave bad care. It was pure greed on the part of the physician. Please help us keep our profession in the hands of the Physical Therapist and allow us to continuing helping our patients. Thank you.

Submitter : **Ms. Jessica Dettore** **Date: 08/29/2007**

Organization : **University of Pittsburgh Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Jessica Dettore, I have been an athletic trainer for the past 5 years. I have worked in the high school setting for the past three years and care for the high school and middle school athletic programs in the prevention and treatment of injuries. I have a Bachelor's degree in Athletic Training and a Masters in Education Administration. I enjoy my job as an athletic trainer because of the rewards you receive getting a player back out onto the field following an injury.

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,

Jessica Dettore ATC, MEd

Submitter : **Dr. Carmencita Castro** **Date: 08/29/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Daniel O'Connor** **Date: 08/29/2007**

Organization : **University of Houston**

Category : **Academic**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am an assistant professor at the University of Houston, Department of Health and Human Performance. I have practiced as an athletic trainer and physical therapist in several different settings, including as a 'physician extender,' or in-office ancillary service. I have a doctorate in kinesiology, and I am the author of a textbook on medical pathology that is currently widely used in university athletic training education programs.

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.

I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting. In particular, I believe that these proposed rules will increase the lack of access to health care for many 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. As I am credentialed as both an athletic trainer and physical therapist, I can assure you the services offered by each profession differ in material ways. Athletic training education, clinical experience, and national certification exam ensure that patients receive quality health care. State laws, hospitals, and medical professionals have deemed athletic trainers as qualified to perform these services. The proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known. It is irresponsible to further restrict their ability to receive those services. The flexibility permitted by current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients that receive the best and most cost-effective treatment available.

CMS seems to have come to these proposed changes without clinical or financial justification. I implore 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,

Daniel P. O'Connor, PhD, ATC, PT

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

Organization : **Augusto Torres**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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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,

Augusto J. Torres

Submitter : Dr. Sharon Tiefenbrunn **Date:** 08/29/2007

Organization : American Society for Mohs Surgery

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

ASMS represents over 850 physicians with this comment.

CMS-1385-P-11887-Attach-1.PDF

#11887

American Society For Mohs Surgery

August 29, 2007

The Honorable Herbert Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Washington, DC 20201
Phone: 202-690-6726
E-mail: herb.kuhn@cms.hhs.gov

Re: CMS 1385-P: 2008 Medicare Fee Schedule
Coding – Multiple Procedure Reduction Rule for Mohs Surgery

Dear Acting Administrator Kuhn:

As President of the American Society for Mohs Surgery, a medical specialty organization representing over 850 Mohs Surgeons, I would like to thank you for the opportunity to comment on the proposed change in the exempt status of Mohs surgery codes 17311 and 17313 from the Multiple Procedure Reduction Rule (MPRR). We are concerned that the proposed rule would represent a significant reversal of CMS's own longstanding exemption of the Mohs codes from the MPRR. This change would result in increased medical costs, increased recurrences of skin cancer, and increased complications following surgery.

Legal and procedural issues regarding Mohs Surgery and the proposed change in the MPRR have been addressed in a joint letter from the American Academy of Dermatology, American Society for Dermatologic Surgery, American College of Mohs Surgery, and the American Society for Mohs Surgery. I understand that a face to face meeting with representatives from these societies is scheduled. The purpose of this communication is to discuss the impact that the proposed rule would have on the treatment of skin cancer, and the resulting increased costs, patient inconvenience, and reversal of prior gains in cure rates and quality measures that would occur.

Exemption of Mohs from the MPRR since 1991 has resulted in an evolution of skin cancer care that has had positive impact on patient outcomes and cost effectiveness. The past 16 years have seen higher cure rates, fewer complications, better functional outcomes, and movement of services out of the O.R. to the physician's office or other outpatient setting, resulting in significant cost savings. Instead of having a skin cancer widely excised in the O.R. under general anesthesia and a skin graft placed, resulting in disfigurement, loss of function and an increased risk of complications, patients are treated by dermatologists who have acquired skills in accurate, margin- controlled excision (MOHS), with a cure rate of 96% to 99%, followed, usually on the same day, with a flap, linear repair, or graft. Dermatologists have enthusiastically acquired great expertise in both Mohs Surgery and the flaps required to achieve the best possible outcome to the surgical cure of skin cancer. This has been enabled by the MPRR exemption for Mohs that has allowed full payment for Mohs and repair of the first lesion on the same day.

The reversal of this rule may encourage separation of the services of extirpation and repair, moving reconstruction back into the hands of other surgical specialists who are accustomed to using general anesthesia and the O.R. to perform their cases. This would result, not in the cost savings anticipated, but

would have the opposite effect, a significant increase in costs. It would also cause inconvenience to our patients, loss of time from work, increased postoperative complications from delay in repair of the Mohs-created surgical defect, and increased risks of general anesthesia and hospital acquired infections.

CMS has suggested that there are efficiencies in performing Mohs surgery on two lesions on the same day. This issue was addressed in 1991, at which time CMS concluded that Mohs surgeries are clearly separate procedures in a series of procedures. In 2006 Mohs codes were changed to 17311 and 17313 to reflect Mohs Surgery performed at different anatomic sites. The technical requirements of the procedure, however, remained the same as the 17304 procedure. Since a large part of the Mohs procedure itself involves pathology services, viz. mapping, creating frozen sections, and interpreting them, and as these pathology services must be performed separately for each separate Mohs case (each separate lesion) , treatment of two lesions on the same patient on the same day results in procedures that are largely separate. Pre- and post- service work is a minimal component of the Mohs procedure. Therefore, the second Mohs procedure performed on the same day should be exempt from the MPRR.

The July 2004 CPT Assistant article also reviewed the rationale behind the MPRR exemption: "The rationale for this policy is that for many surgical procedures some of the work of a procedure is not repeated when two or more procedures are performed. For these procedures the intraservice work is only 50% of the total work, while the other 50% represents pre- and post-service work that overlaps when multiple procedures are performed on the same patient on the same date of service. **For Mohs surgery, however**, greater than 80% of the work is intraservice work that does not overlap when two or more procedures are performed. The pathology portion of Mohs surgery constitutes a large portion of this total and also is not reduced with multiple procedures. The pre-service and post-service work values are small because there is a zero-day global period. Together there is very little overlap or reduction in work when two or more tumors are treated on the same patient on the same day. Therefore, Mohs surgery codes are exempt from the use of modifier 51."

Mohs and the first repair also are distinct and separate procedures. The surgeon achieves very few efficiencies by doing these on the same day. The Mohs procedure must be completed in its entirety before the repair is begun. This requires the surgeon to wait while the frozen tissue sections are being prepared before he can read the sections, determine if the tumor has been cleared, and then begin the repair. Repair requires re-rooming of the patient, repositioning of the patient, re-prepping, re-draping, re-anesthetizing and, in most cases, opening a new pack of sterilized surgical instruments for the repair.

Mohs surgery has been proven to be a cost-effective treatment for skin cancer. The payment policies that have been in place for the past 16 years have resulted in an evolution of excellence in the treatment of skin cancer. Rising costs reflect an epidemic of skin cancer in an aging population; the cost of care does not reflect lack of value. As the epidemic of skin cancer expands, we hope CMS will maintain economic policies that promote excellent, convenient, and cost efficient care which will benefit our patients and our nation as a whole.

In closing, I wish to thank you again for the opportunity to comment on an issue that is critically important to our members and the over 1 million patients with skin cancer whom we serve. Should you require additional information, please do not hesitate to contact Novella Rodgers at execdirasms@aim.com. I appreciate your attention to this important matter.

`Sincerely,

Sharon F. Tiefenbrunn, M.D.
President

cc : Terrence Kay, Director, Hospital and Ambulatory Policy Group, Centers for Medicare and Medicaid Services
Amy Bassano, Director, Practitioner Services Division, Centers for Medicare and Medicaid Services
Diane Baker, MD, President, American Academy of Dermatology
David G. Brodland, MD, President, American College of Mohs Surgery
Allistaire Carruthers, M.D, President, American Society for Dermatologic Surgery

Volume 39, Issue 5, Pages 698-703 (November 1998)

Mohs micrographic surgery: A cost analysis★★★★

Joel Cook, MDa, John A. Zitelli, MDb

Accepted 20 July 1998

Abstract

Background: The incidence of skin cancer is increasing significantly, and many people have declared the increase an epidemic. It was estimated that 900,000 to 1.2 million cases of nonmelanoma skin cancer occurred in the United States in 1994. With increasing pressure to deliver cost-effective medical care, physicians must understand the cost and value of the various methods to treat skin cancer. ***Objective:*** Our purpose was to define the true cost of treating a series of skin cancers with the Mohs micrographic technique and compare our costs with calculated estimates of the costs to treat the same cancers with traditional methods of surgical excision. ***Methods:*** A group of 400 consecutive tumors was selected. The cost of treatment in the reference group included diagnosis, Mohs micrographic surgery, reconstruction (if applicable), follow-up, and the cost to treat disease recurrence. These costs were then compared with traditional methods of surgical excision: excision with permanent section margin control, excision with frozen section margin control, and excision with frozen section margin control in an ambulatory surgical facility. For cost comparisons, it was assumed that all tumors in the comparison groups would be excised with standard surgical margins and the resultant surgical defects would be reconstructed with the simplest method possible. The costs of diagnosis, excision, pathology, reconstruction, and the cost to treat disease recurrence were then calculated and compared with the costs of treating the lesions with Mohs micrographic surgery. ***Results:*** Our calculation of costs documents that Mohs micrographic surgery is similar in cost to office-based traditional surgical excision and less expensive than ambulatory surgical facility–based surgical excision. The average cost of Mohs micrographic surgery was $1243 versus $1167 for excision with permanent section margin control, $1400 for excision in the office with frozen section margin control, and $1973 for excision with frozen section margin control in an ambulatory surgical facility. Analysis based on anatomic location yielded similar results. ***Conclusion:*** Mohs micrographic surgery is a method of surgical excision with high intrinsic value that is cost-effective in comparison to traditional surgical excision. (J Am Acad Dermatol 1998;39:698-703.)

Submitter : **Mr. John Masserant** **Date: 08/29/2007**

Organization : **Mr. John Masserant**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

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

John Masserant, CRNA, MS
3704 East Garden Court
Saline, MI 48176

Submitter : **Dr. Douglas Olin** **Date: 08/29/2007**

Organization : **Dr. Douglas Olin**

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 : Mr. Douglas MacKay **Date:** 08/29/2007

Organization : Evans County Schools

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

2

CMS-1385-P-11890-Attach-1.DOC

#11890

29 August, 2007

Dear Sir or Madam:

My name is Doug MacKay; I am a Certified Athletic Trainer, Emergency Medical Technician, and Special Needs Instructor for the Evans County (Claxton, GA) school system. I also have 14 years' previous experience in the Industrial Health 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,

Douglas J. MacKay, M.Ed., ATC/L, EMT-I

Submitter : Mr. Tim Speicher **Date:** 08/29/2007

Organization : Sacred Heart University

Category : Academic

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am Tim Speicher, the Director of the Human Movement and Sports Science Program at Sacred Heart University in Fairfield, CT. My comments and opinions are NOT representative of the University or its officials, but are solely mine alone. However, based on my role in ensuring the best opportunities for our students and those patients they will provide care to in the future; I am deeply concerned that the proposed regulations will unduly burden allied health care professional preparation programs which are already stretched to meet the market demand for health care professionals and also unfairly limit access to quaility medical care that Certified Athletic Trainers provide.

I am a Certified Athletic Trainer (ATC) and I am also licensed as an allied health care professional in the State of Connecticut. I hold an MS and CSCS certification and I am currently a PhD student at the Univ. of Connecticut.

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 well as the patients of my future athletic training students.

Athletic trainers are recognized by the American Medical Association as qualified to perform physical medicine and rehabilitation services, which is not the same as physical therapy. The nationally accredited education, clinical experience, and the national Board of Certification certification exam of the ATC ensure that patients receive quality health care. State law and hospital medical professionals have deemed the ATC qualified to perform physical medicine and rehabilitation services and these proposed regulations attempt to circumvent these accepted practices and standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. Further restricting access to quality health care provided by ATCs, particularly in rural America will have detrimental effects on the health care delivery system. The current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

I have not seen evidence that CMS has come to these proposed changes with clinical or financial justification, therefore, I strongly encourage CMS to consider the recommendations of those professionals that are tasked with overseeing and providing the day-to-day health care needs of their patients. I respectfully request that CMS withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Tim Speicher, ATC, LAT, CSCS
Director & Clinical Assistant Professor
Human Movement and Sports Science Program
Sacred Heart University

Submitter : **Mr. Earl Doucet** **Date: 08/29/2007**

Organization : **Mr. Earl Doucet**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 30, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

Earl Doucet, CRNA
1364 Chestnut Lane
Rochester Hills, MI 48309

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

Organization : **American Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a member of the American Society of Anesthesiology. I have been in practice for 18 years, serving the needs of the Medicare patients. It is difficult to witness the decline in anesthesiologists entering practice in my area as a result of the diminished compensation we have endured over the last many years. Please be advised that I support the proposed increase in Medicare payments for anesthesia services (CMS-1385 P)as a method of maintaining care of these patients. I most sincerely thank you for the work on this proposal and have hope for its implementation.

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

Organization : **CVA**

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.

Brian Poore, M.D.

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

scc attachment

#11895

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Ms. colleen king** **Date: 08/29/2007**

Organization : **Towson University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Colleen King and I am an athletic trainer at Towson University. I graduated from the accredited Athletic Training Education Program at Towson University in 2000 and earned my Master's Degree in Exercise Science from Fresno State in 2002. I have been working as a Certified Athletic Trainer since May of 2000 at the Division 1 level of collegiate 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,

Colleen A. King, MA, ATC

Submitter : Dr. Les Dutko **Date:** 08/29/2007

Organization : Wellness Coaches USA

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Dr. Les Dutko, Ed.D, LAT, ATC

Dear Sir or Madam:

My name is Dr. Les Dutko and I m currently a Corporate/Occupational Athletic Trainer in which my athletes are workers in the workplace, in which I prevent, evaluate, treat, and rehabilitate work related injuries; saving the workers, pain, suffering, and anxiety while the corporations savings are endless. In addition, I m currently a National Faculty Distance Learning Professor for the United States Sports Academy who resides in Martinsburg, West Virginia with my wife and 3 children.
My career involves working as a Nationally Certified (ATC) and Licensed Athletic Trainer (LAT) in the traditional setting as a high school ATC/LAT and in the non-traditional setting as a co-founder of a free standing sports medicine clinic situated on the campus of our local hospital. In these capacities I have worked with athletes of all sports and the physically active of all ages and skill levels in preventing, evaluating, treating, and rehabilitating injuries of all types and severity. In addition, I have been published in Sports Medicine, Fitness and Exercise, and Wrestling USA, and have taught Health/Physical Education for 25 years in the public school system at the high school level and have coached and played several sports, including Football, Wrestling, Track and Field, Soccer, and Baseball.

I have earned degrees from Virginia Polytechnic Institute, West Virginia University, and The United States Sports Academy and hold my ATC from the National Athletic Trainers Association Board of Certification and my LAT from the Board of Medicine of Virginia.

My career goals are to continue to travel internationally and teach sports medicine as I recently taught "Seminar in Sports Medicine" to a group of coaches/athletes in Bangkok, Thailand via The United States Sports Academy and Thailand Sports Authority. In addition, I'm interested in teaching sports medicine at a University/Sports University, while performing duties as a Corporate/Occupational Athletic Trainer and to perform Athletic Training services in a clinic 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.

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

Organization : Marquette General Hospital Sports Rehabilitation

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11898-Attach-1.TXT

CMS-1385-P-11898-Attach-2.DOC

#11898

National Athletic
Trainers' Association

August 29, 2007

Dear Sir or Madam:

My name is Michael Maciejewski and I am a Certified Athletic Trainer (ATC) with over 10 years of allied health clinical experience. I have earned two advanced degrees; the first being a Bachelors of Science in Sports Medicine from Central Michigan University, and the second is a Masters of Science in Exercise Science from Northern Michigan University. At this time I am taking course work towards a second Masters degree.

I am currently employed by Marquette General Hospital (MGH) in Marquette, Michigan. MGH is the only Level II trauma center in the Upper Peninsula of Michigan. I work in the outpatient physical therapy department providing physical rehabilitation services to a variety of patients with musculoskeletal dysfunctions and injuries. Along with direct patient care, I also provide Athletic Training/Sports Rehabilitation services to a local junior "A" hockey team. MGH also provides this Athletic Training service to a variety of other youth athletic venues in the greater Marquette area. I have worked with individuals who suffer from every day overuse musculoskeletal injuries, workman's compensation injuries, joint replacements, motor vehicle injuries, as well as, athletic injuries (at ALL levels: youth, to professionals, to week end warriors).

My profession allows me to work with a variety of other allied health care providers such as: physicians, physician assistants, physical therapists, occupational therapists, exercise physiologists, research scientists, and nurses. I take my role as an allied health care practitioner very seriously and with great pride and dedication to the patients and individuals I serve. However, now I have great concern that my ability to provide this care that improves the livelihood of many individuals, may be in jeopardy.

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

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

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

Sincerely,

Michael J. Maciejewski, MS, ATC

hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

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

Organization : Marquette General Hospital Sports Rehabilitation

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11898-Attach-1.TXT

CMS-1385-P-11898-Attach-2.DOC

#11898

National Athletic
Trainers' Association

August 29, 2007

Dear Sir or Madam:

My name is Michael Maciejewski and I am a Certified Athletic Trainer (ATC) with over 10 years of allied health clinical experience. I have earned two advanced degrees; the first being a Bachelors of Science in Sports Medicine from Central Michigan University, and the second is a Masters of Science in Exercise Science from Northern Michigan University. At this time I am taking course work towards a second Masters degree.

I am currently employed by Marquette General Hospital (MGH) in Marquette, Michigan. MGH is the only Level II trauma center in the Upper Peninsula of Michigan. I work in the outpatient physical therapy department providing physical rehabilitation services to a variety of patients with musculoskeletal dysfunctions and injuries. Along with direct patient care, I also provide Athletic Training/Sports Rehabilitation services to a local junior "A" hockey team. MGH also provides this Athletic Training service to a variety of other youth athletic venues in the greater Marquette area. I have worked with individuals who suffer from every day overuse musculoskeletal injuries, workman's compensation injuries, joint replacements, motor vehicle injuries, as well as, athletic injuries (at ALL levels: youth, to professionals, to week end warriors).

My profession allows me to work with a variety of other allied health care providers such as: physicians, physician assistants, physical therapists, occupational therapists, exercise physiologists, research scientists, and nurses. I take my role as an allied health care practitioner very seriously and with great pride and dedication to the patients and individuals I serve. However, now I have great concern that my ability to provide this care that improves the livelihood of many individuals, may be in jeopardy.

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

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

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

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

Sincerely,

Michael J. Maciejewski, MS, ATC

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.
Dr. Nwokolo

Submitter : Dr. jeffrey PERPER **Date:** 08/29/2007

Organization : NYSCA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I HAVE A NUMBER OF MEDICARE PATIENTS THAT REQUIRE X-RAY SERVICES TO BETTER EVALUATE THIR CONDITIONS. IF ELIMINATING REIMBURSEMENT FOR THE X-RAYS USED BY THE CHIROPRACOTR IS PROPOSED, IT WILL ADVERSELY AFFECT THE ALREADY TENUOUS DOCTOR-PATIENT RELATIONSHIP AND MAKE ADEQUATE CARE OF THIS POPULATION MORE DIFFICULT, THUS ULTIMATELY INCREASING HEALTH CARE COSTS AND JEOPARDIZING THE HEALTH OF ONE OF THE MORE VULNERABLE POPULATIONS IN OUR SOCIETY. THUS THIS PROPOSAL SHOULD BE REMOVED FROM THE AGENDA OF ACTIVITIES FACING CMS-1385.
SINCERELY,

JEFFRERY I. PERPER, DC

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

Organization : aana

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

CRNAs provide safe, quality, and cost effective care to their patients. Please protect our reimbursement fees.

Submitter : **Mr. Jerry Micho** **Date: 08/29/2007**

Organization : **Northern Indiana Anesthesia Services**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear CMS,

As a practicing Certified Registered Nurse Anesthetist (CRNA) and member of the American Association of Nurse Anesthetists (AANA). I strongly support the Centers for Medicare and Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under this proposed rule, Medicare would increase the anesthesia conversion factor by 15% in 2008 compared with current levels. If adopted, CMS's proposal would help to ensure that 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 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, the 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's proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate 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 CRNA's 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 boots Medicare payment.

Sincerely

Jerry J. Micho CRNA, MS, MSN
23252 Bluff Crest Drive
Elkhart, IN 46516

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

Organization : **Marietta College**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Senior at Marietta College, where i am currently enrolled in the Athletic Training Proram. I have been studying hard for the last 4 years and am very proud of the work I have done. I will be graduating in the spring and be eligable to take the Board of Certification Exam. I have wanted to be an Athletic Trainer for a long time and I am very excited to take the certification exam to become a Athletic Trainer.

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 ereate additional lack of access to quality health care for my patients.

As an student and future athletic trainer, I am will be more then 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 eare 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,

Justin Porta, ATS
Marietta College Athletic Training
215 Fifth St
Marietta, OH 45750

Submitter : Ms. amy mcconaghy **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.
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Sincerely,
Amy McConaghy CRNA
207 Ingrid Place
Carnegie, PA 15106

Submitter : **Dr. Qing Wang** **Date: 08/29/2007**

Organization : **Dr. Qing Wang**

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 effeet, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Kirk Stites **Date:** 08/29/2007

Organization : Dr. Kirk Stites

Category : Physician

Issue Areas/Comments

GENERAL

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Submitter : **Dr. sang chae-kim** **Date: 08/29/2007**

Organization : **asa**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Mrs. Stephanie Stites** **Date: 08/29/2007**

Organization : **Mrs. Stephanie Stites**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : Dr. Suzanne Rivchun **Date:** 08/29/2007

Organization : Dr. Suzanne Rivchun

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

X-ray is needed when treating a Medicare patient to make sure the patient has a chiropractic problem. It is aslo helpful in ruling out a condition that may not respond to chiropractic care ie:Bone Cancer to which an adjustment may be contraindicated.
In order to do our best work we need to differential diagnose and it should not be a t the doctors expense nor should it be a hardship to get healthcare for the patient.

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

Organization : **Mr. Thomas Blubaugh**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Miss. Pauline Martschink** **Date: 08/29/2007**

Organization : **American University**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an assistant athletic trainer at American University. I am the assistant athletic trainer for the women's soccer and lacrosse teams, and I focus on caring for the health and medical well being of the athletes that attend American University. I focus strongly on injury prevention, evaluation, and rehabilitation of athletic injuries on the collegiate level. I have a Masters Degree in health, exercise, and sport science and am a board certified athletic trainer.

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

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

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

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

Sincerely,

Pauline Martschink, MS, ATC

Submitter : **Dr. Raymond Fowler** **Date: 08/29/2007**

Organization : **Integrated Chiropractic, P.C.**

Category : **Chiropractor**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimore, Maryland 21244-8018

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Sincerely,

Ray Fowler, DC, FACO, DACRB

Submitter : **Mrs. Brenda Brandt** **Date: 08/29/2007**

Organization : **Mrs. Brenda Brandt**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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Thank you for your consideration of this serious matter.

Submitter : **Mrs. Diana Bisbing** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

I am one of America's 36,000 CRNAs providing over 26 million anesthetics in the U.S. annually. In many places (rural and medically underserved America), we are the predominant anesthesia providers. Medicare and healthcare delivery in the U.S. depend on our services. I am a member of the American Association of Nurse Anesthetists and have been a practicing CRNA for 22 years. I am writing to support the Centers for Medicare and 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. (72FR 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.
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). The availability of anesthesia services depends in part on fair Medicare payment for them. Thanks you for your attention
Diana K. Bisbing CRNA
1645 Beechshire Drive
Cincinnati, Ohio 45255

Submitter : **Mrs. Jana Hough** **Date: 08/29/2007**

Organization : **AANA**

Category : **Health Care Provider/Association**

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.

? 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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? 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,

Jana W Hough, CRNA
604 Tara Drive
High Point, NC 27265

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

Organization : JENNIFER RIDGWAY

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT
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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Sincerely,
JENNIFER RIDGWAY, CRNA
180 TURKEY HILL RD, WESTVILLE, NJ 08093

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

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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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As a working CRNA it is becoming a very unattractive area for future students to take as a career path due to constant cuts and decreasing reimbursement. When you spend four hours putting all of your knowledge and compassion into saving someones loved one only to struggle with the paper work to collect a very small fee you feel betrayed. When a guy comes to my house to work on my air conditioner for three hours and I MUST PAY $95 and hour (no discount) it is very disheartening. Please vote for a fair anesthesia fee schedule. Anesthesia is what allows surgeons to perform all the wonderful procedures they do. With good anesthesia most of todays fancy and life saving operations would only be a dream.

Sincerely yours,
Michael Gund CRNA
852 Cliff Road
Russellville, AR. 72802

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

Organization : Rite Aid Corporation

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-11918-Attach-1.DOC

CMS-1385-P-11918-Attach-2.DOC

#11918

With us, it's personal.

August 31, 2007

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1385-P,
P.O. Box 8018,
Baltimore, MD 21244-8018

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

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To Whom it May Concern:

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The Rite Aid Corporation is writing to provide our comments on several provisions of the proposed 2008 CMS Physician Fee Schedule regulation. Rite Aid is one of the nation's largest drug store chains, operating approximately 5,100 pharmacies in 31 states and the District of Columbia. We appreciate the opportunity to comment on proposed rules affecting reimbursement of Part B drugs and the potential elimination of the NCPDP SCRIPT standard exemption for computer-generated facsimile transmissions.

Proposed Regulation Does Not Increase Part B Drug Supplying or Dispensing Fees

Medicare payment policies should be designed to ensure that beneficiaries have access to Part B covered drugs. Every year, millions of Medicare beneficiaries choose to receive their Part B drugs from their community retail pharmacies. Despite the reliance beneficiaries have on community retail pharmacies, many aspects of current Part B reimbursement policies create economic and administrative challenges for pharmacies to serve Medicare beneficiaries.

In this regard, the Rite Aid Corporation is concerned that the proposed rule does not increase supply or dispensing fees for Part B drugs in 2008. These fees have not been increased in two years, and increases are needed in 2008 just so these payments keep pace with increases in basic pharmacy operating costs as well as medical inflation.

These increases are also needed to help offset potentially insufficient reimbursement for drug products dispensed under the Part B drug ASP-based methodology, as well as to compensate pharmacies for the additional administrative costs incurred in submitting Medicare Part B claims.

Since 2006, the Part B drug supplying fees have remained at $24 for the first Part B oral drug prescription dispensed for a 30-day supply and $16 for each additional such prescription supply. Medicare pays a one-time $50 fee for the first Medicare Part B immunosuppressive prescription after a transplant. For inhalation drugs, the fees are $57 for an initial 30-day supply and $33 for a subsequent 30-day supply and $66 for a subsequent 90-day supply.

At the same time that these fees have remained stagnant, pharmacists' and pharmacy staffs' salaries continue to increase. According to the Bureau of Labor Statistics, the average (mean) pharmacist salary increased from $88,650 ($42.62 per hour) to $93,500 ($44.95 per hour) from May 2005 to May 2006. That is a 5.5 percent increase. For pharmacy technicians, the increase was $25,350 ($12.19 per hour) to $26,510 ($12.75 per hour). That would be a 4.6 percent increase. Those changes do not account for changes in benefit costs or professional insurance that are traditionally provided to pharmacists by pharmacy employers. These amounts also do not account for pharmacist salary increases through the present time.

CMS will also receive comments that a recent study by the Lewin Group sponsored by the Transplant Pharmacy Coalition finds that the average cost of dispensing a Part B oral immunosuppressant prescription is $30, well above the current payment rates. Moreover, this amount is the average pharmacy cost for supplying each Part B prescription. That means that CMS should eliminate the tiered reimbursement rate (i.e., one rate for the first prescription in a month and a lower rate for subsequent prescriptions in a month), and establish a higher rate for all Part B prescriptions, as well as increase the rate for the initial transplant prescription. In addition, the final regulation should include a provision for these fees to increase automatically each year to keep pace with pharmacy costs of supplying these prescriptions.

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We also believe that the fees should be increased because an ASP-based system may not reimburse pharmacies adequately for Part B drug products, and pharmacies incur higher costs to process Part B drug claims over and above the costs to process other third-party administered claims. These costs are described below:

ASP-based system may not compensate adequately for dispensed drug products: Pharmacies may be negatively impacted by the ASP-based Part B drug reimbursement system, which bases reimbursement for a drug on the HCPCS code and not the drug's NDC number. In certain cases, HCPCS codes reimburse every product, whether brand or generic, listed under a particular code at the same reimbursement amount.

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This has especially become a problem with Xoponex solution, which is known as levalbutetol, a brand name version of albuterol. A recent coverage determination made by CMS and DME MACs reimburses pharmacies for Xoponex at a blended ASP based on the prices for both Xopenex and albuterol. This results in a reimbursement for Xoponex which is below pharmacies costs of purchasing Xoponex, given that albuterol has much lower costs and has a higher overall percentage of albuterol sales.

We urge that the payment policies for Xoponex be revised such that pharmacies are reimbursed appropriately for their costs of dispensing Xoponex when prescribed, and when the physician will not change the prescription to generic albuterol inhalation solution.

No On-Line Claims Adjudication: Unlike almost every other third party prescription plan, pharmacies cannot adjudicate Part B claims in an online, real time manner. As a result, eligibility determination and claims processing in Medicare Part B are exceptionally burdensome. For example, pharmacies do not know at the point of service whether a Medicare beneficiary has already met their Part B deductible for the year.

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We also don't know whether the individual has had a Medicare covered transplant for which Medicare will pay for the Part B drug. Coordination of benefits is also an issue as many individuals have additional private or public sector prescription drug coverage that wraps around Part B. Unlike in other third party benefit programs, pharmacies often are not presented with sufficient information by the beneficiary at the point of sale to successfully achieve COB. This additional paperwork results in higher costs for the pharmacy to fill and bill a Medicare prescription.

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Even after "clean claims" are submitted to the DMERC, Medicare Part B has a higher rejection rate than traditional third party prescription plans because of the lack of an online claims adjudication system. As a result, pharmacies incur significant amounts of "bad debt" in Medicare Part B as compared to other third parties.

Delays in payment: Medicare Part B takes more time to pay pharmacies than traditional third party payers, tying up the pharmacies' cash flow for extended periods of time. This is especially a problem in the case of expensive immunosuppressive drugs. Because of the higher number of claim rejections in Medicare Part B and the longer time it takes to pay Medicare claims on average, a pharmacy may have dispensed several expensive Part B drugs to a Medicare beneficiary before the pharmacy gets any assurance that it will be reimbursed for the initial Part B claim submitted.

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Rite Aid urges CMS to consider the unique challenges community retail pharmacies face in filling Part B prescriptions. Medicare beneficiaries' access to their local pharmacy must be protected by implementing policies that maximize economic and administrative efficiencies in serving Part B patients. For that reason, we urge an increase in both the Part B supplying and dispensing fees for 2008.

Modify Proposed Elimination of NCPDP SCRIPT Standard Exemption for Computer-Generated Faxes

We support the proposed rule's elimination of the NCPDP SCRIPT standard exemption for computer-generated prescription faxes, with modifications. We have included some suggestions on how to make the proposal more workable for physicians and pharmacists, and better for patient care.

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Narrow Elimination of Exemption: Rite Aid asks that CMS continue to take a step-wise approach to implementation of e-prescribing regulatory requirements. Rather than remove the exemption for all electronically generated faxed prescriptions, as the proposed regulation would do, we ask that CMS narrow the exemption to eliminate the exemption for prescribers that have software or an application that has the ability to generate NCPDP SCRIPT transactions. These prescribers and dispensers can convert to true electronic prescribing quickly without changing their workflow and without significant expense. That is because any required upgrade should be included in the costs that the prescriber has already paid.

The costs for other prescribers could be significant, however, if CMS were to completely eliminate the fax exemption. Some prescribers and dispensers do not currently have the functionality to engage in true e-prescribing. To force them to adopt this functionality would be disruptive to their workflow and may require them to expend significant time and money toward such adoption. We believe that most of them would revert to paper and oral communications for prescriptions, potentially reducing some of the gains made toward the adoption of true e-prescribing. This could also impair patient care as a computer generated faxed or e-prescription is generally always easier to read than a hand written prescription. Moreover, a computer-generated faxed prescription or e-Rx also reduces the potential for transcription errors when a pharmacist takes an oral prescription over the phone. Patient safety is generally enhanced with computer-generated faxed prescriptions or e-Rxs.

For prescribers and dispensers who move to adopt true e-prescribing after the effective date of the proposed rule, we ask that CMS allow a transition period of one year after they adopt the necessary technology, application, system, or software. This would allow for workflow changes, training, and the resolution of any technical glitches that might occur.

Proposed Rule Could Increase Diversion of Controlled Substances: Current DEA regulations prohibit the e-prescribing of a prescription for a controlled substance. This prohibition acts as a tremendous barrier to prescriber adoption of e-prescribing. As currently written, CMS' proposed rule would exacerbate the problems caused by this prohibition.

If prescribers could use neither electronic prescribing (because of DEA regulations) nor computer-generated prescription faxes (because of the CMS proposed rule) for controlled substance prescriptions, then many prescribers would have to revert to using traditional fax machines or paper and oral prescriptions for controlled substances. This could increase diversion in the prescribing of controlled substances because e-Rxs and computer generated faxed prescriptions are harder to forge and less subject to diversion than paper or oral prescriptions.

For these reasons, until such time that DEA amends its regulations to allow for the electronic prescribing of controlled substances, we believe that prescribers and dispensers need to retain the ability to use computer-generated faxes to send and receive prescriptions for controlled substances.

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Pharmacies Cannot Enforce Requirements: CMS cannot hold pharmacies responsible for enforcing the requirements of the rule on prescribers. For example, there is no way for a pharmacy to know whether the fax received by the pharmacy was generated by a physician's computer system that complies with the NCPDP SCRIPT standard versus a computer that does not. Nationwide, physicians transmit hundreds of thousands communications every day to pharmacies. This number continues to grow as prescription volumes increase.

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To require pharmacies to know if a prescriber has sent a communication in a SCRIPT-compliant manner could reverse many of the gains made in the adoption of electronic connectivity. Accordingly, CMS cannot allow for the recoupment of prescription claims after pharmacies filled them in good faith only to find out, after the fact, that the prescription violated the CMS regulation. Community pharmacies should not be penalized for prescriber non-compliance.

Concerns about Liability on Pharmacies: Prescriptions transmitted before the compliance deadline but filled or refilled after the compliance deadline should not be subject to the rule. We ask that CMS clarify this point. Otherwise, pharmacies would be forced to obtain new prescriptions for patients after the rule's effective date. Finally, we ask that CMS advise states that the dispensing of a prescription transmitted in a noncompliant manner should not be considered a violation of either federal or state false claims acts.

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The proposed rule is designed to foster the adoption of true e-prescribing, not to increase the potential legal liability of pharmacies. However, we are concerned that additional litigation against pharmacies could be encouraged by allowing the dispensing of a prescription transmitted in a noncompliant manner to be deemed fraud and abuse. This could increase Medicare program participation costs for pharmacies and could potentially discourage pharmacy participation in the program.

We thank you for the opportunity to submit comments on proposed rules affecting Medicare Part B oral and inhalation drug reimbursement and the potential elimination of the NCPDP Script standard exemption for computer generated prescription faxes. We support CMS' proposal to foster further adoption of true e-prescribing, and we urge CMS to move forward with the proposed rule, incorporating the recommendations we have provided above. For further information, I can be reached at 703-888-0859 or jcoster@riteaid.com. Thank you.

Sincerely,

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John M. Coster

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John M. Coster, Ph.D., R.Ph.
Vice President, Federal Affairs and Public Policy

30 Hunter Lane
Camp Hill, PA 17011

Submitter : **Dr. Samuel Goodloe** **Date: 08/29/2007**

Organization : **ACI**

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.

Samuel L. Goodloe,M.D.

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have been working as a physical therapist for 10 years in the outpatient orthopedic setting. In the last few years the number of physician owned physical therapy clinics have increased significantly in my region. Recently it has come to my attention that many of these physicians order physical therapy for their patients but tell them they have to be treated at their facility. It is a patients right to choose but many times the patient feels intimidated and "follows doctor's orders".

Submitter : Dr. David Clair **Date:** 08/29/2007

Organization : Fetzer Clair Urology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachmcnt

#11921

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Dr. David Rosen** **Date: 08/29/2007**

Organization : **WEst Virginia University**

Category : **Academic**

Issue Areas/Comments

GENERAL

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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 training our future anesthesiologist. General practice anesthesiologists are being forced away from areas with disproportionately high Medicare populations, and this is placing undue burden on academic centers who have a difficult time attracting top anesthesia trainers when they can make so much more in private practice.

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. Particularly as it relates to medicare patients, 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 : Laura Cohen **Date:** 08/29/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetists (AANA), I support the CMS proposal to boost the value of anesthesia work by 32%. Under this proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) The adoption of this 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. First, as 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 MedPAC and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of 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.

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Sincerely,

Laura A Cohen, CRNA, BS,
911 Crystal Springs Ave,
Pensacola, FL 32505

Submitter : **Mr. Ty Butler** **Date: 08/29/2007**

Organization : **SportsWorks**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Ty Butler. I have a Masters in Public Administration with an emphasis in Healthcare Administration and hold a license as an Athletic Trainer in the state of Tennessee. I am employed in a rural hospital in Western Tennessee.

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,
Ty Butler, MPA, ATC/L

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

Organization : **American Association of Nurse Anesthetists**

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:
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Sincerely,

Brian D. Campbell
14 Townsend Street
Malden, MA 02148-6323

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

Organization : **Ripon Medical Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a Licensed Athletic Trainer practicing in Wisconsin. My current role serves as the hospital/industrial outreach industrial rehabilitation coordinator.

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 insure 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 abilities 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,

Daniel Trampf LAT, CSCS
Industrial Rehabilitation Coordinator
Ripon Medical Center
Ripon, WI54971
920-748-9156
dtrampf@netscape.com

Submitter : Mr. Kurt Wile **Date:** 08/29/2007

Organization : Marietta College Athletic Training Program

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear to Whom It May Concern,

I am Kurt Wile, a senior Athletic Training student at a small college in southeast Ohio named Marietta College. As I am a senior student in an Athletic Training Program I will be taking the NATA Board of Certification Exam in the spring to become a Certified Athletic Trainer. I will soon be looking for employment in the field of Health Care as I will be a Health Care Professional. Employment, whether it be in a Athletic Training position or in the clinical atmosphere working with Physical Therapists and other such Health Care Professionals, will be my greatest concern come the summer of 2008. Due to my future in this field, I am writing today to voiee 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 a future Athletic Trainer, I will be qualified to perform physical medicine and rehabilitation services, which is not the same as physical therapy or occupational therapy. My education, clinical experience, and future certification will ensure that I will be qualified to treat any patient with quality health care. 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.

Of more concern to myself and my fellow classmates at Marietta College and other colleges across the United States of America is the potential to be denied from the workplace in the future due to these changes by the CMS. I feel that this change will hurt my future after working hard in a very expensive private school for four years. A tuition of approximately $33,000 per year over four year adds up to a large sum of money I will eventually have to pay back this money and if there are not jobs out there to make money and to help payback my loans.

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, Kurt Wile ATS

Submitter : **Dr. Raymond Graber** **Date: 08/29/2007**

Organization : **Case Western Reserve**

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.

Raymond Graber, MD

Submitter : **Mr. Steve Allen** **Date: 08/29/2007**

Organization : **Regional Therapy Services, Inc.**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Comments to CMS

Please accept these comments, respectfully submitted, on

the July 12 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception.

From: Steve Allen, M.S.,P.T.

I am a physical therapist and co-own a business with my wife who is also a physical therapist. She has been in practice for over twenty five years and I have been in practice since 1991. In addition, I have seventeen years of teaching in medical school and physical therapy school. Our practice is primarily very small offices in small, somewhat rural, towns.

Although we are encountering physician owned physical therapy services (POPTS) only in our larger cities of Valdosta and Tallahassee (other towns are suspected of have a more disguised arrangements), the POPTS affect the level of services in all our communities.

1. We are frequently told by our former patients in our Quincy, Florida office, that Tallahassee physician (I will be happy to identify if appropriate) tells patients they need to come to his office for physical therapy because he has equipment that other clinics do not have. This is not true and is only a ploy to increase his revenue while patients suffer by having to drive from small out-lying towns into Tallahassee traffic costing the patients time and money.

2. In Marianna, Florida, Dr. (I will be happy to identify if appropriate) uses a similar plan and convinces patients that they need to drive from other towns for therapy which financially benefits Dr. Gilmore. According to the local newspaper in Jackson County, Florida, Dr. Gilmore has already been under investigation by government agencies and has lost his privileges at that Jackson County hospital and now does all his surgeries in Panama City, Florida.

3. Dr. (I will be happy to identify if appropriate) in Thomasville, Georgia operates a clinic and refers patients to his own business but does not even have a licensed physical therapist on staff.

4. We deal with orthopedic surgeons form all over South Georgia and north Florida. Most of those who are not in a referral for profit situation, write specific orders such a 2X/week for 3 weeks or 3X/week for 6 weeks, for example. They expect results in that time or less, or they expect to have a good case presented as to why more visits are needed. It is my understanding that information already gathered by CMS indicates increased utilization by physicians referring with a financial incentive.

5. Patients should have the right to choose their most convenient and highest quality care option. Allowing patients to be bullied and influenced by greedy physicians for financial is not in the best interest of the American public nor the interest of CMS.

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

Organization : Alexandria Orthopaedic Associates, P.A.

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I have been a certified athletic trainer since 2005. Before obtaining my national certification I received my four year Bachelor of Science degree in Athletic Training and passed the national certification exam for athletic training. I am also currently a semester away from receiving my Master of Science degree in Exercise Science. Through my education I have received extensive training, both in the classroom and through clinical experience, in injury prevention, recognition, treatment, and rehabilitation. I am currently working as an athletic trainer and physician extender in an orthopaedic clinic where I work closely with physicians and physical therapists and see an extensive population of patients with a wide array of injuries and conditions.

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

Submitter : **Dr. Joseph Mokulis** **Date: 08/29/2007**

Organization : **Florence Urological Associates**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

see attachment

CMS-1385-P-11931-Attach-1.DOC

#11931

RE: Physician self-referral rules

Dear Sir,

I am an urologist practicing in Florence, Alabama. I am concerned about some proposed changes in self-referral laws proposed by CMS. I understand the reasons for trying to minimize conflicts of interest regarding self-referral for financial gain, however I think the proposed rules are unlikely to reduce utilization and thus the cost of delivering urologic care.

As an urologist, I see the benefits of joint ventures making useful technology such a lithotripsy, available to Medicare and Medicaid patients. I believe that having physicians make this technology available promotes the proper availability of new medical technology and does not promote over utilization or increase the cost of health care.

I will discuss the anti-physician ownership proposals in the 2008 proposed Physician Fee Schedule which I believe will be detrimental to Medicare and Medicaid patients and physicians without the assumed benefit of reducing the cost of delivering health care.

Burden of proof

I understand this provision to force the physician to bear the burden of proving that a referral did not violate any existing anti-self referral laws, Stark laws. This seems nearly impossible for a physician's office to accomplish even if they the unlimited time and resources to dedicate to arguing with the government. As you are aware, doctors and their office staff have very limited time to argue about denial of payment, especially something that can be as ambiguous as self referral for supposed unnecessary evaluation or treatment. When there are concerns that laws that CMS has proposed are being broken, CMS should bear the burden of proving self referral arrangements are illegal, not the physician.

Per Click Payments

The proposal to eliminate time based or unit-of-service payment for space and equipment leases appears to go against what Congress has already deemed to be a proper and fair method of payment. Per click payments are necessary to make it worth the risk for joint ventures to risk providing expensive technology to rural areas. The hospitals in rural areas many times cannot afford to risk investing in expensive technology when lower than expected usage might result in a loss to the hospital. Allowing joint ventures to spread the risk by providing technology to multiple regional hospitals seems to me the best option to provide treatments such as lithotripsy to the most patients at least cost.

Stand in the Shoes

As I understand the implications of this proposal, if a physician referred a patient to a hospital owned Ambulatory Surgery Center (ASC), then this would be considered a violation if the service provided at the ASC was part of physician owned joint venture. This would force physicians to treat their patients in a different ASC to allow them to treat their patients, very likely causing more ASCs to be built. I believe that in the end this would cause increased costs for Medicare.

Services Furnished Under Arrangements

The proposed changes to the Stark rules regarding services furnished under arrangements are to prevent physician owned joint ventures from performing diagnostic Designated Health Services (DHS). Unfortunately it appears that the new rules will also prohibit therapeutic services also. In urology this would include laser prostate procedures for voiding problems and cryotherapy for localized cancers. Even though I currently do not perform either of these treatments I believe that they are becoming better and better and eventually may become the best way to treat certain conditions. Hospitals can be reluctant to purchase expensive alternative treatment technology when they already are getting paid to treat the condition the old way. By allowing physicians, through joint venture arrangements, to take the risk of purchasing expensive new technology and offering the new treatments to patients at the hospital, I believe this is one of the best ways to offer Medicare and Medicaid patients access to new technology. These arrangements allow the new technology to rotate to numerous regional hospitals. Each hospital does not need to buy technology that they cannot afford due to inadequate volume to cover the costs. I am not aware that data suggests that therapeutic technologies such as lithotripsy owned by physician joint ventures are being over utilized. I share CMS's concern that physician owned diagnostic equipment is being over utilized by some physicians, thus driving up cost without apparent benefit. I believe that the vast majority of physicians are unwilling to perform potentially risky therapeutic procedures when there is not clear cut indications and potential for a lawsuit. With diagnostic procedures there is essentially no risk and ordering an unnecessary test can easily be justified as practicing defensive medicine to prevent being sued.

Lumping diagnostic testing and therapeutic procedures into a rule that is really trying to reign in ordering unnecessary diagnostic tests will limit patient access to proven beneficial therapeutic technology. I ask CMS to separate therapeutic joint ventures from diagnostic imaging which I would agree is being abused. I do not believe there is sufficient evidence to show that therapeutic technology is being abused and needs to be curtailed. Physicians, who know what is best for their patients, should be allowed to offer the best technology to their patients. Placing restrictions on this arrangement I believe would only increase costs in the long run.

Sincerely,

Joseph Mokulis MD
Florence Urological Associates
541 West College Street, Suite 3300
Florence, AL 35630
(256) 766-6026

Submitter : **Dr. Jeff Jekot** **Date: 08/29/2007**

Organization : **Texas Society of Anesthesiologists, Treasurer**

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:

On behalf of the Texas Society of Anesthesiologists, I would like to express my 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 the Texas Society of Anesthesiologists 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.

Jeffrey M. Jekot, MD
Treasurer
Texas Society of Anesthesiologists

Submitter : **Dr. William Gall, MD** **Date: 08/29/2007**

Organization : **Dr. William Gall, MD**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Theodore Wynnychenko** **Date: 08/29/2007**

Organization : **Evanston Northwestern Healthcare**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Sincerely,

Theodore M. Wynnychenko, M.D.

Submitter : **Dr. Joseph Dankoff** **Date: 08/29/2007**

Organization : **Dr. Joseph Dankoff**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a urologist in a group practice, and our patients have come to depend a great deal on the convenience and personlaized care offered through our offices. We offer a wide range of services, and it is very worrisome that our Medicare beneficiaries might have to resort to highly expensive and burdensome hassles for treatment of conditions such as prostate cancer. Our treatment centers continually receive high patient-satisfaction marks, and we worry that the proposed changes could impact this.

Submitter : **Ms. Dana Marshall** **Date: 08/29/2007**

Organization : **Ms. Dana Marshall**

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
Baltimore, MD 21244 8018
August 20, 2007
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,

Dana Marshall, CRNA
17 Duck Cove Road
West Gardiner, ME 04345

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

Organization : Guthrie

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Steven C. Hicks. I am Certified Athletic Trainer working for Guthrie Sports Medicine in Sayre, Pennsylvania. I am not only contracted to provide Athletic Training Services but also work in the clinical setting at Robert Packer Hospital. Before the change in law I was able to see patients in the clinical setting and was very successful in doing so. I was trained at Slippery Rock University where I received my Bachelors of Science degree and then received my Master s Degree from Ohio University both with the specialization in Athletic Training. Every day at Athens High School I treat injured student athletes, which allows them to return to sports and also saves Medicare/Medicaid/ and the Insurance companies a lot of money.

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 a certified 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,

Steven C. Hicks, MS, ATC

Submitter : **Mr. John ODonnell** **Date: 08/29/2007**

Organization : **Univ of Pittsburgh**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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.

Submitter : Mrs. Mary L Taylor **Date:** 08/29/2007

Organization : American Association of Nurse Anesthetists; Penna

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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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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).

Submitter : **Mrs. Ursula Bethea** **Date: 08/29/2007**

Organization : **Mrs. Ursula Bethea**

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 urge the CMS to support the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. The job of an anesthesiologist is extremely important. Without qualified, competent anesthesiologists, patient care will suffer. It is imperative that the Medicare payments be increased so that the anesthesiologists can be more fairly compensated for their work of helping ensure the patient safely make it through surgery. The areas that are more densely populated with Medicare patients are increasingly finding it more difficult to provide the care of the highly trained anesthesiologist. Please pass the CMS-1385-P to help ensure the high level of care that the patients deserve.

Thank you for your cooperation in this matter.

Sincerely,

Ursula A. Bethea

Submitter : **Mr. Nichiolas Chiofalo** **Date: 08/29/2007**

Organization : **Suffolk County Community College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am the Head Athletic Trainer for the Suffolk Longhorns at Suffolk County Community College in Brentwood NY.

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,

Nicholas Chiofalo, ATC
Head Athletic Trainer
Suffolk County Community College

Submitter : **Ms. Tori Noda** **Date: 08/29/2007**

Organization : **University of Oregon**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attachment

CMS-1385-P-11942-Attach-1.DOC

CMS-1385-P-11942-Attach-2.DOC

#11942

UNIVERSITY OF OREGON
College of Arts and Sciences

Dear Sir or Madam:

My name is Tori Noda ATC, CSCS and I am a second year graduate Athletic Training student at the University of Oregon under the Department of Human Physiology. 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,

Tori Noda ATC, CSCS
Graduate Teaching Fellow/Graduate Athletic Trainer
541.346.5304
tnoda@uoregon.edu

DEPARTMENT OF HUMAN PHYSIOLOGY

1240 University of Oregon, Eugene OR 97403-1240

T (541) 346-4107 F (541) 346-2841

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Studies have already confirmed that thousands of fraudulent charges are paid out every year to physician owned practices. In my region, there is presently a push from a large physician group to start and expand their own therapy. What is concerning is that the primary motivation for opening their own therapy is to increase their revenues, not to improve patient care. The system as it is now allows physicians to do just that. Physicians can increase the number of their referrals and enjoy financial gains. The ability for physicians to self refer provides an ideal environment for fraud and abuse. I would hope in a time when our Medicare system is struggling, controlling fraud would be a priority. I appreciate your diligence in correcting this matter

Submitter : **Mrs. Aimee Holley** **Date: 08/29/2007**

Organization : **St. Ursula Academy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Aimee Holley and I am a certified and licensed athletic trainer in Ohio. I graduated from an athletic training program at Grand Valley State University and have been practicing as a certified athletic trainer since February 2005. I work at an all girls high school, St. Ursula Academy, in Toledo, OH. I am responsible for the health care concerns of the athletes, which include but is not limited to prevention, evaluation, treatment, education, and rehabilitation. Many athletes will come to me asking for specific exercises to help them get back to play quicker and safer. As an athletic trainer, I am qualified to do this whether it is in a high school setting, clinic, or college. The injuries are the same and we as professionals can adapt to meet the needs of others.

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,

Aimee Holley, LAT, ATC

Submitter : **Mr. Willard Branch** **Date: 08/29/2007**

Organization : **AANA**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
___Willard Branch CRNA MSN_____
Name & Credential
____108 Johnston Ln._____
Address
___New Bern, NC 28562_____
City, State ZIP

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

Organization : **Springfield Public Schools**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Gary Danielson and I am currently an elementary principal and an athletic trainer. My educational administration degree allows me to work in the educational arena and my athletic training education allows me to work with the physical active population. I work in an At-risk elementary and work with students of poverty. My athletic training background allows students care who otherwise might not be able to afford care. I work in conjunction with the school nurse and the physicians who will see our population. I have been an athletic trainer at West Virginia, Boston University, Drury University and in all those settings have facilitated care for the athletic participants of various teams.

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,

Gary Danielson MS.,Ed.,ATC

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

Organization : St. John Anesthesia Services

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,

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.

James S. Day, M.D.

Submitter : **Mr. Sean Hurney** **Date: 08/29/2007**

Organization : **St. Andrew's Episcopal School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer in a secondary school. I am the first person my athletes after they get hurt. I am the the one that helps calm the parents and athletes down after an incident and help them seek the appropriate medical care that they need. When injuries are bad enough I am also the one that immoblizes before advanced medical personal arrive. MD's, PT'S etc are not their when injuries occur. They see athletes after we do. Certified Athletic Trainers are the first responders in life threatening incidents. If we were not present more athletes would have fatalies in athletic competions. Also athletes could suffer more serious injuries because they were not properly taken care of immediately after the injury. Also I am available on campus so that an athlete can Rehabilitate an injury properly. Realistically athletes can only see a PT 2-3 time a week when they can't the quality time that they actually need. ATC's can meet with athletes 5-7 times a week and actually know the athlete better as they see them more often and know them personally.
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 a certified 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,

Sean Hurney, ATC and CMT

Submitter : **Dr. Fernando Esclopis** **Date: 08/29/2007**

Organization : **Dr. Fernando Esclopis**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Crystal River, Florida, as part of a 5-member pathology group, located at a hospital and in an independent laboratory.

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

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

Opponcnts to thcse proposcd changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providcrs furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program. The financial incentives currently being exploited at the clinical level not only is morally reprehensible, but also pose a risk for patient safety if biopsies are generated solely for financial gain.

Sincerely,

Dr. Fernando Esclopis

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.

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

Organization : East Stroudsburg University of Pennsylvania

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

"see attachment"

CMS-1385-P-11951-Attach-1.DOC

#11951

August 29, 2007

Centers for Medicare and Medicaid Services (CMS)
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Sir or Madam:

My name is Dr. John M. Hauth and I currently serve as the Program Director and Chairperson of the CAATE-accredited Athletic Training Education Program at East Stroudsburg University of Pennsylvania. In addition, I am also certified by the national Board of Certification® in athletic training and credentialed to practice as an athletic trainer in Pennsylvania through the State Board of Medicine. I have worked as an athletic trainer and rehabilitation specialist in secondary schools, colleges and universities, outpatient physical therapy settings and sports medicine centers.

While my primary role today is as a teacher-scholar and researcher, I continue to practice as an athletic trainer and share my expertise in rehabilitation with colleagues and friends in medicine, physical therapy, clinical exercise physiology, physical education and other related professions. My twenty-five years in practice have further strengthened my belief that patients in need of physical medicine and rehabilitation services are best cared for when a team of qualified individuals work together to deliver evidence-based practices.

This is why I am writing you today to express my tremendous concern regarding the proposed changes in 1385-P. In recent years we have seen explosive growth in health care spending and substantial changes and shifts in health insurance. The major problem with affordable health insurance and access to affordable and competent health care is the continued increase of health care in the United States. With health care costs projected to rise over $4 trillion by 2015, it is perplexing that the Centers for Medicare and Medicaid Services would continue to make decisions that restrict qualified health care practitioners like athletic trainers, clinical exercise physiologists and others from assisting in a health care system that is clearly in crisis. It would be prudent at this time for CMS to take a step back and examine how they can appropriately engage other qualified health care providers in the fight to save our health care system.

In short, I am writing to oppose the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. Again, this decision is another uninformed action that will continue to drive the cost of health care in America up while ignoring the education and qualifications of several health care

providers that could undoubtedly help maintain the standard of care Americans desire and deserve. Additionally, I am concerned that the proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting. As a practitioner who has cared for a diverse population, I am confident that this decision will harm patients and further weaken our fragile health care system.

Athletic trainers and other health care providers restricted by the proposed changes in 1385-P have the education and training to perform physical medicine and rehabilitation services to a variety of patients. This is not the same as physical therapy which certainly holds a very important place in the health care; but not the only place. The education, clinical experience and national certification examination for athletic trainers ensures that patients will receive competent and quality care. State laws and an array of hospital medical professionals have recognized and sanctioned our qualifications to perform these services and these proposed regulations attempt to circumvent those standards. It is hard to see how CMS believes that this will best serve the patient-consumer.

CMS is certainly aware of the statistics shared earlier in this letter and the lack of access and workforce shortage in the physical medicine and rehabilitation industry. If CMS is truly concerned with delivering the highest standard in health care to the American public, they will withdraw these proposed changes and seek ways to improve upon the flexible standard of staffing in hospitals and other rehabilitation facilities. In today's health care environment, this is the only way we can ensure patient's the ability to receive the best treatment while containing health care costs.

My research suggests that CMS has come to these proposed changes without clinical or financial justification and therefore, I respectfully request that CMS delay making any decisions regarding 1385-P or physical medicine and rehabilitation until they have fully investigated how to integrated qualified health care providers more fully into the flexible guidelines that currently exist. On behalf of my faculty and the 200 future practitioners I am preparing for the health care industry, I 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. John M. Hauth, ATC
Chairperson and Program Director
Full Professor
Athletic Training Education Program
East Stroudsburg University of Pennsylvania
East Stroudsburg, PA 18301
(570) 422-3231

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

Organization : **Family Chiropractic Center for Wellness, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Brian K. Dahmer

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

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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

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,
Robert Dorroh, SRNA
12860 Sipsey Valley Rd South
Ralph, Alabama 35480

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

Organization : **Western Anesthesiology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I support 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.

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. It has taken far too long to get this inequity addressed, and I am pleased that this correction has received support. This is a problem that needs repair.

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 important situation.

James J. Gibbons, MD
St. Louis, MO

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11955-Attach-1.TXT

11955

I am writing to comment on the July 12 proposed 2008 physician fee schedule and to express my concerns for the current practice of physician in-office self-referral for physical therapy services. As a young man, I knew that I would pursue a career in healthcare because of my desire to help people achieve their highest level of functioning. I initially began my studies wanting to be a physician, but following a summer job at a hospital in Camden, AR, I knew that physical therapy was the career choice for me. This occupation allows me to spend hours with my patients learning every aspect of their movement and their physical deficits and then create a treatment plan that is customized for them. I completed my PT degree at the University of Pittsburgh and later a graduate degree in PT from the University of Florida.

Over the past 15 years as a therapist, I have had the great opportunity to work in the field of orthopedics, sports, neurology, pediatrics, long term care, administration, home health, and even eight years as a faculty member in academia. I have seen many great changes in the field of physical therapy but I have also seen the tremendous abuse of the profession from physician-owned practices. In these practices, patients who may not require physical therapy services are issued an order for therapy because of the financial incentive to the physician. In my local area, I have seen therapist-owned practices close because physicians directed their referrals to their own practice.

In the clinic where I work, I have patients tell me that they would have came to my clinic earlier since it was closer to their home, but their physician told them they had to use services at the physician-owned practice. The patient stated that the therapy was performed in a small treatment room, unlike my large gym space that more closely matched the patient's needs. Many of my employees have once worked in physician-owned practices. One of which told me that the physician would tell them how many units to bill, whether or not they had actually done so. The current rule allows physicians to increase their profits by often providing Medicare patients a lesser quality of services.

I currently work with over 50 physical therapists who treat a variety of diagnoses. Ironically, it is the physical therapist who often derives the diagnosis since the referral was made for pain or simply for a "PT eval." I am proud to work in a profession that stresses a comprehensive evaluation of the patient and a Code of Ethics that helps build a reputable practice. I ask that you listen to the physical therapists who are negatively affected by the current in-office ancillary services provided by physicians. There is no logical or rational reason why a physician should provide in-office PT services except for profit. Unfortunately, this situation does not provide the best utilization of services for the Medicare patient. Please correct and close this loophole and provide Medicare beneficiaries with non-compromised physical therapy services. Thank you for considering my comments on this important issue.

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

Organization : American Association of Nurse Anesthetist (AANA)

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Tania Derington, CRNA
5340 Westminster dr
Austin, tx 78723

Submitter : **Dr. Peter Nickel** **Date: 08/29/2007**

Organization : **Anesthesia Medical Group of Santa Barbara**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Sevices
Attn: 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 thank the CMS for reviewing the payment schedule for anesthesia services. For many years it has been grossly undervalued and your proposed increase will help to bring the Medicare payment more into line with other payers.

Our current payment is only $15.96 per unit, this is about one third of the rate of most private payers. The situation in my group is probably not unlike most other anesthesia groups - about one third of our patients are covered by Medicare and they represent only about 12 percent of our income. Given that they are often the most complicated and high risk patients you can understand why many in the field consider leaving Medicare entirely.

The RUC has recommended an increase of nearly $4.00 per anesthesia unit. I am pleased the Agency accepted this recommendation and I would urge you to support full implementation of the RUC's recommendations. This will go a long way in ensuring continued access to quality anesthesia care for Medicare patients.

Thank you for considering this important issue.

Peter Nickel, M.D.

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

Organization : **School District of Lancaster**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Scott Kimbel and I am an ATC or Certified Athletic Trainer working at a large urban school district in central Pennsylvania. I have been practicing Athletic Training for 11 years and am also a certified Physical Education and Health teacher in the state of Pennsylvania. I received my bachelor's in Sports Medicine from Messiah College in Pennsylvania.

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 P. Kimbel ATC
Head Athletic Trainer
JP McCaskey High School
445 N. Reservoir St
Lancaster, PA 17602

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

Organization : **Self**

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.

Robert D. Evans, M.D., M.Ed.

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

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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

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,
Deborah Dorroh, SRNA
12860 Sipsey Valley Rd South
Ralph, Alabama 35480

Submitter : Ms. Kathleen Rovito **Date:** 08/29/2007

Organization : Ms. Kathleen Rovito

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I have recently started my career in Maryland as an Athletic Trainer for Physiotherapy Associates. My position is considered clinic-outreach in which I split my time between the Physical Therapy clinic and the local high school. I recently earned my bachelors degree in Athletic Training from an accredited program at Southern Connecticut State University. Immediately after graduating, I earned certifications as an Athletic Trainer and as a Strength and Conditioning Specialist. 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,

Kathleen Rovito, ATC, CSCS

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

Organization : Guthrie Health

Category : Nurse

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:
My name is Mary Hicks, RN, MS. I am currently a student in a PhD. In Rural Nursing program. As a clinician, I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is 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,
Mary Hicks, RN, MS

Submitter : **Dr. Larry Lindenbaum** **Date: 08/29/2007**

Organization : **Medical College of Wisconsin**

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.

Larry Lindenbaum, MD
Anesthesiology Resident

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

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Please choose to increase the value of anesthesia services and vote for the proposed boost of 32%.
Thank you,
Cheryll Benson, CRNA

Submitter : Mr. Dean Gibson **Date:** 08/29/2007

Organization : Mr. Dean Gibson

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a CRNA I am concerned with the erosion of payment for our services to medicare patients. Please do not support the further loss of medicare dollars for anesthesia care. Medicare currently deos not pay the cost of anesthesia providers,so a further drop will exacerbate an already critical situation.

Submitter : **Dr. Jason Rigol** **Date: 08/29/2007**

Organization : **Dr. Jason Rigol**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Jason Rigol, MD
Anesthesiologist
Metairie, LA

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

Organization : **Dr. John Bradley**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

John C. Bradley

Submitter : **Ms. marielle gatenby** **Date: 08/29/2007**

Organization : **Ridgeview Medical Center**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified Athletic Trainer working in outpatient rehabilitation clinic. I have been working with medicare orthopaedic patients since 1989.

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. I am required to have at a minimum a bachelor of science degree in athletic training, pass an accredited national exam process,and maintain skills via a monitored CEU process. This is more than some of the health professionals you are presently trying to put forth changes to ensure properly trained health care providers for medicare patients. I applaud these efforts, but want to remind you that certified athletic trainers already meet your standards. By making the present changes, you are elimnating this qualified group of health care professionals from being able to treat medicare patients. You are emlinating a group of healthcare professionals who are more than capable to treat medicare patients and have been for the last 18 years.

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,

Marielle Gatenby, MA, ATC

National Athletic Trainers' Association
2952 Stemmons Freeway ? Dallas, TX 75247

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

Organization : **Anesthesia Medical Group, P,C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Most Sincerely,

Thomas C. Thomas, III, M.D.
Anesthesia Medical Group, P.C.
Nashville TN 37204

Submitter : Dr. Wayne Kleinman **Date:** 08/29/2007

Organization : ASA,AMA,CMA,CSA,LACMA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am an Anesthesiologist practicing in suburban Los Angeles. Anesthesia services have long been under valued. Many of the highest quality members of our specialty elect not to work in a hospital with the overnight call schedule and the large percentage of sick Medicare patients. Instead they work at Surgery Centers to make more money. This proposed increase would help stem the "brain drain" and make help ensure access to quality care for our seniors.
Please contact me with any questions.
Thank you,
Wayne Kleinman, M.D.
wklcinman@aol.com

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

Organization : **Rehab Group of Morristown**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is James Bond and I am a certified athletic trainer and a physical therapist assistant. I am currently employed at the Rehab Group of Morristown,a privately owned physical therapy clinic. I am also getting my doctorate as a physical therapist. Due to issues that Medicare have with trained professionals such as athletic trainers, I had to go back to school to get my associates degree to be recognized as a health professional. I find this disturbing because I am more trained with my bachelors degree in athletic training than the training and assoeiates degree I received as a physical therapist assistant (PTA). My job setting consists of seeing orthopedic patients with many types of problems which the physical therapist in my clinic would rather me treat the orthopedic patients because I get better and quicker results than he does. Based on the shortage of your definition of "qualified personnel" and the quality of care, there is no reason a company should be trying to take away qualified HEALTH PROFESSIONALS such as ATHLETIC TRAINERS. As an athletic trainer, I hold a bachelors degree which is 2 more years of training and education than a PTA's associates degree. Not only are athletic trainers in many states nationally licensed but also state licensed, which is more than physical therapists and physical therapist assistants. Athletic trainers are also health professionals which must possess and pass a health professional licensing exam, as do other health professions.

Based on my qualifications and education as an athletic trainer 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,

James Bond, ATC/L, PTA

Submitter : **Mr. Carl Cheramie** **Date: 08/29/2007**

Organization : **Mr. Carl Cheramie**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Office of the Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P (BACKGROUND, IMPACT)
ANESTHESIA SERVICE

Dear Administrator:

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This is important for many reasons:

1. Medicare currently under-reimburses for anesthesia services, putting the availabilty of anesthesia services for Medicare recipients at risks. With only a 40% of private market rates reimbursement for anesthesia services compared to 80% for other Medicare Part B services.

2. The proposed rule reviews and adjust anesthesia services for 2008, while most other services have already been reviewed and adjusted since jnuary of this year.

3. This propsed adjustment would change the relative value of anesthesia work whch would help to correct the value which have slipped behind inflationary adjustments.

If the propsed change does not occur, or not enacted by Congress, the average 12-unit anesthesia service will be 17% below 2006 payment levels and more than 33% below 1992 levels (adjusted for inflation).

There are 36,00 CRNA's providing anesthsia in every setting requiring anesthesia services. We are the predominant providers of anesthesia in most of the rural and medically underserved areas of the USA. The continued availability of anesthesia to these medicare recipients is dependent in part on adequate reimbursement of these services. I support the agency's acknowledgement of of the undervalue of anesthesia's reimbursement and its proposal to increase the valuation of anesthesia work that boosts Medicare payments.

Carl A. Cheramie, CRNS, BSN, MHS
5714 Bon Aire Dr
Monroe, LA 71203

Submitter : **Dr. Douglas Lundy** **Date: 08/29/2007**

Organization : **Resurgens**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician owned PT is very important to the care of patients. Patients have the right to choose who provides this service to them. Competition is highly beneficial in regard to cost, and owning this service increases our ability to closely follow our patients.

Submitter : **Dr. Janet Passman** **Date: 08/29/2007**

Organization : **Louisiana College**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer employed by Louisana College. I am an assistant professor teaching in the Athletic Training Educational Program. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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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,

Janet Passman, PhD, ATC

Submitter : **Mrs. Pamela Allred** **Date: 08/29/2007**

Organization : **Mrs. Pamela Allred**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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,
Pamela Allred CRNA

Submitter : **Dr. Mahmud Elbackush** **Date: 08/29/2007**

Organization : **American Society of Anesthesiologists**

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.

Mahmud R. Elbackush M.D.

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

Organization : **Fort Wayne Dermatology Consultants**

Category : **Physician**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

August 29, 2007

Thomas W. McGovern, MD
5223 West Hamilton Road S
Fort Wayne, IN 46814-9415

The Honorable Herbert Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Washington, DC 20201
FAX (202) 690-6262

Re: CMS 1385-P: 2008 Medicare Fee Schedule
Coding Multiple Procedure Payment Reduction for Mohs Surgery

Dear Acting Administrator Kuhn:

As the only fellowship-trained Mohs surgeon within a 90-minute to two-hour drive in any direction from Fort Wayne, I am profoundly concerned about the proposed change to the Multiple Procedure Payment Reduction for Mohs Surgery. I appreciate the opportunity to offer comment on section II.E.2 (P-122) of the 2008 Medicare Fee Schedule Proposed Rule.

The proposal reverses a 16 year-old policy of the Centers for Medicare and Medicaid Services (CMS) that the Mohs codes should be exempt from the Multiple Procedure Reduction Rule (MPRR). Because Mohs surgery includes both surgery and pathology services, no efficiency is gained by performing multiple procedures on each patient. The proposed rule contradicts the Relative Value Update Committee s (RUC) policy regarding procedures that qualify for exemption from the MPRR.

This proposal will directly impact my patients access to care, since I will need to reduce surgery to one cancer per patient per day. I cannot cover overhead with a 50% reduction in reimbursement. About 20% of my patients have more than one cancer treated at a time, and many of them travel over an hour to see me or are driven by transportation service providers from nursing homes. I will more likely send patients to other surgeons for repairs after Mohs surgery, since I will not be adequately reimbursed for that aspect of my patients care. During the past several weeks, many of my Medicare patients have expressed their extreme disappointment with the proposed rule.

On behalf of my patients, I ask that you reconsider this proposed rule and provide a permanent exemption for Mohs codes 17311 and 17313.

Thank you for your consideration.

Sincerely,

Thomas W. McGovern, MD

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

Organization : **Christopher Adams**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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.

Submitter : Mrs. Pamela Schield **Date:** 08/29/2007

Organization : Lakeside Physical Therapy

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Pamela Schield and I have been a Certified Athletic Trainer since 1999 and have been working with athletes since 1996. My education includes a Bachelor Degree in Health and Human Performance and a Master in Education with an emphasis in Health and Physical Education. I have been employed in the secondary and collegiate level providing health care services to student athletes that includes evaluation and progressive rehabilitation needs for injuries. My current employment includes rehabilitative services in the private physical therapy industry.

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

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

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

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

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

Sincerely,

Pamela Schield, ATC, M.Ed.

Submitter : **Dr. Radha Sukhani** **Date: 08/29/2007**

Organization : **SameDay Surgery River North Chicago**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. Kay Argrovesw **Date:** 08/29/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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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Sincerely,

Kay M. Argroves, CRNA

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

Organization : SameDay Surgery River North Chicago

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Axel Vargas **Date:** 08/29/2007

Organization : SameDay Surgery River North Chicago

Category : Physician

Issue Areas/Comments

GENERAL

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

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Rob Chance** **Date: 08/29/2007**

Organization : **St John Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Rob Chance, D.O.
2738 S. Woodward
Tulsa, OK 74114

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

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Thank you for your consideration of this serious matter.

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

Organization : AANA

Category : Health Care Provider/Association

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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Submitter : Mr. Wesley Green **Date:** 08/29/2007

Organization : Mr. Wesley Green

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Dear Administrator:
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Sincerely,
Wesley Green CRNA
Janesville Wl 53548

Submitter : Mr. Noel Tenoso **Date:** 08/29/2007

Organization : Advance Sports & Spine Therapy, LLC

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11987-Attach-1.DOC

11987

Mr. Kerry N. Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
US Dept. of Health and Human Services
Attn: CMS-1385-P
PO Box 8018
Baltimore, MD 21244-8018

Attention: CMS-1385-P

Dear Mr. Weems,

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

I am a physical therapist in private practice in the Portland, Oregon area. I have been a practicing Physical Therapist for 20 years and have worked in a variety of practice settings such as hospitals, outpatient clinics associated with hospitals, and private practice. As a private practitioner, being aware and involved with issues that impact my profession and practice are very important.

I have been involved in various capacities in the American Physical Therapy Association (APTA) and its Oregon chapter activities. The issue of physician self-referral is a major topic nationally and locally, and personally it impacts my practice, both as a clinician and business owner. I support eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception. I believe this would accomplish the following:

- eliminate the potential for fraud and abuse in arrangements where there is financial interest,
- reduce cost by preventing financial incentive to over-utilize the referral to physical therapy, and
- Improve care by sending patients to the physical therapist who is best qualified to handle the patient's needs.
- Restore fair competition of physical therapy services

The unique nature of the physician owned physical therapy practice has the tendency to encourage a fraudulent relationship. The physicians directly benefit from generating referrals. This sort of design will encourage referral to physical therapy, even if it is not medically necessary. The temptation to refer to physical therapy more frequently and the potential to continue physical therapy beyond what is necessary would be difficult to ignore when there is financial gain involved. While every Physical Therapist has the obligation to treat what is only medically necessary, an employee of a referring physician may fear for their job should they reject unnecessary referrals

Like many other services physicians employ in their office, physical therapy in a physician owned practice is used as a means for additional income. This sort of arrangement has the potential to create over utilization of physical therapy services, by its design. For example, a physician owned practice in my community schedules their physical therapist to see an average of 25-30 patients per day. In my practice I see 11-12 patients per day spending 30 to 45 minutes of one-on-one care. After twenty years of practice, I find this schedule essential to provide the quality of care needed to treat and educate in an adequate manner.

Physician owned physical therapy practices impact on patient care and can limit their ability to access the best services for the patient's individual needs. I used to receive referrals from a spinal diagnostic physician in our local community. Being a specialist, this physician relies on primary care physicians' referrals for his business. In this particular example the primary care physician group that referred to the specialist owned their own physical therapy clinic. The spinal diagnostic physician did not see good outcomes with this physician owned physical therapy clinic and decided to refer patients to my clinic, where I demonstrated better results. This physician was warned by the physicians that referred to him that if he did not refer to their physical therapy clinic that it would affect referrals to his practice. Given this dilemma he felt forced to refer physical therapy to his referrer's clinic despite his desire to refer to my clinic, which produced better outcomes for his patients.

Since Physicians are patients' primary access to musculoskeletal disorders, the referral for profit relationship creates an unfair competitive environment.

Physicians who have Physical therapy in their clinic will boast better care because the communication between therapist and physician is more convenient. This is a myth since a phone call from any location to the physician's office is just as efficient. If a patient's condition deteriorates when I see them in my clinic, I have always been able to get that patient in the same day to see their physician. Furthermore, the physician's physical therapy may be geographically inconvenient for the patient having them drive many miles out of their way to go to therapy when they can be seen at a physical therapy clinic near their home or work.

Most patients are not aware they have a choice in choosing their physical therapist, and physicians who employ physical therapists would not benefit by disclosing this to their patients. The temptation to refer to physical therapy more frequently and the potential to continue physical therapy beyond what is medically necessary would be difficult to ignore when there is financial gain involved. This is one area of healthcare that controlling costs and improving quality care CMS could impact immediately. **I strongly urge CMS to remove physical therapy as DHS permissible under the in-office ancillary exception of the federal physician self-referral laws.**

Sincerely,

Noel M. Tenoso, PT, OCS

Submitter : **Dr. Bradford Moss** **Date: 08/29/2007**

Organization : **Dr. Bradford Moss**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

Dear Mr. Kuhn:

I am a urologist who practices in a 12 man single specialty group (Urology) in Akron, Ohio. A large portion of my practice involves the care of Medicare patients especially men with prostate disease. I am writing to comment on the proposed changes to the physician fee schedule rules that were published on July 12, 2007 that concern the Stark self-referral rule and the reassignment and purchased diagnostic test rules.

The changes proposed in these rules will have a serious impact on the way I practice urology and will not lead to the best medical practices. With respect to the in-office ancillary services exception, the definition should not be limited in any way. It is important for patient care for urologists to have the ability to provide pathology services in their own offices. It is equally important to allow urologists to work with radiation oncologists in a variety of ways to provide radiation therapy to patients. We also provide x-ray (CT Scan and ultrasound) diagnostic services that allow rapid, convenient and accurate care, that might be limited if the definition of an in-office ancillary service was limited to those tests and services that are needed to immediately diagnose or treat a patient. Many of my patients know that I am actively involved with where they go to have their treatment and testing. It is my concern that many of my patients who currently have there treatment and testing under my guidance will have to be turned over to hospitals, insurance company run facilities and most importantly: everyone BUT their doctor.

The sweeping changes to the Stark regulations and the reassignment and purchased diagnostic test rules go far beyond what is necessary to protect the Medicare program from fraud and abuse. The rules should be revised to only prohibit those specific arrangements that are not beneficial to patient care.

Thank you for your consideration,

Bradford Moss

Submitter : Ann McHale-Sass **Date:** 08/29/2007

Organization : American Association of Nusre Anesthestists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a member of AANA, I write to support the CMS proposal to boost the value of anesthesia work by 32%. If adopted CMS proposal would help to ensure that CRNAs as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services. CRNAs provide some 27 million anesthetics/year in the US, mostly in rural and medically underserved America. Medicare patients depend on our services. 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,
Ann McHale-Sass, CRNA, ARNP

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

Organization : **Miss. Kelly Kimmel**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment. Thank you.

CMS-1385-P-11990-Attach-1.DOC

#11990

August 29, 2007

Dear Sir or Madam:

Hello. My name is Kelly Kimmel and I've been a Certified Athletic Trainer for 6 years. After working in both collegiate and clinic-secondary school settings, I am now working full time at my church. Though I am not practicing athletic training full time, I do assist other athletic trainers when coverage help is needed. The reason I write is that I believe it is fundamental for you to hear from each of us who represent our profession of athletic training, especially from one who has experience in a clinical 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.

Thank you for taking the time to consider what withdrawing the proposed changes will do for the health and well-being of yourself or someone you love.

Sincerely,

Kelly Kimmel, ATC

Kelly Kimmel, ATC

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

Organization : **WCS Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Ian Petersen and I work for a rehabilitation program called WCS Physical Therapy. I am a Certified Athletic Trainer who helps people get back to work. When Physical Therapists are done with their scripts they will then send their patients to me. Physical Therapists usually work with the patients for one to two hours while I work with the patients for four hours. I give them more advanced flexibility, strength, and stability exercises to allow them to get a smoother transition to work. I also assist some of their patients when necessary. Our company is located in the Chicago, Illinois area and we make quality health care possible with Physical Therapists and Athletic Trainers working together.

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

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

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

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

Sincerely,

Ian Petersen, ATC

Submitter : Dr. Harold Pierre **Date:** 08/29/2007

Organization : SouthCrest Anesthesia Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

We need the help of congress to provide us the funds to take care of America's sickest patients. This is long overdue to attract and retain our physicians in this field.

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

Organization : **Mountain State Medical Specialties**

Category : **Physician**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Over a million Americans per year are diagnosed with skin cancer, and over the last ten years the rate of new skin cancer diagnoses is growing by what many would call epidemic proportions. Mohs micrographic surgery is a common way of treating some of these cancers and is considered the gold standard among treatments for skin cancer, allowing the physician to examine 100% of the cancer margin to insure complete removal of the cancer with loss of as little normal skin as possible. It also provides the patient with the highest cure rate of any treatment for skin cancer. Mohs surgery is an outpatient procedure that utilizes onsite laboratory analysis of excised tissue while the patient waits for the results.

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

I am one of only two skin cancer surgeons in the state of West Virginia with specialized fellowship training to perform this procedure. We are the only West Virginia members of the American College of Mohs Surgery. I have removed approximately 1200 cancers from patients since July 2006 alone using Mohs micrographic surgery. My patients come to me from up to 200 miles away. This rule may require us to limit the number of cancers treated per patient and require more waiting and repeat visits. My Medicare patients, who make up 50% or more of my population will be hit hardest.

I greatly appreciate your assistance in this important matter.

Submitter : **Dr. paul hoell** **Date: 08/29/2007**

Organization : **Dr. paul hoell**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

#11994

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Dr. Frederic Holcmb **Date:** 08/29/2007

Organization : Dr. Frederic Holcmb

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Overall physicains need to be involved in the delivery of services and have the ability to see a fair compensation that allows all areas of medicine to participate. We should bc ablc to dcliver these services in all venues. Limitations in a lot of communities are going to have an adverse impact on less costly and often duplicatcd scrvices cspecially if provided in more costly settings ,ie hospitals or facilities that are purely for profit. Limitng our ehoices are going to be counterproductivc and ultimately more expensive.

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Living in a small community we have been able to offer a full time service for lithotripsy in an a heavy stone burden poulation. This is a service that otherwise would not bc cmployed other than on an occasional basis which causes both an increase in proceedures to stabilize a patient and to increase lost time as well as increased hospitalization for pain control. By having a joint venture we have provided an efficient and timely service. We do not need to return to these more costly mcthods and unduc burdens on the patient and thei families.

Resource-Based PE RVUs

Resource-Based PE RVUs

Thc sustainable growth formula must be changed to a more equitable and sutainable method. We can no longer continue to stabilize this method and have physicain continue to absorb losses for seeing Medicare patients. This is especially true when ancillary services are growing at a rapid rate providing egregious profits to pcople on the periphery of medical care.

Submitter : **Mr. John Akers** **Date: 08/29/2007**

Organization : **Anesthesia Resources Management**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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 demostrated 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.

John Randall Akers, CRNA
6417 North Hills Circle
Gardendale, AL 35071

Submitter : **Ms. Katelyn Benning** **Date: 08/29/2007**

Organization : **AthletiCo LTD.**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Katelyn Benning and I am an athletic trainer with Athletico. AthletiCo is a Chicago-based provider of outpatient, orthopedic rehabilitation. I work in an Athletico clinic in Glenview, Illinois and am the team athletic trainer for North Shore Country Day School in Winnetka, Illinois. At the clinic I assist the physical therapists with the rehabilitation of their patients. When I am at the high school, I work with all of the students at the school and provide coverage for all practices and home games. I graduated from Concordia University in Wisconsin in May of 2004 with a Bachelor of Science Degree in Athletic Training and received my athletic training certification in December of 2005.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients. As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

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

Sincerely,

Katelyn Benning, ATC/L

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

Organization : **Natalie Shannon**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I have just finished my undergraduate degree in Athletic Training in May and just took my athletic training certification test this summer. I am now a Certified Athletic Trainer, and I will begin Physical Therapy School in January. I am currently working as an athletic trainer on an event-by-event basis until I begin school.

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

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

As a certified 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. As a person who is pursuing a dual degree in both athletic training and physical therapy, I know the requirements and qualifications of both professionals, and I am completely confident that athletic trainers are fully qualified to provide healthcare to these patients.

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,

Natalie Shannon, ATC

Submitter : **Dr. vu huynh** **Date: 08/29/2007**

Organization : **AAMG**

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.

vu huynh MD

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

Organization : **University Hospitals, Case Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12000-Attach-1.DOC

#12000

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,
Jennifer M. Potzman MD
Resident, Department of Anesthesiology, University Hospitals, Case Medical Center

Submitter : **Dr. Rohan Sundaralingam** **Date: 08/29/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

I am writing to cxpress 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 thc RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to othcr physician scrvices. 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 arcas with disproportionatcly high Medicarc populations.

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To cnsurc 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.

Rohan Sundaralingam, M.D.

Submitter : Dr. Luciana Young **Date:** 08/29/2007

Organization : Children's Memorial Hosp/Northwestern University

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

To CMS:
I am a Pediatric Cardiologist and Director of the Echocardiography Laboratory at Children s Memorial Hospital. I am writing this letter because it has recently come to my attention that CMS is proposing a change to eliminate CPT code 93325 and bundle this code into other CPT codes. In my opinion, this change is being pursued without following the appropriate process and as a result the usual specialty societies (i.e. the American College of Cardiology, American Heart Association and American Society of Echocardiography) have not had an opportunity to poll their membership and assess the proposed change in a careful, systematic manner.

Color flow Doppler is an integral part of all echocardiograms performed to assess patients with congenital and non-congenital heart disease. This technique is used in conjunction with other imaging to define structural and physiologie abnormalities, as well as a guide for positioning the cursor to perform other Doppler modalitics. It involves sonographer time for performance and physieian time for interpretation. I am concerned that this change will adversely impact access to care of patients with congenital heart disease. Programs such as Children's Memorial Hospital, care for patients with the resources to afford private insurance but also for those with Medicaid or no coverage at all. This change will reduce reimbursement for congenital cardiac services across all payor groups and therefore will reduce current resources which allow us to support programs that provide this much-needed care to our patients. Our children s hospitals and academic programs arc already challenged with respect to resources and this change will only make matters worse.

I am requesting that CMH withdraw the proposed change with respect to bundling CPT 93325 with other echocardiography codes until an appropriate review of all related issues can be performed, with the prescribed process and timeframe, in order to achieve the most appropriate solution.

Thank you for your consideration.
Sincerely,

Luciana Young, MD, FAAP, FACC, FASE
Director, Echocardiography Laboratory
Children's Memorial Hospital
Associate Professor, Pediatrics
Northwestern University Feinberg School of Medicine

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

Organization : **Dallas VA Medcial Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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

BRIEF INTRO ABOUT SELF: I work at the Dallas VA Medical Center as a Registered Kinesiotherapist. I have a B.S. in Kinesiology with certification in Kinesiotherapy. I have been a therapist for seven 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 care industry. It is irresponsible for CMS to further restrict PMR services and specialized professionals.

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

Sincerely,
Parisa Mazandarani, RKT

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

Organization : **april fraiser**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

I write to support the CMS proposal to boost the value of anesthesia work by 32%. Under CMS's proposed rule Medicare would increase the anesthesia conversion factor by 15% in 2008 compared w/current levels. (72 FR 38122, 7/12/2007). If adopted, this would help to ensure that CRNAs as Medicare Part B providers can continue to provide Medicare with cost-effective, high quality anesthesia service.

Submitter : Mrs. Meryl Loeb **Date:** 08/29/2007

Organization : Mrs. Meryl Loeb

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. As a healcare consumer, 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.

Submitter : **Ms. Theresa Haines** **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.
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,
____Theresa M.Haines CRNA MS_____
Name & Credential
____44020 Cottisford Rd_____
Address
_____Northville, MI 48167_____
City, State ZIP

Submitter : **Dr. Karen Hwang** **Date: 08/29/2007**

Organization : **Fortanasce**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician self-referral to physical therapy services ultimately hinders the growth of the profession. As a new graduate of the University of Southern California's Doctor of Physical Therapy program, I have been taught the latest and greatest research affecting our profession, and more importantly, our patients. I know that when a patient is referred to me, I use evidence-based treatments that I learned at USC to get them back on their feet to be a functioning member of society. Not only do I use the knowledge that I earned at USC, but I am an active member in the American Physical Therapy Association which keeps me up to date with the research. I want my patients to know that they are receiving quality care, and to hold physical therapists in high regard. Physician self-referral does not allow those physical therapists to practice with evidence-based practice. Often, they are under the strict supervision of physicians who do not quite understand the practice of physical therapy. I am aware of several physician-owned clinics that practice with only physical therapy assistants performing the treatment, and billing under one physical therapist's license number. This image of physical therapy ruins the profession, as it does not emulate quality care. In America, we are given the freedom of choice; physician self-referal does not allow patients the freedom to choose a quality physical therapy clinic that uses research-proven interventions. I urge you to reconsider the physician self-referral provision in the hopes that you have the patients' interests at heart.

Sincerely,
Karen Hwang, PT, DPT
USC Class of 2007
Fortanasce & Associates Physical Therapy/Sports Medicine Center

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. Celine Qureshi **Date:** 08/29/2007

Organization : AC Cardiovascular Sonography, INC.

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

I am requesting Medicare law maker to reconsider bundling the payment policy for color flow in Echo. Color flow Doppler is important in evaluating valvular regurgitation and cardiac shunting. It is necessary in every Echo exam; therefore, taking up more time and effort for technicians as well as interpreting physicians. It also cost more to use Ultrasound with good color Doppler. Cutting the reimbursement for Color Doppler would mean less quality in patient care. Thank you for reconsider not to bundle the Color flow Doppler reimbursement.
Celine Qureshi, BS. RVS, RCS.

Submitter : Mr. amir qureshi **Date:** 08/29/2007

Organization : AC Cardiovascular Sonography Inc.

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

I am requesting Medicare law maker to reconsider bundling the payment policy for color flow in Echo. Color flow Doppler is important in evaluating valvular regurgitation and cardiac shunting. It is necessary in every Echo exam; therefore, taking up more time and effort for technicians as well as interpreting physicians. It also cost more to use Ultrasound with good color Doppler. Cutting the reimbursement for Color Doppler would mean less quality in patient care. Thank you for reconsider not to bundle the Color flow Doppler reimbursement.

Submitter : **Dr. denis o'fallon** **Date: 08/29/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.

Denis O'Fallon MD

Submitter : **Ms. Mary McLendon** **Date: 08/29/2007**

Organization : **Mississippi State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer working in the college setting, and 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,

Mary McLendon, ATC, NCTMB

Submitter : Mr. Brett Cooley **Date:** 08/29/2007

Organization : AANA

Category : Other Health Care Professional

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.
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.

Thank you,
Brett Cooley

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

Organization : **Mrs. Mary Sanders**

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Mary Sanders and my son, Christopher J. Potter, is an athletic trainer. My concern for his welfare, including his ability to perform the job for which he trained extensively, is the reason for my letter.

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 his patients.

As an athletic trainer, he is qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. His education, clinical experience, and national certification exam ensure that his patients receive quality health care. State law and hospital medical professionals have deemed him 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. My son, and many other professionals in his field, have expended considerable time and financial resources to fulfill their dreams of becoming an athletic trainer. 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, A Concerned Parent!

Mary Sanders

Submitter : **Mr. Glenn Lever** **Date: 08/29/2007**

Organization : **Nutfield Anesthesia Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007

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

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

This increase in Medicare payment is important for several reasons.

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.

Submitter : **Dr. Tammily Carpenter** **Date: 08/29/2007**

Organization : **Oregon Anesthesiology Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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.

Tammily Carpenter, MD

Submitter : Mr. Bradley Pierce **Date:** 08/29/2007

Organization : Marietta College

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12017-Attach-1.DOC

#12017

Dear Sir or Madam:

My name is Brad Pierce and I am currently a 21 year old fourth year student at Marietta College seeking a B.S. in Athletic Training. I am also employed by Marietta Memorial Hospital where I work in the Orthopedic Outpatient Physical Therapy Department as a Rehab Aide. When I first heard of the proposed changes to 1385-P and the impact that it would have on my position as an athletic trainer in a clinical setting I was immediately concern. Upon my graduation from Marietta College I had planned on working as an athletic trainer in a clinical setting for a year before moving onto graduate school. The changes, if passed, could limit my career as a athletic trainer along with countless others just like me.

I am writing concerning the recent proposed changes to staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. I would at this time like to state my opposition to these proposed changes due to the restriction of medical access that it could cause to patients I will see in the future.

As a future athletic trainer I will be more than qualified to perform physical medicine and rehabilitation services, which you know is not he same as physical therapy. The clinical experience I have gained, the preparation for the national licensure exam, and four years of education make me more than qualified to provide quality care to my patients.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the healthcare field today. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas just like Marietta, Ohio, 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,

Brad Pierce

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

Organization : **Dr. William Rodes**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **American Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Please note the support for CMS Medicare increase for anesthesiologists.

CMS-1385-P-12019-Attach-1.DOC

12019

James W. Futrell Jr., M.D. *Diplomate American Board of Anesthesiology*

6141 So. Bedford Avenue
Los Angeles, Ca., 90056-2014

310-641-2265 Office
Jfutrell@expertmedical.org

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

August 29, 2007

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.

James W. Futrell, M.D.

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

Organization : **Dresher Physical Therapy, Inc.**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To: Mr Kerry N. Weems
Administrator-Designate
Center for Medicare and Medicaid Services
US Dept. of Health and Human Services

Attn: CMS-1385-P
PO Box 8018
Baltimore, MD 21244-8018

Mr Weems,

My name is Matthew Seabrook, and I am a physical therapist with nearly fifteen years of experience. I own a private outpatient practice, Dresher Physical Therapy, in the northern suburbs of Philadelphia.

I am writing to urge CMS to remove physical therapy as a designated health service permissible under the in-office ancillary exception of the federal physician self-referral laws.

To not do so is to continue to passively allow unethical self-referral behavior, waste of health care resources, and abuse of the best interest of Medicare beneficiaries.

I have seen countless instances of physicians abusing the self-referral loophole that exists in the Stark Law just to capture additonal revenue in their offices. Clearly it is more appropriate and equally convenient for patients to receive services in an independendent physical therapy office than in their physician's office due to the repetitive nature of rehab services.

Thank you for consideration of my comments.

Sincerely,

Matt Seabrook, PT, MS
Dresher Physical Therapy
1650 Limekiln Pike
Dresher, Pa 19025
215 283 5071

Submitter : Dr. Alec Rooke **Date:** 08/29/2007

Organization : Dr. Alec Rooke

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As the Founding President of the Society for Geriatric Anesthesia, I, and my colleagues, recognize that the amount of care provided to older patients will increase substantially for the foreseeable future. Their anesthetic care is considerably more complicated and difficult than for their younger, healthier counterparts. These patients are at high risk for perioperative complications and present with multiple co-morbid disease processes that require complex geriatric expertise. I strongly believe that one of the reasons anesthesiologists show little interest in older patients is because they are being asked to care for the sickest patients while being paid poorly for this more difficult care. It is a basic human response to feel that if nobody values our service, why show an interest? In fact, we do care, and we (anesthesiologists) take great pride in what we can accomplish toward helping older patients through the stress of surgery. But the low value CMS places on anesthetic care in comparison to other medical specialties is demoralizing to me - and I am one of the strongest proponents of geriatric anesthesia in the country!

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.

Submitter : Mr. Guy Picard **Date:** 08/29/2007

Organization : Mr. Guy Picard

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Re: CMS-1385-P 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.
1. 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.
2. 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.
3. 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,

Guy Picard, CRNA, MSN
102 Kentville Circle
Lafayette, Louisiana 70508
337-988-6706 (home)
337-349-2100 (cell)

Submitter : **Ms. Shiho Goto** **Date: 08/29/2007**

Organization : **University of Toledo**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a graduate assistant at University of Toledo, and a certified athletic trainer. I work at the local high school in relation with physical therapy clinic.

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

Whilc 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 thcsc proposcd rulcs will crcate additional lack of access to quality health care for my patients.

As an athlctic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical expcrience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to pcrform 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,

Shiho Goto, ATC/L

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a physical therapist I disagree with any legislation limiting access to physical, occupational, or speech therapy services where physician self-referral is provided. I don't believe the data is present to constitute a financial relationship between a therapist and physician creating overutilization of services. Referral and treatment options should be left up to referring physicians including what practitioners the physician may refer to. The quality and quantity of services in physician self-referral practices is currently governed appropriately by legislation enacted in the past several years and further legislation would only hinder access to services provided to Medicare beneficiaries. Thank you for your concern. Again, I am opposed to any further legislation limiting access to physician self-referral therapy services.

Submitter : **Dr. Clifford Friesen** **Date: 08/29/2007**

Organization : **Dr. Clifford Friesen**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Attention: CMS-1385-P

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Mr. Weems:

I am a physical therapist who has worked in private practice in Wisconsin for 17 years. I would like to comment on the July 12th proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception.

At Freedom Physical Therapy our staff is very well educated with experienced therapists who provide exceptional care. With declining reimbursement and limited visits with both Medicare and other insurers it has become increasingly difficult financially, for us to provide the high level of patient care our patients have experienced in the past. To further compound the problem, we now have physician groups reaping the financial rewards of referring patients to therapy practices they own instead of independently non physician owned therapy practices that often provide superior and more cost-effective care. This loophole is possible due to the in-office ancillary services exception to the Stark Law, as physical therapy is currently considered a designated health service (DHS) . In some cases, PT s are not even treating these patients, but instead by PTA s and ATC s under the physician s direction. This is often unethical and needs to stop, so patients do not suffer from receiving unlicensed physical therapy skills.

Generally speaking, physical therapy services are provided on a multiple treatment basis. With that said, it is no more convenient for the patient to receive PT services 2-3 times per week in the physician s office than to attend an independent physical therapy location. Furthermore, physician-direct supervision is not necessary to administer physical therapy services. In fact, an increasing number of physician-owned physical therapy clinics are using the reassignment of benefits laws to collect payment in order to circumvent incident-to requirements.

Thank you for your consideration of my thoughts and comments. I hope these comments have helped to highlight the abusive-nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

Sincerely----------A Concerned Physical Therapist in zip code 53213

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist with 15 years of experience and lately I have found it troubling the emergence of physician owned rehab clinics. Earlier in my career they were just small rooms in a single Dr. s office. No real threat to competition there. I also see it being acceptable in a rural setting where there may be only a Dr s office for miles around and he is able to provide rehab services to his patients. But the emerging trends that I have seen and have experienced first hand in several cities are the large inter-disciplinary group practices and/or orthopedic groups that provide rehab services. Many times these groups have several clinics in a geographic area not just one central office.

These arrangements not only can affect the quality of care received by Medicare beneficiaries but also stifle competition in the market place. The private practice I work for has been devastated when the large orthopedic group opened up there own rehab facility. Our hand therapy business has been cut in half if not more. We also have past patients who tell us when they have returned to us for another illness that required rehabilitation their doctor wanted to send them to their own clinic so they could keep a closer eye on them . This is even after the patient has told them they wanted to return to our clinic.

The potential for fraud and abuse can be found in any type of practice whether it is privately owned, corporate owned or physician owned. But its hard argue for physician owned practices because they hold all the cards when it comes to patient referrals.

Thank you for your time.

Submitter : Mr. Alton Ardoin **Date:** 08/29/2007

Organization : AANA

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.

? 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.

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Antonio Santos Jr **Date:** 08/29/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Lynn Bott** **Date: 08/29/2007**

Organization : **Baker University**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

LYNN BOTT
3613 PARKVIEW CT
LAWRENCE, KS 66049

August 29, 2007

Dear Centers for Medicare and Medicaid Services:

As an assistant professor and director of sports medicine at Baker University in Baldwin City, KS, I teach students that are pursuing many allied health professions, one of which is athletic training. With my background in athletic training along with board certification and licensure in Kansas, I have a lot to offer our future students who are pursuing allied health professions that care for our population in the USA.

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, board certification, Kansas State licensure and teaching of our future health care providers in their undergraduate preparation, 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 of the Board and the State of Kansas.

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 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 to 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 with draw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Lynn Bott, MS, ATC, LAT
Director of Sports Medicine / Assistant Professor
Baker University
Baldwin City, KS
lbott@bakeru.edu
lynndebbott@sunflower.com

cc: Honorable US Sen. Pat Roberts www.roberts.senate.gov
Honorable US Rep. Nancy Boyda www.boyda.house.gov

Submitter : **Dennis Forcelle, CRNA, MNA** **Date: 08/29/2007**

Organization : **Dennis Forcelle, CRNA, MNA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007

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

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

Dennis Forcelle, CRNA, MNA
65862 386th Ave
Lake City, MN 55041

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

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am currently an athletic training student at Central Michigan University. I am working with our Track and Field and Cross Country teams at this point. In the past I have worked with our Men's Basketball Team, Baseball Team and Women's Soccer Team as well as an injury care center in our fitness center, an emergency room in Clare County and a rehabilitation center on campus as well. I am in my senior year, getting ready to attend graduate school.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
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,
Megan VanSumeren, ATS

Submitter : **Mr. jeff weir** **Date: 08/29/2007**

Organization : **HealthStyles Health and Wellness**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer and currently work in a health and wellness center that includes physical therapy as well as a fitness center.

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,

Jeff Weir, ATC, CSCS

Submitter : **Dr. Paul Burns** **Date: 08/29/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **individual anesthesiologist**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Mark A. Wix, MD

Submitter : Mr. Marvin Vinitsky **Date:** 08/29/2007

Organization : Mr. Marvin Vinitsky

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As a senior citizen, I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. Anesthesiologists deserve to be paid equitably for the care that they provide to senior citizens.

Submitter : **Mr. Lyle Christensen** **Date: 08/29/2007**

Organization : **Hays Medical Center**

Category : **Hospital**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Lyle Christensen and I'm a certified athletic trainer working in Northwest Kansas. I currently work in the clinic setting (outpatient rehabilitation through Hays Medical Center) and provide athletic training services to two high schools in the area. Our clinic has six certified athletic trainers and provides coverage to fifteen schools in the area. I hold an undergraduate degree in physical education emphasis in athletic training and graduate degree in education with an emphasis in athletic adminstration.

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,

Lyle Christensen MSEd, ATC, LAT

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)

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

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

Thank you for your consideration of this serious matter

Submitter : **Dr. vernon hofmann** **Date: 08/29/2007**

Organization : **osa**

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
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Thank you for your consideration of this serious matter.

Submitter : Mrs. Shirley Vinitsky **Date:** 08/29/2007

Organization : Mrs. Shirley Vinitsky

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a senior citizen, and I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. Anesthesiologists provide pain relief, psychologic support, and patient safety to senior citizens having surgery. They deserve to be paid equitably for the services that they provide.

Submitter : **Mrs. Rochelle Lauret** **Date: 08/29/2007**

Organization : **Orthopedic Institute/O'Gorman High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Rochelle Lauret, and I work as a Certified Ahtletic Trainer for the Orthopedic Institute doing out reach to O'Gorman High School in Sioux Falls, SD. I have my masters degree in Sports Medicine and have been a working ATC since 1990. I also have a certification in the area of strength and conditioning.

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,

Rochelle M. Lauret, MS ATC CSCS

Submitter : **Dr. Clifford Friesen** **Date: 08/29/2007**

Organization : **Dr. Clifford Friesen**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

LeslieV. Norwalk, Esq
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-80189

Re: CMS-1385-P

Dear Mrs. Norwlk:

I am writing to express my support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

Today. Medicare payment for Anesthesia services stands at just $16.19 per unit. This is less than 50% of the ujnit value in absolute terms as compared to the unit value in 1990, not taking into account inflation.

The RUC has recommended that CMS increase the anesthesia conversion factor to offset a calculated 32% work undervaluation. I am pleased that the Agency accepted this small increase in its proposed rule.

Medicare patients require expert Anesthesiology care, and this small increase will ensure that there are still a few Anesthesiologists who are willing to take care of the Medicare population.

Thank you for your consideration of this serious matter.

Cliff Friesen M.D.

Submitter : **Dr. Christopher Erkmann** **Date: 08/29/2007**

Organization : **Western Anesthesiology Associates, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **STAR Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Clint Sanders and I am an athletic trainer in the state of Tennessee. I am currently employed by STAR Physical Therapy, LLC of Nashville, TN as a clinical athletic trainer and in a community outreach setting to area high school athletes, where I have been employed the last 5 years. I was educated at the University of Tennessee, where I received a BS in Exercise Science and MS in Human Performance and Sports Studies. During my time at UT I also spent five years obtaining clinical instruction in athletic training with the UT Men s Athletic Department. I have been a practicing athletic trainer for six years and I have spent many years caring for people the Tennessee, from the most talented athletes to the youngest of children and eldest of adults in my community.

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.

In addition, I question the following statement from the Federal Register (Vol.72, No.133) that notes CMS considers education and training the main qualifications for assuring skilled treatment for Medicare beneficiaries: We are seeking comment on appropriate grandfathering provisions relating to qualifications of therapists and assistants to assure that skilled therapists and assistants with comparable and appropriate education and training treat Medicare beneficiaries in all settings. p. 72

I am concerned that this language seems to imply that comparable education and training are the important factors for determining qualification of providers of physical medicine and rehabilitation services, yet athletic trainers, who are required to have significant educational background and training in physical medicine and rehabilitation in order to become nationally certified, are not deemed to be comparable to any of those professions that CMS proposes to include in this grandfathering provision. This inequity by CMS is not justified, given the many similarities of the educational and training backgrounds of PTs, OTs, and ATs.

As an athletic trainer, I am highly qualified to perform physical medicine and rehabilitation services. These services are regulated by the State of Tennessee, where I am licensed to practice as an athletic trainer under the direction of the highly qualified physicians in my state. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. Since, State law and hospital medical professionals have deemed me qualified to perform these services, I am extremely concerned that 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,

Clint Sanders, MS, LAT, ATC

Submitter : Mrs. Cheryll Martiny-Jorgensen **Date:** 08/29/2007

Organization : Mrs. Cheryll Martiny-Jorgensen

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

I am a provider of predominantly Medicare patients. I am concerned for their access to appropriate anesthesia services. 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 : Ms. paula sylvester **Date:** 08/29/2007

Organization : american association of nurse anesthetists

Category : Other Practitioner

Issue Areas/Comments

Background

Background

see attachment

CMS-1385-P-12048-Attach-1.PDF

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

As a member of the American Association of Nurse Anesthetists (AANA), I write to sup for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia wor CMS' proposed rule Medicare would increase the anesthesia conversion factor (CF) by compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS' proposal wou ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B provi 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 anesthesia services, putting at risk the availability of anesthesia and other health Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) others have demonstrated that Medicare Part B reimburses for most services at approx 80% of private market rates, but reimburses for anesthesia services at approximately private market rates.

°
Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Pa providers' services had been reviewed and adjusted in previous years, effective Janu However, the value of anesthesia work was not adjusted by this process until this pr

°
Third, CMS' proposed change in the relative value of anesthesia work would help to c value of anesthesia services which have long slipped behind inflationary adjustments

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

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

Sincerely,

Name & Credential

Address

City, State ZIP

[]

Submitter : **Dr. Mary faller** **Date: 08/29/2007**

Organization : **Western Anesthesiology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a practcing anesthcsiologist in a large private-practice physician based group. I and most of the physicians with whom I practice enjoy our profession and helping others greatly. Our livelihood and our ability to maintain our practice and continue to care for all patients brought to our practice is dependent upon adequate rcimburscment. I urge all to support suggested increases in reimbursement so that we can continue to offer the highest standard of medical care to all patients coming for surgery and procedures as well as treatment of painful conditions.

Submitter : **Dr. Jarmila hofmann** **Date: 08/29/2007**

Organization : **ret.oral surgeon**

Category : **Health Care Professional or Association**

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 : Mr. Lloyd Nagbe **Date:** 08/29/2007

Organization : Mr. Lloyd Nagbe

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:
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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,
Lloyd R. Nagbe, CRNA
Univeristy of Maryland Medical Center
Baltimore, MD

Submitter : **Mr. Mark Wise** **Date: 08/29/2007**

Organization : **Beaufort Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am writing in regards to in-office ancillary service arrangements that have impacted the delivery of quality Physical and Occupational Therapy.

The in-office ancillary services exception has created a loophole which has resulted in many physician-owned arrangements that provide substandard physical and occupational services. Physicians are in a position to refer Medicare beneficiaries to in-office physical and occupational services in which they have a financial interest. There is an inherent financial incentive to overutilize services under the in-office ancillary services exception.

Additionally, therapy treatments tend to be repetitive in nature and often follow a "cook book" approach rather than identify the individual needs of a patient's particular deficits. Unfortunately, I've even heard patients reporting that their physicians have "better trained therapists" to provide services. (In actuality, I am 1 of 2 certified orthopedic specialists in the county, the other does not work for the physicians.)I have doubts the that indiviualized treatment plans are even addressed or exist.

I have often worked with patients who informed me that their individual physician never mentioned an individual's right to choose their therapy provider; rather, they were simply advised to go schedule therapy "down the hall." Patient's are often mislead into believing their care will be more closely followed by the physician since they tend to reside in the same building.

Finally, I do not feel that the actual therapist working for a referring physician could actually strive to be a strong patient advocate. If the PT finds a "serious" problem either overlooked by the physician or determined to be "not really a problem" by the physician, could the PT really speak out or recommend the patient seek a second opinion or specialist appointment? No, I'm certain there would be a fear of losing their job. (I have actually known PTs in facilities who are afraid of confronting there referring "BOSS" doctors.)

Thank you for considering these comments and eliminating this in-office ancillary services .

Sincerely,

Mark Wise, PT, OCS

TRHCA-- Section 201: Therapy CapS

TRHCA-- Section 201: Therapy CapS

Dear Sir or Madam:
I am writing this letter to express my concern with respect to the Medicare Therapy Cap on outpatient physical therapy services which ultimately impacts the ability to advance these elder patients to their maximal physical abilities and functional independence. This "cap" limits the financial allotment of therapy on Medicare patients and dramatically affects the ability to achieve maximal functional independence for these older patients in the community. You must certainly understand that everyone heals at a different pace and everyone's individual needs and goals from therapy differ to such a great extent that maintaining the cap will only force people into "cook book" treatment approaches which may leave them in a "handicapped" state. For example, perhaps Mrs. Smith and Mr. Brown both have knee replacement surgery and are released on the same day from the hospital, they start outpatient PT after 3-4 home therapy visits for 1 week. However, Mr. Brown complains of pain in his leg and the PT discovers a blood clot and Mr. Brown needs to return to the hospital. He returns 1 week later with some regression in his mobility and strength while Mrs. Smith continues to progress. Perhaps Mr. Brown "catches up" after some time; however, he unfortunately has to climb a flight of 13 steps to get to his bed at night or use his commode; however, he has limited strength and endurace which allows him to only complete 5 steps. Oh, and now Mr. Brown has reached his cap. Now what? Do you want to tell Mr. Brown too bad but your insurance will only allow you get half way up your stairs? Certainly not! Put an end to the cap and continue to monitor for abuse and exhuberant treatment; but please do not let the Mr. Brown's of the world be stuck half way up the stairs. Would you allow a surgeon to perform an intense open hear surgery but awaken Mr. Brown and inform him that he would have to pay out of pocket for the surgeon to close the wound?

Thank you for considering these comments.

Sincerely,

Mark B. Wise, PT, OCS

Submitter : **Mrs. Blanka Juchelka** **Date: 08/29/2007**

Organization : **Henry Ford Hospital**

Category : **Other Health Care Professional**

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.

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,

Blanka Juchelka RN, CRNA

15 E. Kirby St. #810
Detroit, MI 48202

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

Organization : **Lyn Meiring**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. mitze everson** **Date: 08/29/2007**

Organization : **asa**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing to implorc CMS to remove physical therapy from the 'in-office ancillary services' exception to the federal physician self-referral laws.

As a physical therapist I personally know physicians and physical therapists who work in a self-referral environment. In my experience these profcssional associations have been established for the financial benefit of the physician resulting in overutilization of physical therapy services by those physicians and compromised patient care. Some examples are as follows:

I know of physicians who cmploy athletic trainers to carry out care instead of physical therapists. Although they do not have the equivalent training or skill level to providc carc at the same standard as a physical therapist, they are cheaper to hire.

I havc observed physicians who have a financial interest in therapy refer their patients to therapy more often and for longer periods of time than those who do not have a financial interest.

I havc seen several patients who went to a physician who had a physician owned physical therapy practice and they felt pressured to utilize their therapy service although they did not feel they received the same level of care as compared to an independent clinic.

I am aware of a physician owned practice in which the therapist quit and another therapist had not been hired. The physician isntructed the patient to delay getting care for weeks until a new therapist was hired in spite of the patient's request to begin treatment immediately.

Physicians who refer to independent clinics refer to clinics where their patients are seen by experienced clinicians who provide the best care for their patients and obtain the best results. This breeds competition among therapists at these clinics to achieve a high level of skill, obtain excellent outcomes in the fewest number of visits and provide outstanding patient service. This is in contrast to several physicians who opened physician owned therapy clinics and hired newly graduated or inexperienced therapists. They hired the cheapest labor at the expense of their patients.

In conclusion, for the protection of the public, physician financial interests in physical therapy needs to be eliminated and I respectfully request you remove physical therapy from the 'in-office ancillary services' exeeption to the federal physician self-referral laws.

Submitter : **Dr. Edgar Jenkins** **Date: 08/29/2007**

Organization : **Dr. Edgar Jenkins**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

X-ray is an important component of Chiropractic practice. To further sanction the profession will do harm to the chiropractic patient. The need to know bone health is imparitive to an expected out come. If changes are needed it is in the area of re-imbursment of Chiropractic x-rays. The need is not to further cut the chiropractic profession, bsut to increase the safety of the Chiropractic patient.
PLEASE HEED THE NEED OF THE PATIENT. DO NOT IMPLEMENT THIS PROPOSAL!
PLEASE LISTEN TO THE AMERICAN CHIROPRACTIC ASSOCIATION. The ACA has it right.

Thank you,
Edgar B. Jenkins, D.C.

Submitter : Dr. Matthew Linsenbardt **Date:** 08/29/2007

Organization : Dr. Matthew Linsenbardt

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12058-Attach-1.TXT

CMS-1385-P-12058-Attach-2.DOC

12058

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Ms. Mary Connors** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

reimbursement for anesthesia services is woefully inadequate. If not corrected to bring it to levels that other specialities have been granted, the quality and quantity of providers is bound to suffer. Already hospitals are finding it necessary to augment the income of anesthesia practices in order to maintain coverage and the situation will only get worse. Anesthesia care is so scarse these days that less vigilant providers are used too often. Patients must never suffer because a more proficient provider was not available to do their anesthesia. Anesthesia is one of the few times that people must give full control for life or death over to a stranger. We all deserve proficient, vigilent care while we are at the mercy of a complete stranger in a cold, sterile room.

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

As we all know the move to ASCs is both cost efficient and patient friendly. However reimbursement for implants is poor or nonexistant. To continue the positive effects of the use of ASCs reimbursement must be made equal to the reimbursement of inpatient facilities. ASCs provide equal if not better care and patients are not exposed to resistant bacteria and rampent bureaucracy.

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

Organization : **Missouri Delta Medical Center**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:
I am a Physical Therapist practicing in a rural setting. I have been practicing for the past 15 years in both hospital and non-hospital settings. Currently, I am the Assistant Director of Rehab services for Missouri Delta Medical Center. Being in a rural setting, staffing has been an ongoing issue. Qualified Professionals are desperately needed especially as our patient population continues to grow.

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.
My colleagues, athletic trainers, are highly qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. Their education, clinical experience, and national certification exam ensure that patients receive quality health care. State law and hospital medical professionals have deemed them 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 A. Heeb P.T. MO101392

Submitter : Mrs. Rebecca Spicer **Date:** 08/29/2007

Organization : Mrs. Rebecca Spicer

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

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

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

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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. Ashley Goodman** **Date: 08/29/2007**

Organization : **University of South Carolina**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

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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,

Ashley Goodman, MAE, ATC, CPed

Submitter : **Brent Ledford** **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,

Brent Ledford CRNA
Staff Anesthetist Huntsville Hospital
Huntsville, Alabama, 35741

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

Organization : Western Anesthesiologists Associates Inc

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I implore that the reimbursement increase for anesthesiologists should be increased. Anesthesiologists have maintained the highest safety standards, far exceeding the safety standards of our safe commercial aviation industry. For many years our hard work has not been rewarded or recognized. Since most of the surgeries occur in individuals older than 50 years old, these patients come to the operating room with many, many medical issues, i.e diabetes, heart disease, pulmonary disease, renal failure.The average patient that is coming to the operating room is older and sicker. This translates into complicated anesthetic management, greater risk, and lengthier procedures. As an example, we are seeing more and more 90 year old patients having surgery. Personally, I was involved in the care of a 92 year old lady undergoing her third heart bypass surgery--she left the hospital after 8 days and did well in her recovery.

In addition, surgical techniques are getting more complicated and involved. New techniques like robotic heart surgery or prostate surgery presents new challenges to our field that we must face. These procedures are longer and present their own challenges that were not present five or ten years ago. As a specialty we have grown in our skill, versatility, and knowledge.

Anesthesia is an evolving specialty that grows in the scope of knowledge and resources that the anesthesiologists must have at hand every day in the OR. We as physicians are working harder and longer because our patient population is sicker, older, and undergoing longer and more complicated surgical procedures.

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

Organization : **Radiological Associates of Sacramento**

Category : **Radiologist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The original in-office exception was created to allow certain testing to take place at the time of, or incident to, a patient visit, without leaving the doctor s office. Congress assumed that such testing only involved simple examinations, such as laboratory tests on body fluids and x-ray tests to evaluate the status of fractures. Importantly these excepted tests would be necessary at the time of the office visit for contemporaneous decision making. Congress believed that the exception would be necessary for patient convenience and speed of treatment and, because of its narrow scope, the possibility of inappropriate financial gain would be limited.

Application of the in-office exception beyond its intended scope has increased over time and now represents the majority of its use. Specifically, advanced imaging tests, such as CT, MRI, and cardiac nuclear testing have become commonly billed under the in-office exception and the very use of the term in-office has become stretched to an unrecognizable extent. The advanced imaging tests clearly lie outside of Congress intentions because they are almost never performed the same day as the office visit. So in reality the argument that these tests are necessary to assist the physician at the time of the visit is spurious. These expensive machines are not kept empty in the chance that a scan may be suddenly necessary. Rather the imaging tests are scheduled, sometimes several weeks in advance. The term in-office now encompasses numerous creative arrangements, some legal, but generally designed to flout the intent of the in-office exception. Comments from CMS in the 2008 Proposed Rule recognize this development. Financial conflict of interest now exists as the primary unifying characteristic of these arrangements. Physicians generate more revenue by ordering more tests. If they also provide professional component services, they may have a second conflict of interest because they can interpret the imaging tests in a way that justifies additional surgeries or interventional procedures on their patients. In other words, they can function as judge, jury and executioner.

This contained patient encounter, whereby the treating physician orders the test, performs it and gets paid for it, precludes other providers from competing on the basis of quality and service, and limits the incentive for the self-referring physician to focus on quality and service. In general patients imaged in a self-referred arrangement are not made aware of the fact that their options may be limited in this fashion. What is more, patients do not have a way of knowing that better options may exist in their community.

CMS might consider some of the following recommendations to refine the in-office ancillary exception for imaging services;
a. Modality-specific
i. no exception for CT, MRI, nuclear medicine, including PET and PET/CT
ii. exception for urgent/emergent, subject to audit
b. Time-specific no exception if different date of service from patient encounter, subject to audit
c. Quality Assurance technical component reimbursement only to accredited imaging centers/equipment
d. Non-specialist physicians concern about use of specialized services diminished if above proposals enacted

I appreciate the opportunity to submit comments and hope that CMS will take the steps necessary to modify the physician self referral prohibitions and ability to mark-up services to ensure appropriate utilization of imaging services .

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

Organization : **Darrell Jenkins**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear CMS Administrator:

I am requesting that you finalize the proposal to increase the value of anesthesia work by 32% and to increase the anesthesia conversion factor up 25% in 2008. I have been a nurse anesthetist for the past 19 years. Congress has made it easier every year for more people to join the ranks of medicaid and we have many more people turning medicare age yearly. Our anesthesia reimbursement has been increased from time to time only to be decreased later. The anesthesia rates have always been extremely undervalued. Anesthesia providers have one of the lowest rates of reimbursement campared to all other types of providers. The amount we get paid to provide these services to both medicaid and medicare patients has reached a ridiculous low level. It is generally not enough to even cover our overhead. It is basically one fifth of a normal billing charge. The safety of the patient during a surgery is literally in our hands yet we receive very little for our service and expertise. Large hospitals, like the one I practice at, take the majority of the medicare and medicaid patients from our community while more of those with insurance are being sent by their own doctors to the physician owned surgical centers and physician owned hospitals. Congress has done nothing to stop this unethical practice. We are the centers open 24/7 who take care of everyone irregardless of their ability to pay. As nurse anesthetists we are also the predominant anestheaia providers to rural and medically underserved America. The hospital still does fairly well with their reimbursement but the anesthesia services really take a financial hit. The day will come when we will not be able to cover these services and will be forced to go to the private hospitals or surical centers in order to provide for our own families. I support the agency's acknowledgment that anesthesia payments need to be increased. Thank you for your help in this critical need.

Sincerly,
Darrell Jenkins

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

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Submitter : **Mr. Cornelius Myrick** **Date: 08/29/2007**

Organization : **ASA**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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 : **Mr. James Jones** **Date: 08/29/2007**

Organization : **Children's Health Systems of Alabama**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is James L. Jones and I am work for the Children s Health Systems of Alabama as a Certified Athletic Trainer. In my position, I am responsible for facilitating physical medicine and rehabilitations services for the Birmingham City Schools system s athletic programs. I received my Bachelors of Science in Education from The University of Alabama and my Masters of Arts in Education from the University of Alabama at Birmingham, majoring in Athletic Training and Exercise Physiology, respectively. Having taken the National Certification examination along with state licensure and my education, I have the adequate training necessary to provide quality healthcare to the public I serve.

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,

James L. Jones, MA, ATC

CMS-1385-P-12069-Attach-1.DOC

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

Organization : **ASA**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Walter Loeb** **Date: 08/29/2007**

Organization : **Dr. Walter Loeb**

Category : **Physician**

Issue Areas/Comments

Background

Background

Gentleperson:
I support a $4.00 per unit increase in Medicare payment to anesthesiologists. Currently Medicare pays 1/8 to 1/2 what other insurers pay. Sincerely yours,
Walter F. Loeb

Submitter : **Mrs. Sara Young** **Date: 08/29/2007**

Organization : **ASA**

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

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Thank you for your consideration of this serious matter.

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

Organization : **ASA**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Doug Bayless** **Date: 08/29/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

Doug Bayless, M.D.
Oklahoma City, OK

Submitter : **Mrs. Kathy Lockhart** **Date: 08/29/2007**

Organization : **ASA**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I am an Athletic Trainer and Physical Therapist with 19 and 15 years of experience respectively and I currently work in a private practice setting. I have also worked in the hospital and corporate settings. The fact that I have worked in both professions and in many settings gives me reason to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in1385-P.

Working in both fields I have noticed the lack of access and workforce shortages to fill therapy positions throughout the industry. The Athletic Trainer is a very viable option in the rehabilitation arena to help maintain access to healthcare for many beneficiaries. I have worked with many rehab professionals over the years including PTA s. PTA s are recognized as qualified providers but yet they have 2 years of training. An Athletic Trainer on the other hand has at least a baccalaureate degree and most have post-baccalaureate degrees and are trained to evaluate and treat patients and provide rehabilitation if needed. Yet in the PT field they are considered non licensed personnel but yet again many Athletic trainers are licensed in their respective states. Many states do not even recognize the PTA as a licensed provider. Do not get me wrong the PTA has a place but so does the Athletic Trainer if not more so.

Given my experience and the fact that I have worked in various settings with various healthcare workers and knowing what each professional is capable of doing, I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Thank you for your time.

Submitter : **Dr. Peter Brinkley** **Date: 08/29/2007**

Organization : **Missoula Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Peter Brinkley M.D.
400 McLeod Ave.
Missoula, MT 59801

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

Organization : **WAAI**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Scott R. Smout, D.O.

Submitter : **Dr. Sarah Aronson** **Date: 08/30/2007**

Organization : **Dr. Sarah Aronson**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Dr. Howard Green **Date:** 08/30/2007

Organization : Dermatology Associates, PA of the Palm BAeaches

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Medicare can insure quality of care and save money if it restricts Mohs surgery to physicians who have performed advanced formal training in the procedure in an American College of Mohs Surgery sponsored 1-2 year fellowship training after completing their dermatology residency.

Submitter : **Dr. David E. Lind** **Date: 08/30/2007**

Organization : **Dr. David E. Lind**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : **Dr. Chester Hu** **Date: 08/30/2007**

Organization : **Billings Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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.

Chester Hu

Submitter : **Mr. John Bour** **Date: 08/30/2007**

Organization : **Chabert Medical Center - LSU**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Background

Background

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

RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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

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

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

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

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

Sincerely,
John Bour CRNA
234 Oakdale Loop
Houma, La 70360

Submitter : **Mr. Kenneth Lockhart** **Date: 08/30/2007**

Organization : **Mr. Kenneth Lockhart**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Mrs. Beverly Green** **Date: 08/30/2007**

Organization : **Mrs. Beverly Green**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : **Dr. Shawn Dunn** **Date: 08/30/2007**

Organization : **Dr. Shawn Dunn**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 (the Proposed Rule) published in the Federal Register on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.
There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the all physicians crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as interventional pain physicians for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.
II. CMS Should Develop a National Policy on Compounded Medications Used in Spinal Drug Delivery Systems
III. CMS Should Incorporate the Updated Practice Expenses Data from Physician Practice Survey in Future Rule-Making
IV CMS Should Work Collaboratively with Congress to Fix the SGR Formula so that Patient Access will be preserved.

Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing intervention pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,
Shawn G. Dunn, M.D.
10101 Park Rowe Ave.
Baton Rouge, La. 70810

Submitter : **Mr. Rob Evenson** **Date: 08/30/2007**

Organization : **Mr. Rob Evenson**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Johnny Tice** **Date: 08/30/2007**

Organization : **Mr. Johnny Tice**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Submitter : **Mr. Johnny Tice** **Date: 08/30/2007**

Organization : **Mr. Johnny Tice**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

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Submitter : **Mr. Ken Berry** **Date: 08/30/2007**

Organization : **Mr. Ken Berry**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Submitter : **Mrs. Jean Bassett** **Date: 08/30/2007**

Organization : **Mrs. Jean Bassett**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Submitter : **Mr. Ron Bassett** **Date: 08/30/2007**

Organization : **Mr. Ron Bassett**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Centers for Medicare and Medicaid Services
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Submitter : **Mr. Doug Zerger** **Date: 08/30/2007**

Organization : **Mr. Doug Zerger**

Category : **Individual**

Issue Areas/Comments

GENERAL

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

Submitter : **Dr. Jong Lee** **Date: 08/30/2007**

Organization : **University of Arizona**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Submitter : **Ms. Benjamin Pringle** **Date: 08/30/2007**

Organization : **Portland Trailblazers**

Category : **Private Industry**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Benjamin Pringle here, originally from Boston, MA and graduate of Northeastern University with a Bachelors of Science in Athletic Training. I am a Certified Athletic Trainer and a Strength and Conditioning Specialist now Interning with the Portland Trailblazers as an additional assistant athletic trainer, strength coach and equipment manager.

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.

Athletic Trainers are some of the most versatile and well rounded health care professionals in this country. We combine the general skills of a physical therapist, strength and conditioning coaches, first responders, risk management professionals and act as a general extension of orthopedic, internal medicine as well as many other medical doctors. To restrict the practice of Athletic Trainers from what our education allows us to perform is not only hurting an up and coming profession but mostly taking away from patients in need more options and access to the health care that they need. The general health care system in this country is far from perfect and should be working together to become stronger as a team of professionals to improve patient care.

Sincerely,
Benjamin J Pringle, ATC, CSCS

Submitter : **Mrs. Debbie Zerger** **Date: 08/30/2007**

Organization : **Mrs. Debbie Zerger**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Mrs. Phyllis Melton** **Date: 08/30/2007**

Organization : **Mrs. Phyllis Melton**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
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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 : **Mr. Phillip Melton** **Date: 08/30/2007**

Organization : **Mr. Phillip Melton**

Category : **Pharmacist**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Jay Belt** **Date: 08/30/2007**

Organization : **Dr. Jay Belt**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Jacqueline Brown** **Date: 08/30/2007**

Organization : **Athletic & Therapeutic Institute**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer employed by Athletic & Therapeutic Institute(ATI) in Joliet, Illinois. I graduated with a Bachelor of Science degree in Physical Education, with a concentration in Athletic Training, from Western Illinois University and returned to school two years later to gain a Master of Science degree in Kinesiology, with a specialization in Athletic Training, from the Indiana University. Completion of an accredited undergraduate program allowed me to sit for the national certification exam. Since then I have used my certification to gain state licensure and employment in my degree field. I now work primarily in a physical therapy setting, treating all ages and physical levels, with all different ailments. I also spend a small amount of time in an outreach setting with a gymnastic club where I primarily perform injury evaluations, recommend treatment strategies and adjust conditioning programs for prevention and rehabilitation of injuries.

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

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

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

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

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

Sincerely,

Jacqueline J. Brown, MS, ATC, LAT

Submitter : **Kristen McCarty** **Date: 08/30/2007**

Organization : **Marmount School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a full time employee of a secondary school teaching health education and providing athletic training services to the student athletes. I have degrees in Sports Medicine/Athletic Training and Physiology.

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

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

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

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

Sincerely,

Kristen McCarty, MA, ATC

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I fully support the increase in the Medicare reimbursement with respect to Anesthesiology services.

Submitter : **Dr. Hasmukh Joshi** **Date: 08/30/2007**

Organization : **San Dimas Anesthesia Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Submitter : Dr. Nicholas Abidi **Date:** 08/30/2007

Organization : Santa Cruz Orthopaedic Institute

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

We have lost and can not recruit physicians to our community due to area 99 reimbursement rates as compared to our cost of living. Median home prices are over $800k. Staffs here are paid up to 30% higher than many other parts of the country. When our staff members are offered higher paying jobs at local hospitals, they generally take the jobs. The lack of independent physicians in the community is allowing the proliferation of large practice foundations. This is bad for patients with unique diseases and trauma/ER patients. Santa Cruz County needs to be lifted out of area 99. It has hurt our ability to provide timely medical care and permit adequate access to care as we struggle to recruit new physicians to our community. Medicare rates in our community have affected our insurance contracts in a negative way as well. Many of our colleagues have picked up and moved into other communities in the bay area, some of which pay up to 25% higher reimbursement rates. The remaining physicians are working overtime to keep up with patient demand. Many suffer burnout or ignore their families. This needs to be solved soon.
thank you

Submitter : **Dr. Russell Dorado** **Date: 08/30/2007**

Organization : **Dr. Russell Dorado**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Ernest Hoeckel **Date:** 08/30/2007

Organization : Anesthesia Consultants of Colorado

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12107-Attach-1.TXT

#12107

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. nancy corso** **Date: 08/30/2007**

Organization : **Dr. nancy corso**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

File code CMS-1385-P. Technical Corrections"

Please note:
The Issuc about eliminating medicare reimbursement for a doctor of chiropractic re: xrays, should be abolished in my opinion. Thank you.

Nancy Corso

Nancy

Submitter : Dr. Clark Davis, DC **Date:** 08/30/2007

Organization : Dr. Clark Davis, DC

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Do NOT eliminate patient reimbursement for x-rays taken by a radiologist requested by a non-treating physician and then used by a doctor of chiropractic(chiropractor). If approved this proposal would reverse a long-standing policy. This could severely decrease the chiropractic profession's ability to care for Medicare patients. X-rays, when needed, are important in chiropractic assessment of Medicare patients, and if approved Medicare patients may suffer by this proposed change in coverage, by requiring unnecessary and additional visits to their medical providers, significantly driving up costs of patient care. The proposed change would specifically eliminate Medicare reimbursement in connection with the referral of a patient by a doctor of chiropractic to a radiologist or other non-treating physician for x-rays. X-rays are often taken to rule out contraindications to care or determine appropriat treatment plan of action and determine necessity for other diagnostic testing such as MRI. I urge you to eliminate the proposal to eliminate patient reimbursement for x-rays taken by a radiologist requested by a non-treating physician and then used by a doctor of chiropractic. Thank you. Clark Davis, DC

Submitter : **Mr. Tyler Daniels** **Date: 08/30/2007**

Organization : **American Association of Nurse Anesthetists**

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
Baltimore, MD 21244 8018
August 20, 2007
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,

Tyler Daniels, CRNA
13944 Battenberg Ct
Boise, ID 83713

Submitter : **Dr. Johnathan Pregler** **Date: 08/30/2007**

Organization : **University of California, Los Angeles**

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Marc Leib **Date:** 08/30/2007

Organization : Arizona Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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 believe that anesthesia services have been undervalued and am glad that CMS is taking steps to address this complicated issue.

When the RBRVS was instituted, it significantly undervalued anesthesia work compared to other physician services, creating a significant payment disparity for anesthesia services. The Medicare payment for anesthesia services currently stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating a system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

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:

It's amazing how you use all kinds of formulas to figure out that you should pay anesthesiologists less than a plumber costs. It's high time that CMS altered its abusive relationship with the nation's anesthesia community.

Thank you.

Submitter : **Mrs. Miriam Arnold** **Date: 08/30/2007**

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:

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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,
Miriam Arnold CRNA
14535 118th St N
Stillwater, Mn 55082

Submitter : **David Nitschke** **Date: 08/30/2007**

Organization : **David Nitschke**

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:
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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).
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Sincerely,
__David James Nitschke, RN_SRNA_____
Name & Credential
__2025 Woodmont Blvd Unit 320_____
Address
___Nashville, TN 37215_____
City, State ZIP

Submitter : Dr. Charles Louy **Date:** 08/30/2007

Organization : General Anesthesia Specialists Partnership

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12116-Attach-1.DOC

#12116

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.

One of the areas affected by the undervaluation of anesthesia services is the use of regional anesthesia (epidural and other nerve block infusions) for pain management after surgery. Typically, this kind of pain management requires two, three or more days of continuous management to maintain postoperative pain at tolerable levels. This kind of pain management is particularly needed for major surgeries such as lung resections or major abdominal surgery. The lack of regional pain management not only increases pain levels, but also increases the rate of complications after surgery because patients cannot breathe as well or cannot get out of bed as early because of pain.

Large anesthesia groups typically subsidize the costs of postoperative pain management. Smaller community hospitals or individually practicing anesthesiologists, however, cannot afford to offer these essential services.

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

Thank you for your consideration of this serious matter.

Sincerely,

Charles Louy, Ph.D., M.D., M.B.A.
Attending Anesthesiologist
Director, Pediatric Pain Service
Department of Anesthesiology
Cedars-Sinai Medical Center
Los Angeles, CA 90048

Submitter : Mr. Juan Gonzalez **Date:** 08/30/2007

Organization : Mr. Juan Gonzalez

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetist (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 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 Anesthetist (CRNA's) as Medicare Part B providers can continue to provide Medicare beneficiaries with acces to anesthesia services.

Submitter : **Mr. Jim Lovell** **Date: 08/30/2007**

Organization : **Atlanta Braves**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Jim Lovell. I am employed as an athletic trainer. I hold a Master's degree, and am certified by the NATABOC as an athletic trainer, licensed by the state of Georgia. I also hold EMT credentials and licensure.

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,

Jim Lovell, M.Ed., ATC, EMT

Submitter : **Dr. Jeffrey Ho** **Date: 08/30/2007**

Organization : **Dr. Jeffrey Ho**

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.

Jeffrey Ho, MD

Submitter : **Janet Culver** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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.

Please see attached file.

CMS-1385-P-12120-Attach-1.PDF

#12120

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.

- 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,

Janet Culver, CRNA, MS
Name & Credential
25 Baileys Place Court
Address
Sugar Land, TX 77479
City, State ZIP

Submitter : **Patrick Byrne** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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 : Lisa Nicastri **Date:** 08/30/2007

Organization : Lisa Nicastri

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a Certified Athletic Trainer, as well as a Certified Orthopedic Technologist. My degree in Sports Medicine from the Central Michigan University was an intense program which prepared me well for working with injured populations in rehabilitation settings.

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

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

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

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,

Lisa B. Nicastri, ATC, OTC, Certified Pilates Instructor

Submitter : Dr. Kathleen Hance **Date:** 08/30/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-12123-Attach-1.DOC

CMS-1385-P-12123-Attach-2.DOC

CMS-1385-P-12123-Attach-3.DOC

#1213

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Kathleen MacNaughton Hance
Leawood, KS

Submitter : **Mr. Jon Bennett** **Date: 08/30/2007**

Organization : **Mr. Jon Bennett**

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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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,

Jon Bennett, CRNA

Name & Credential

8 Pine Brook Lane D-6

Address

North Springfield, VT. 05150

City, State ZIP

Submitter : **Dr. Anupama Gotimukula** **Date: 08/30/2007**

Organization : **Dr. Anupama Gotimukula**

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.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Practitioner**

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
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Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Dr. Wei Chao** **Date: 08/30/2007**

Organization : **Dr. Wei Chao**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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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,

Wei Chao, MD

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see comments attached.

CMS-1385-P-12128-Attach-1.DOC

CMS-1385-P-12128-Attach-2.DOC

#12128

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

August 29, 2007

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

PHYSICIAN SELF-REFERRAL ISSUES

Dear Mr. Weems:

The following comments are on behalf of the Minnesota Chapter of the American Physical Therapy Association (MN APTA). I currently practice in a Physical Therapist-owned private practice, having practiced for 28 years, and I serve as the Vice President of the Board of MN APTA.

As a physical therapist practitioner and as an Association member, I wish to comment on the July 12 proposed 2008 physician fee schedule rule, and in particular the issue surrounding physician self-referral and the "in-office ancillary services" exception. I support the removal of physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws.

I believe that a conflict of interest exists whenever physicians are permitted to refer to, and profit from physical therapy services in which they have a financial interest. In these arrangements physicians seek income beyond the fee for their own services and enter into arrangements that amount to voluntary, or avoidable, conflicts of interest. These types of arrangements are being marketed to physicians as "passive revenue streams." The physical therapist's services are distinct from the medical services and are not pertinent to the patients visit to the physician.

Since Stark II the number of physician-owned and chiropractic-owned physical therapy practices has rapidly increased in this state. I have personally suffered from physicians who had previously referred patient to my practice, hire physical therapists to work for them. I have lost 30% of my practice and closed one office due to physicians opening their own physical therapy clinic. Again, previous to the physician opening its physical therapy clinic, my services were of acceptable cost effectiveness and quality to those physicians. In essence, one day my services were worthy of a referral, and then the next day they were not.

As a professional association MN APTA opposes allowing one profession to control the marketplace of another profession. We do not believe that patients are well-served when avoidable conflicts of interest exist. Our concern is that physician self-referral is a cost-driver in healthcare and that it can lead to over utilization in the forms of unnecessary referrals, excessive durations or frequencies of treatment, and unnecessary procedures and equipment. We are also concerned about under utilization in the forms of denial or restriction of physical therapy. This has been reported to occur when the therapy might eliminate the need for other high cost services, such as imaging or surgery, from which the physician profits. Finally, MN APTA has concerns over the limited choice that the Medicare beneficiary might have in physical therapists. Beneficiaries have reported that they feel pressured to discontinue the relationships they have with their own physical therapist in order to receive the physical therapy that they need.

Physician self-referral is being defended as allowing physicians a "greater role" in the physical therapy services provided to patients. However the trend in Minnesota has been for physician-owned physical therapy clinics to take advantage of the reassignment of benefits laws to collect payment in order to circumvent the "incident to" requirements. Either way, the physician is controlling demand and access to services and at the same time is profiting from that control.

MN APTA strongly supports any efforts to eliminate abusive financing arrangements under the Stark law that are contrary to the best interest of the Medicare beneficiary. MN ATPA strongly urges the CMS to remove physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws.

Finally, in our state there are other physical therapist-owned practices that have suffered measurable and significant losses in the number of patients who are referred to them, specifically from those physicians who employ their own physical therapists. In a survey of our members done early in 2005, 30% of respondents indicated that their clinics had been adversely affected by physician self-referral. Since then, the number has increased, although we cannot accurately report the severity of the impact.

On behalf on myself and MN ATPA, thank you for your consideration of our comments.

Craig Johnson, PT
55419

Submitter : **Dr. heather mcfarland** **Date: 08/30/2007**

Organization : **Dr. heather mcfarland**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Dr. Heather McFarland, DO

Submitter : **Dr. Jonathan Uri** **Date: 08/30/2007**

Organization : **Dr. Jonathan Uri**

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,

Jonathan Uri MD

Submitter : Mrs. kimberly merill **Date:** 08/30/2007

Organization : Harford County Ambulatory Surgery Center

Category : Ambulatory Surgical Center

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

It is imperative that we increase the reimbursement in ASC's! As a Nurse Administrator I am having to take a loss or turn away a ton of cases because of poor reimbursement. Especially Implants! It needs to change- Asc's are the wave of the future and should get better reimbursement.

Submitter : Mr. Corey Tremble **Date:** 08/30/2007

Organization : University of South Florida

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Corey S. Tremble and I am a certified and licensed athletic trainer at the University of South Florida. I am currently attending graduate school and serve as a graduate assistant here at the university. Upon hearing and reading about this issue, I feel as though it is my duty to comment on this matter.

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,

Corey S. Tremble, ATC, LAT, CSCS

Submitter : Dr. L. Jill Krasner **Date:** 08/30/2007

Organization : West Chester Anesthesia Associates

Category : Physician

Issue Areas/Comments

Impact

Impact

The overall patient population is older, and the co-morbidities are increasing in complexity. This extends to the community hospital setting in addition to the tertiary care centers. We give the utmost attention to the depth of care needed for these patients. The responsibility for safely providing anesthesia continues to deepen. Increasing payments for anesthesia services would thus be a small recognition of the efforts put forth for the anesthesia care team.

Submitter : **Ms. Julie Carroll** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Sincerely,

Julie Carroll CRNA
1361 Lincoln Heights Ave
Ephrata, PA 17522

Submitter : Dr. Susan Bogdan **Date:** 08/30/2007

Organization : Montefiore Med Center

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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 : **Beth Guckin** **Date: 08/30/2007**

Organization : **University of New England**

Category : **Nurse**

Issue Areas/Comments

Background

Background

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,
_Beth Guckin RN, BA_____
Name & Credential
2155 Oneida Road_____
Address
Danville, Vt. 05828_____
City, State ZIP

Submitter : Dr. Arthur Eccleston **Date:** 08/30/2007

Organization : North Carolina Division of MH, DD, and SA Services

Category : State Government

Issue Areas/Comments

Medicare Telehealth Services

Medicare Telehealth Services

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Comment on Proposed Rule Changes to the Physician Payment Schedule.

File Code: CMS-1385-P

Issue Identifier: Medicare Telehealth Services.

The proposed additions to the telehealth services covered by Medicare includes a regulatory impact analysis by CMS. This analysis states the following: 'To date, Medicare expenditures for telehealth services have been extremely low. For instance, in CY 2006, the total Medicare payment amount for telehealth services (including the originating site facility fee) was approximately $2 million. Moreover, previous additions to the list of Medicare telehealth services have not resulted in a significant increase in Medicare program expenditures.'

If the intent of CMS analysis is to provide a rationale to make reductions in Medicare payment for telehealth services in the future, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC DMH/DD/SAS) offers the following comment.

The NC DMH/DD/SAS system has recently begun telepsychiatry pilot projects in ten localities across the state. Our intent is to further expand the provision of telepsychiatry services in the near future. North Carolina has many rural areas to which we are hoping to bring increased availability of mental health, developmental disability, and substance abuse (mh/dd/sa) services via telepsychiatry.

In numerous areas of the state, there are shortages of mh/dd/sa service professionals (e.g., psychiatrists, child psychiatrists, etc.). Telepsychiatry will help ensure that needed mh/dd/sa expertise is accessible in areas that suffer from a lack mh/dd/sa professionals.

We urge CMS to continue to fund a wide variety of telehealth services via Medicare and Medicaid coverage. Thank you for the opportunity to comment on the proposed rules changes.

Submitter : Dr. Angela Vick **Date:** 08/30/2007

Organization : Montefiore Medical Center

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Thank you for the opportunity to comment on this important issue. I want to give you 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 concern.

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Peter Bogdan** **Date: 08/30/2007**

Organization : **American Board Internal Medicine**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. JOAN SCHOEN **Date:** 08/30/2007

Organization : FLORIDA PAIN MANAGEMENT

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

PLEASE CHANGE IT TO 09

Submitter : Mr. Kevin Seale, MS, CRNA **Date:** 08/30/2007

Organization : Cottage Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,
Mr. Kevin R Seale MS, CRNA
Name & Credential
25 Main Street
Address
Monroe, NH 03773
City, State ZIP

Submitter : Mr. Jack Neary MS, CRNA **Date:** 08/30/2007

Organization : Cottage Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Background

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August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
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Sincerely,
Jack Neary MS, CRNA
Name & Credential
410 Hooper Hill Road
Address
Groton, VT 05046
City, State ZIP

Submitter : Dr. William Lichter **Date:** 08/30/2007

Organization : Dr. William Lichter

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

This proposal to eliminate payment for x-ray services which are referred by a chiropractor is outrageous. Chiropractors are licensed in all 50 states. The scope of practice includes taking and reading x-rays. It's bad enought that chiropractors as a profession have historically not been reimbursed for these services that they are licensed to perform. Ths has increased the cost of health care and made it inconvenient for millions of Medicare beneficiaries.
Wake up and smell the coffee. Chiropractic care is effective and cost effective. Requiring a Medicare patient to be referred back to their primary physician and only then to be referred to a diagnostic facility for a simple x-ray is a waste of time, a waste of gasoline and a waste of tax payer dollars. What is the point of Medicare coverage for chiropractic services when Medicare handcuffs the chiropractor from conducting his or her practice in the manner he or she is licensed to do so?

Submitter : Mr. Michael Braid **Date:** 08/30/2007

Organization : Hackley Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam: I currently am working at a Hospital Outpatient Physical Therapy Clinic where I have been employed for 13 years. Prior to this position I was the Head Athletic Trainer at Northern Illinois University. I have over 20 years experience in providing quality healthcare to an active population of people. I graduated from an approved major in Sports Medicine/Athletic Training, became certified by our National Athletic Trainers Association Board of Certification, and obtained a Masters Degree to improve my skills and knowledge. I am greatly concerned about your potential decisions regarding rehabilitation in hospitals. 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, Mike Braid, MSEd, ATC

Submitter : Mrs. Patricia Halpin RN **Date:** 08/30/2007

Organization : Cottage Hospital

Category : Nurse

Issue Areas/Comments

Background

Background

August 20, 2007
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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,
Patricia Halpin RN
Name & Credential
PO Box 95
Address
West Danville, Vt 05873
City, State ZIP

Submitter : **David Hall** **Date: 08/30/2007**

Organization : **Fairview Chiropractic Center**

Category : **Chiropractor**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimore, Maryland 21244-8018

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Submitter : Dr. Colleen Lancz **Date:** 08/30/2007

Organization : University of Toledo Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-12147-Attach-1.DOC

#12147.

CMS-

Because the referenced comment number does not pertain to the subject matter for CMS- , it is not included in the electronic public comments for this regulatory document.

Submitter : **Mr. Steven Gardner** **Date: 08/30/2007**

Organization : **LakeView Community Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I am a Certified Athletic Trainer working at a small community hospital in Michigan. I work closely with Doctors, Physical Therapist, and Nursing professionals. I hold a B.S. in Sports Medicine, and am a Nationally Certified Athletic Trainer.

I am writing today to voice my opposition to the 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 recieved the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As a Certified 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 experence, and national certification exam ensure that my patients recieve quality health care. State law and hospital medical professionals have deemed me quite 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 throught the industry. It is irresponsible for CMS, which is suppose to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to recieve those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients recieve 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 rehabilition facility.

Sincerely,

Steven J. Gardner, ATC

Submitter : **Mr. Chad Adams** **Date: 08/30/2007**

Organization : **NF/SG Veterans Health System**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

BRIEF INTRO ABOUT SELF:
My name is Chad Adams. I work for the North Florida/ South Georgia Veterans Health System in Lake City, Florida as a registered kinsiotherapist and a registered orthopedic technologist. I completed my undergraduate degree in 1993 form Slippery Rock University; currently I am pursuing a Masters of Health Sconce degree at Florida Gulf Coast University.

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

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

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

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

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

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

Sincerely,
Chad A. Adams, RKT

Submitter : **Ms. Jennifer Dullen** **Date: 08/30/2007**

Organization : **Summa Health System**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dcar Sir or Madam:

My name is Jennifer Dullen and I am a cerified Athletic Trainer at Summa Health System in Akron, Ohio. I have a masters degree in sports medicine. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certifieation 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,

Jennifer Dullen MS, ATC

Submitter : **Mrs. Kelly Potteiger** **Date: 08/30/2007**

Organization : **North Park University**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dcar Sir or Madam:

My namc is Kelly Potteiger. I am a certified athletic trainer and Assistant Professor at North Park University in Chicago, IL.

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,

Kelly Potteiger, MS, ATC, LAT

Submitter : **Mrs. Christine Boote** **Date: 08/30/2007**

Organization : **University of Michigan MedSport**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I have been a Certified Athletic Trainer for over 15 years and have provided quality rehabilitation services to countless patients with excellent results. I work at the Univeristy of Michigan MedSport with physicians, physician assistants, physical therapists and physical therapy assistants in a team approach that benefits everyone. I have a bachelor of science degree in Sports Medicine and keep current with at least 25 hours of continuing education annually. 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. As a person that helps to fill our staff vacancies I realize how challenging it is to find qualified staff and I am grateful for the skill and knowledge that our athletic trainers bring to the clinic. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

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

Sincerely,
Christine Boote, ATC

Submitter : **Dr. Mark Malinowski** **Date: 08/30/2007**

Organization : **Ohio State**

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 signifieant 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.

Mark N Malinowski, DO

Submitter : **Mrs. Karie Johnson** **Date: 08/30/2007**

Organization : **Union Memorial Sports Medicine at Bel Air**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Karie Johnson and I am a Certified Athletic Trainer working at Union Memorial Sports Medicine at Bel Air, a division of MedStar Health Services, part of National Rehabilitation Hospital. My present role in the clinic is to assist our Physical and Occupational Therapists with the set-up and instrucion of therapeutic exercises for their patients. We also perform outreach services to area high schools, where we assess athletic injuries and conditions to determine whether the injured athlete needs further medical care. I have a Bachelor's degree in Athletic Training from Minnesota State University, Mankato and a Master's degree in Exercise and Sports Sciences from the University of Florida. I took and passed the National Certification Exam in 1999 and have kept my certification up to date. While working in Florida, I obtained my licensure through the state to practice as an Athletic Trainer and would do the same in Maryland if it was available.

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,

Karie Johnson, ATC

Submitter : **Ms. Erin Buenzli** **Date: 08/30/2007**

Organization : **Ms. Erin Buenzli**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Erin Buenzli and I am a certified athletic trainer and hold a master's degree in exercise science. I am currently employeed at Lawrence University. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilitics proposed in 1385-P.

While I am concerned that thesc proposed changes to the hospital Conditions of Participation have not received thc proper and usual vetting, I am more concerned that these proposcd 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 mc qualificd to perform these services and these proposed regulations attempt to circumvent those standards.

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Sincerely,

Erin Buenzli, MS,ATC

Submitter : Dr. Mary O'Connor **Date:** 08/30/2007

Organization : Dr. Mary O'Connor

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing regarding the proposal to potentially limit the ability of an orthopedic surgeon to have physical therapists working in the surgeon office providing therapy to patients. The physical therapists must work under the direction of a physician. I know that some physical therapists are seeking more independence in this regard, that would be unwise and very costly for the health care system. They do not have adequate training to be independent care providers. Moreover the best care for the patient is went the "team" of the surgeon, therapist and patient are all working in harmony. This requires input and review by the surgeon. Also it is far more convenient for the patient to go to one location and see both the surgeon and the therapist.

Submitter : **Dr. Raymond Parkhurst** **Date: 08/30/2007**

Organization : **Dr. Raymond Parkhurst**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

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

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

Sincerley,
Raymond Parkhust D.C.

Submitter : Dr. Gary Cooper **Date:** 08/30/2007

Organization : Innovative Pathology Services

Category : Physician

Issue Areas/Comments

CAP Issues

CAP Issues

August 30, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Knoxville, Tennessee as part of a twelve Pathologist group and an independent anatomic pathology lab which covers two large city hospitals, a children s hospital, six small community hospitals, and three surgery centers along with an outpatient pathology service.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of abusive pathology service arrangements in my practice area that give physician groups (non-pathologists) a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services which will lead to over utilization of services and an increase in medical care costs.

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of anatomic pathology services unless the physician is capable of personally performing or supervising the service. The original in-office ancillary services exception to the Stark law was never meant or developed to allow the practice of building anatomic pathology labs by urologists, gastroenterologists, dermatologists, or OB-GYN doctor groups; referring all of their office biopsies to the in-office lab; hiring pathologists to sign out the biopsies for below market fees; billing Medicare a marked up global fee (technical and professional); and pocketing a big profit. These arrangements are designed to increase the groups revenues and can lead to over utilization of services. There are several groups of physicians engaged in this practice of forming a loose merger or corporation (joint venture essentially) in order to comply with the in-office ancillary services exception to the Stark law for the sole purpose of building these anatomic lab profit centers. The anatomic lab is built in one of the groups office locations usually near the contracted pathologists offices. This process is occurring now and will proliferate at a very fast rate if CMS doesn t act now to stop this abusive arrangement. I also feel that it is somewhat unethical and may not be totally following the exception guidelines.

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

Sincerely,
Gary L. Cooper M.D.
Pathologist

Submitter : Mrs. Laura Pruitt **Date:** 08/30/2007

Organization : BEAT

Category : Other Health Care Provider

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

In order to make health care more available and affordable to a larger population, government must recognize the high quality and standards that Licensed/ Certified Athletic trainers must meet and maintain. Licensed/ Certified Athletictrainers should be permitted to bill for services in hospital and rehabilitation settings. Not allowing this to occur only adds to the cost and burden of the entire health care system.

Submitter : Mrs. Caro Mackin **Date:** 08/30/2007

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
Baltimore, MD 21244 8018

RE: CMS-1385-P (Background, Impact) Anesthtesia 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,

Carol A. Mackin CRNA

115 Bluestone Drive

Betheel Park, PA 15102

Submitter : **Mrs. Holly Chandler** **Date: 08/30/2007**

Organization : **Mrs. Holly Chandler**

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.
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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,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Ms. Lisa Hughes** **Date: 08/30/2007**

Organization : **Cancer Research and Prevention Foundation**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Coding--Multiple Procedure
Payment Reduction for Mohs
Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

August 30, 2007

Mr. Terrence Kay
Director, Division of Practitioner and Ambulatory Care
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Proposed change to payment policy for Mohs micrographic surgery

Dear Mr. Kay:

The Cancer Research and Prevention Foundation (CRPF) is writing today to register concern about the proposed change to the payment policy concerning Mohs micrographic surgery. This planned change would remove Mohs surgery from a longstanding exemption from the multiple surgery reduction rule (MSRR, indicated by CPT modifier -51). CRPF believes that this change could be detrimental to both providers and patients seeking to diagnose and treat skin cancer.

Over a million Americans are diagnosed with skin cancer each year. Mohs surgery is the gold standard among skin cancer treatments for the deadliest forms of the disease. This unique and effective procedure has the highest cure rate for any treatment for skin cancer. Changes in the code could affect the way physicians treat the patients and out of pocket expenses for the patient, forcing each party to make treatment decisions based on cost as opposed to quality of the medical care and procedure.

We urge you to reconsider the proposed changes. Please do not hesitate to contact me with questions.

Sincerely,

Lisa Hughes
Senior Director, Policy and Advocacy

Submitter : Dr. John Cottone **Date:** 08/30/2007

Organization : State University of New York at Cortland

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 30, 2007
Dear Sir or Madam:
My name is John Cottone, EdD, ATC. I have been a practicing athletic trainer and teacher for 30 years. I am currently the department chair in the Department of Kinesiology at the State University of New York at Cortland. I have been preparing students for the field of athletic training throughout my entire professional career.
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,
John Cottone, EdD, ATC-Chair
Department of Kinesiology
Program Director for Athletic Training

Submitter : Dr. Jay Smith **Date:** 08/30/2007

Organization : Mayo Clinic

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a physiatrist practicing at the Mayo Clinic in Rochester, Minnesota. My clinical practice is primarily sports medicine and is based in the Mayo Clinic Sports Medicine Center. In the hospital, clinic, and playing fields, I have found the services of the athletic trainers with whom I work to be integral to the successful evaluation and management my athletes. The skill set of the athletic trainers is unique and complementary to other medical team members.

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 you are aware, athletic trainers are qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. Athletic trainer s education, clinical experience, and national certification exam ensure that our patients receive quality health care. State law and hospital medical professionals have deemed athletic trainers qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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

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

Sincerely,

Jay Smith, MD, FACSM
Fellow, American College of Sports Medicine
Associate Professor of Physical Medicine and Rehabilitation
Mayo Clinic College of Medicine
Rochester, MN, 55905

Submitter : **Ms. Rianne Howard** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

I support the Centers for Medical & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under the CMS' proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels.

Ths increase in payment is important because Medicare currently under-reimberses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries.

I support the agency's acknoledgement 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,

Rianne M. Howard, CRNA
1103 Sunset Point Road
Clearwater, FL 33755

Submitter : **Rae Emrick** **Date: 08/30/2007**

Organization : **West Virginia Wesleyan College**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Rae Emrick. I am currently an athletic training educator at West Virginia Wesleyan College in Buckhannon, WV. I hold the ATC (certified athletic trainer) and CSCS (certified strength and conditioning specialist) credentials in addition to a master degree from Marshall University. I am currently pursing a doctoral degree from West Virginia University.

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

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

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,

Rae Emrick, MS, ATC, CSCS

Submitter : Erin Boydstun **Date:** 08/30/2007

Organization : Erin Boydstun

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Erin Boydstun and I am a Certified Athletic Trainer for St. John's Sports Medicine in Springfield, MO. I have a Bachelor's Degree in Sports Medicine/Athletic Training and a Master's of Science in Education with an emphasis on Health and Human Performance.

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

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

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Sincerely,

Erin Boydstun, MS, ATC

Submitter : Mr. Michael O'Brien **Date:** 08/30/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

http://www.accessdata.fda.gov/scripts/oc/dockets/comments/COMMENTSMain.CFM?EC_DOCUMENT_ID=143&SUBTYP=CONTINUE&CID=&AGENCY=CMS

Submitter : **Dean Thompson** **Date: 08/30/2007**

Organization : **Dean Thompson**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. mathew chengot** **Date: 08/30/2007**

Organization : **amityville heart center**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

see attached comment

Submitter : **Dr. Thomas Warren** **Date: 08/30/2007**

Organization : **Dr. Thomas Warren**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

This comment is to let you know of my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. That the CMS has recognized the gross undervaluation of anesthesia services is long overdue. I and my Anesthesiologist colleagues are grateful that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, a huge payment disparity for anesthesia care was created, 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 is less than the Medicare paymentwhen I went into practice in 1982. 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 aceepted this reeommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have aceess 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 considering this topic.

Sincerely,
Thomas M. Warrren, M.D.

Submitter : **Pat Thompson** **Date: 08/30/2007**

Organization : **Pat Thompson**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Ursula Smith, RN, BSN **Date:** 08/30/2007

Organization : Ursula Smith, RN, BSN

Category : Nurse

Issue Areas/Comments

Background

Background

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 support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

As a Registered Nurse for the past 27 years, I have watched since the beginning of DRGs and I have seen the effects on health care. I do not work in anesthesiology, but even from the outside of that practice field, the huge strides that have been made in improving patient safety, in increased efficiency of practices, and in overall better care of patients are obvious. Yet, compensation for anesthesia services has lagged considerably.

From the beginning, RBRVS created a huge payment disparity for anesthesia care. Anesthesia was significantly undervalued. It should be recognized that most of the new procedures available and the increased ability to improve the health of senior citizens through surgical procedures (that would not have even been considered on the elderly 20 years ago) have been dependent upon vastly improved anesthesia services. Yet payment remains at a low enough level that on complex cases anesthesiology departments can LOSE MONEY saving the lives of the elderly!

Medicare payment for anesthesia services now sits at LESS than what I pay my mechanic to work on my car. (Note: the mechanic has the benefit of working on my car while it is turned OFF. Anesthesiologists must "keep the car running" during surgical procedures, and often on extremely frail elderly.) The amount paid 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.

The CMS needs to increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would serve as a major step forward in correcting the long-standing undervaluation of anesthesia services.

I support full implementation of the RUC s recommendation to increase unit valuation of anesthesia care.

To ensure that the practice of anesthesia be available to all senior citizens, 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 : **Ken Dunlap** **Date: 08/30/2007**

Organization : **Ken Dunlap**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Denis Duncan** **Date: 08/30/2007**

Organization : **Duncan Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

MEI-------RE:CMS Proposes Changes to Chiropractic X-Ray Reimbursement
I am ABSOLUTELY opposed, as are many patients that I have discussed this issue with, i.e. eliminating the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a D.C. to determine a subluxation.
This proposed change hurts ALL Chiropractic PATIENTS & DOCTORS.
It is BAD enough that I have slaved for over 20 years without a penny EVER of reimbursement for ANY and EVERY X-ray I have taken ...literally many thousands ...and I have discounted every one at my OWN expense to help the defenseless ELDERLY! AT least show some RESPECT and DECENCY for the many millions of ELDERLY patients,if not for the many thousands of Chiropractic doctors.
I strongly urge you to TABLE this proposal !!!

Submitter : **Levah Dunlap** **Date: 08/30/2007**

Organization : **Levah Dunlap**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Janey Dunlap** **Date: 08/30/2007**

Organization : **Janey Dunlap**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Tom Dunlap** **Date: 08/30/2007**

Organization : **Tom Dunlap**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Yanzhang Dong** **Date: 08/30/2007**

Organization : **St. Anthony Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Ms. Jumpei Harada** **Date: 08/30/2007**

Organization : **Ms. Jumpei Harada**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My Name is Jumpei Harada, currently serving as an assistant athletic trainer at Columbia University.

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

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of aceess 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 acccss 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,

Jumpei Harada, MS, ATC

Submitter : **Mr. Harold Leme** **Date: 08/30/2007**

Organization : **The Ohio State university**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

to Whom It May Concern:

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.

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Sincerely,
Harold Leme ATC

Submitter : **Dr. Robert Brandt** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

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.

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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,

Robert W. Brandt M.D.

Submitter : **Mr. Antonio Acosta** **Date: 08/30/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Provider**

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.

CMS-1385-P-12183-Attach-1.DOC

Submitter : **Dr. Wai Gong Chin** **Date: 08/30/2007**

Organization : **Dr. Wai Gong Chin**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue. Patients want and need anesthesia for more and more procedures.
Wai Gong Chin M.D
Stony Brook, NY

Submitter : **Dr. jatinder bhangoo** **Date: 08/30/2007**

Organization : **Dr. jatinder bhangoo**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Jean-Paul Matter** **Date: 08/30/2007**

Organization : **Dr. Jean-Paul Matter**

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 a practicing Anesthesiologist in Cincinnati Ohio and I would like to voice my opinion.
I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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

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Thank you for your consideration of this serious matter.

Jean-Paul Matter MD

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician referal to self-owned Physical therapy practice is clearly conflict of interest. The argument that the PT is unable to assess and treat without the direct intervention of the MD demeans and undermines the value of PT as a whole and is blatently untrue. In private non-physician owned practice we are driven by the successful patient outcome. We are able to draw from a wide spectrum of interventions not limited to those that the physician may be aware of. As a practitioner I accept the responsibility inherent to my position to evaluate symptomology and report back to the referring MD, or in the case of self-referral,advise an MD of record if the symptoms fall outside the scope of my practice. I personally have intervened on numerous occasions when medical diagnosis did not match symptoms, recommending alternatives directly to the MD which in turn have impacted the patients care directly , and in more than one occasion saving a life. If the MD directly paid my salary, I may have chosen differenly, being wary of insulting him or other repercussions to my position.Clearly not all MDs would be aggrevated, but, when egos are involved anything can happen.The patients are served best by an open market system that requires we treat them well and with their best interests in mind, not by the thought that the doctor knows best about therapy. Poll the graduating classes of MDs regarding their eduеation in rehab.It is minimal at best. PTs specialize in rehabilitation and should be respected as the professionals we are. We respect the MDs for their knowledge, but our ability to provide private practice options for the patients is being crushed by MDs seeing dollar signs in owning their own practice and referring strictly to their clinics, often telling patients that they will not treat them if they don't see their own therapy or that other therapists not under their direct supervision "will likely hurt them".

I ask that Physician owned private Physical Therapy practice be seen for what it is, a conflict of interest which is really just another way for Doctors to generate incomc,not to provide the best of services to their patients.As the reimbursments in other areas decline, they continue to search for income options, driving the rest of us out of business.

Submitter : Mr. William Elmblad **Date:** 08/30/2007

Organization : MGH Sports Rehab

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12188-Attach-1.DOC

#12188

National Athletic
Trainers' Association

August 29, 2007

Dear Sir or Madam:

My name is William Elmblad and I am a Certified Athletic Trainer (ATC) employed at Marquette General Health Systems, located in Marquette, Michigan. MGHS is the only Level II trauma center in the Upper Peninsula of Michigan. I have 15 years of allied health clinical experience at MGHS. I have a Bachelors degree in Physical and Health Education from Saginaw Valley State University and been certified as an Athletic Trainer since 1992.

I currently continue to work at MGHS in the outpatient physical therapy department providing physical rehabilitation to a variety of patients with musculoskeletal dysfunctions and injuries. Along with direct patient care I also provide Athletic Training services to an area high school. Also, MGHS provides Athletic Training services to many youth athletic venues in Marquette and the surrounding area.

My profession allows me to work with a variety of other allied health care providers such as: physicians, physician assistants, physical therapy, occupational therapist, exercise physiologist, and nurses. I approach my role as an allied health care provider with great compassion and dedication to my patients and to my profession I serve. However, I'm concern that my ability to provide this care that improves the livelihood of many individuals, may be in jeopardy.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provision 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,

William Elmblad, ATC

Submitter : Mr. Matthew Marzullo **Date:** 08/30/2007

Organization : Wheaton Warrenville South High School

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer/high school teacher in the state of Illinois and have been for the last 18 years. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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

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

Sincerely,

Matthew A Marzullo, M.Ed., ATC
Head Athletic Trainer

Submitter : **Ms. Cara DeSalvo** **Date: 08/30/2007**

Organization : **UPMC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dcar Sir or Madam:

My name is Cara DeSalvo and I am a Certified Athletic Trainer working for UPMC at Serra Catholic High School. I earned my BS in Athletic Training from Duquesnc University in 2002 and am 6 credits away from my MSEd, Secondary Science-Biology. In additions to my duties at the high school, I provide physician extender services at the UPMC Center for Sports Medicine. I greatly enjoy this part of my job as well.

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,

Cara A. DeSalvo, ATC

Submitter : **Dr. Brett Coldiron MD FAAD** **Date: 08/30/2007**

Organization : **American Academy of Dermatology**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Response to CMS Request for additional PE direct input data
Tables 5 and 6 of the Proposed Rule

CMS-1385-P-12191-Attach-1.DOC

CMS-1385-P-12191-Attach-2.PDF

#1291

American Academy of Dermatology and AAD Association

Physicians Dedicated to Excellence in Dermatology™

Diane R. Baker, MD, FAAD
President

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Assistant Secretary-Treasurer

Ronald A. Henrichs, CAE
Executive Director & CEO

Tuesday, August 28, 2007

The Honorable Herbert Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Washington, DC 20201
Phone: 202-690-6726
E-mail: herb.kuhn@cms.hhs.gov

Re: CMS 1385-P: 2008 Medicare Fee Schedule – 2. PE Proposals for CY 2008
b. RUC Recommendations for Direct PE Inputs and Other PE Input Issues
(x) Supply and Equipment Items Needing Specialty Input,

Dear Acting Administrator Kuhn:
On behalf of the members of the American Academy of Dermatology (AAD) we are submitting comment to you on the 2008 Medicare Fee Schedule: Proposed Rule regarding the explicit request for information on Tables 5 Supply Items Needing Specialty Input and 6 Equipment Items Needing Specialty Input.

CPT 36522 Extracorporeal Photopheresis
Please be advised that the Academy responded to the CMS request for data related to CPT 36522 Extracorporeal Photopheresis listed in the 2007 Medicare Fee Schedule: Proposed Rule. However, we are providing updated information as requested.

Table 5 Supply Items Needing Specialty Input

SC088 Fistula set, dialysis, 17 g
This is not a supply item used in photopheresis procedures. The supply item that should be listed instead is **"fistula needle, dialysis, 17g"** (quantity used = 2 per procedure). However, there does not seem to be a supply item currently in the CMS Medical Supply database with a description that approximates this specialized needle, (which is also used routinely in chronic renal dialysis procedures).

Fistula needle, dialysis, 17g"
The price at which 17g fistula needles are widely available for physician office-based providers is approximately **$1.62** per needle (x 2 = $3.24). This price was secured from Baxter Healthcare, whose price list for large quantity price for 250 twin packs or 500 single needles is $810.00. That price list as provided by the manufacturer is attached (See Baxter-Fistula needle_17g_ID & Pricing_08 23 07 MS Excel file attached).

Additional Extracorporeal Photopheresis Supplies clarification:

SA024 Kit, photopheresis procedure:
The current average kit ASP price is **$976.39**,
not $858. This value was calculated and supplied by Therakos, which is the sole manufacturer of the device. A contact at Therakos to confirm this information is Monica Martyak.

SJ075 Methoxsalen, 10ml vial:
The current ASP price is **$59.48**, not $49.50. Again this information supplied by the manufacturer Therakos.

Table 6 Equipment Items Needing Specialty Input
CPT 36522 Extracorporeal Photopheresis

EQ206 **Plasma pheresis machine w/UV light source**
This device has been improperly identified. It does *not* include a "UV light source." The machine is also very distinct in design and important functional features from a conventional device used to perform plasma pheresis procedures. We recommend that this item be re-designated as a **"plasma pheresis machine, photopheresis."**

Photopheresis light assembly
This is a separate piece of equipment that has an Average Selling Price (ASP) **of** $1,616.65.
The **Photopheresis light assembly** including the UV bulbs has an average useful life of 187 procedures (cost per procedure = $8.65). This information is supplied by Therakos.

Note: As with UV-A and UV-B bulb replacement costs for photo chemotherapy (CPT 96910-96912-96913) the cost of light source replacement exceeds the usual parameters for medical supplies and needs to be factored into the medical equipment cost on an ongoing basis.

CPT 96904 Whole body photography

Camera mount, floor
Cross slide attachment
These are listed as products of Manfrotto which is a Registered Trademark of Bogen Photo Corporation with additional information available from http://www.bogenimaging.us/jsp/index.jsp

Dermoscopy attachments (CPT 96904)
The current market for digital Dermoscopy includes two varieties of relatively simple and cheap attachments which can convert a consumer digital camera into a digital dermoscope. A coupling adapter acts as a fastener between the camera and an ordinary dermoscope, whereas a dermoscopy attachment includes the dermoscope optics and light source and can be attached directly to the camera. Other options for digital dermoscopy include complete dermoscopy systems that use a hand-held video camera linked directly to a computer. These systems differ from each other in whether or not they are calibrated as well as the quality of the camera and software interface.

Pricing information on dermoscopy attachments is available from **3Gen, LLC**
31521 Rancho Viejo Road, Suite 104 • San Juan Capistrano, CA 92675 email: info@3GenLLC.com • www.3GenLLC.com Tel 949.481.6384

Camera Lens, macro, 35-70mm (CPT 96904)
Standard camera equipment manufactured by Canon, Contax, Nikon, Sony, etc. with price ranging from $50 (used) to $250-$600 (new)

Dermal imaging software (CPT 96904)
Canfield Scientific is recognized as primary source of this type of software. Attached is pricing information on Mirror Body Mapping software designed to assist in location and monitoring of lesions. (See attached 082907 Dermal Imaging Software pricing.pdf)

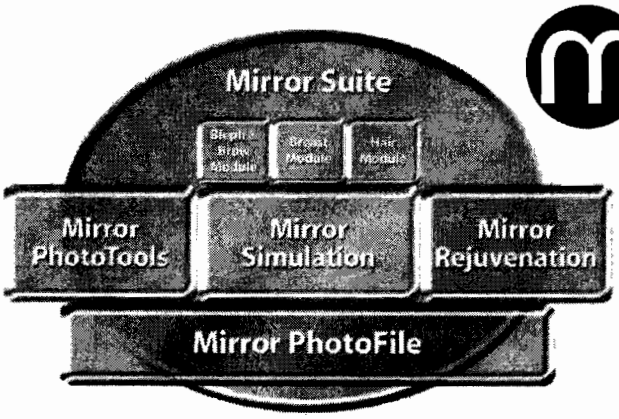
We hope the information supplied is helpful. If you have any questions regarding these items and the related information, please feel free to contact: Norma L. Border at nborder@aad.org or 847 240 1814.

Best regards,

Brett Coldiron MD

Brett Coldiron, M.D. Chair
AAD/Health Care Finance Committee and AAD RUC Advisor

Attachments: Baxter-Fistula needle_17g_ID & Pricing_08 23 07 MS Excel file
082907 Dermal Imaging Software pricing.pdf



Mirror software bundles

		Mirror PhotoFile $825	Mirror PhotoTools $2,500	Mirror Rejuvenation $3,000	Mirror Simulation $6,000	Mirror Suite $12,500	Mirror Body Mapping $4,500
Mirror PhotoFile*							
advanced medical image management	patient charts	●	●	●	●	●	●
	unlimited, user-definable image data fields	●	●	●	●	●	●
	database search	●	●	●	●	●	●
	image import from digital cameras	●	●	●	●	●	●
	loupe tool	●	●	●	●	●	●
	side-by-side image viewing	●	●	●	●	●	●
	patient privacy	●	●	●	●	●	●
Mirror PhotoTools							
streamline workflows, enhance visual communication and facilitate surgical planning	tethered image capture	–	●	–	–	●	●
	MatchPose	–	●	–	–	●	●
	image overlay (compare)	–	●	●	●	●	–
	color correction	–	●	–	–	●	–
	orientation matching	–	●	–	–	●	–
	layout board	–	●	–	–	●	–
	label/annotation layer	–	●	–	–	●	–
	whiteboarding	–	●	–	–	●	–
	consultation tools (Enhance, asymmetry, mirror)	–	●	–	–	●	–
	presentations tool	–	●	–	–	●	–
	measurement tools	–	●	–	–	●	–
Mirror Simulation modules							
simulate the results of aesthetic procedures quickly and easily with Mirror's elegant, patented tools	Aesthetic Simulation: a core set of tools for simulating most aesthetic procedures. Ideal for rhinoplasty, face lift, otoplasty, chin augmentation, abdominoplasty and liposuction.	–	–	–	●	●	–
	Rejuvenation module	–	–	●	–	●	–
	Hair module	–	–	–	–	●	–
	Breast module	–	–	–	–	●	–
	Bleph & Brow module	–	–	–	–	●	–
Mirror Body Mapping							
accurately compare and track lesions	body map	–	–	–	–	–	●
	image linking/mole mapping	–	–	–	–	–	●
	create stand-alone viewer CD	–	–	–	–	–	●
additional features							
rhinoplasty diagrams for surgical planning and education	Gunter rhinoplasty diagrams	–	–	–	–	●	–
	network licenses included*	1	1	1	1	3	1
	1-year support & upgrades included	–	●	●	●	●	●
	initial training included**	▲ 1-hour	▲ 2-hour	▲ 2-hour	■ 1-day	■ 2-day	■ 1-day

* Mirror Suite license allows software to be used on any three network workstations concurrently. Other products may be used on one workstation at a time. Additional network licenses available for all products at $500/seat.

▲ live, web-based training ■ on-site training

** Training is also available for all products on a per diem basis at $1,400/1-day or $2,300/2-day. All travel costs included in 48 contiguous United States only. Four week advanced scheduling required.

Live, web-based training is available at $95/hour for users with high speed internet access.

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0603-02

Submitter : Dr. Scott Kelly **Date:** 08/30/2007

Organization : Resurgens Orthopaedics

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician owned Physical Therapy is a benefit to the patients we serve. Physicians are able to more closely monitor their patients and their progress, the standard of their care is improved, and it is often more accessible and convenient for the patient.

Submitter : Douglas Wardy **Date:** 08/30/2007

Organization : University of South Florida

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Douglas Wardy, and I am a certified athletic trainer with the University of South Florida football team. I am currently pursuing my master's degree while working as a graduate assistant with the team.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

Whilc 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 thesc proposcd rules will create additional lack of access to quality health care for my patients.

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

Thc 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, espccially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilitics arc pertinent in ensuring patients receive the best, most cost-effective treatment available.

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

Sincerely,

Douglas Wardy, ATC/LAT

Submitter : **Dr. Joe Banach** **Date: 08/30/2007**

Organization : **Integrated Rehabilitation Group**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist in Redmond, Washington and wanted to voice my opposition to physician owned physical therapy clinics. The CMS should remove physical therapy from the in-office ancillary services exception to the federal physician self-referral laws.

I believe that it is in the best interest of the patient to not have a referral for profit by their attending physician. As a physical therapist I have seen the referral of post-op patients significantly decrease to independent PT practices and are almost exclusively referred to the physician owned clinic.

By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutlization of physical therapy services under the Medicare program, and enhance the quality of patient care.

Sincerely

Joe Banach, DPT,CSCS

Submitter : **Dr. Johnny Hobbs** **Date: 08/30/2007**

Organization : **ACILLC**

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.

Johnny L. Hobbs, MD

Submitter : **Mr. Joseph Lueken** **Date: 08/30/2007**

Organization : **Indiana University Department of Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern:
My name is Joseph S. Lueken and I am a state licensed and nationally certified athletic trainer currently working at Indiana University in the Department of Sports Medicine. I have been providing quality health care to patients and athletes for twenty years via athletic departments, medical sports medicine clinics and the United States Olympic Training Center in Colorado Springs, CO. 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 a certified and state licensed athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, national certification exam and state of Indiana license 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. My wife is a physical therapist and there is a huge lack of practicing physical therapists. 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,

Joseph S. Lueken, MS, LAT, ATC
Athletic Trainer/Instructor
Indiana University
1001 E 17th Street
Bloomington, IN 47408-1590

Submitter : **Ms. Wendeline Poppy** **Date: 08/30/2007**

Organization : **Indiana University**

Category : **Physical Therapist**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

August 30, 2007

Dear Sir or Madam:

My name is Wendeline Poppy, and I have been a licensed physical therapist for thirty four years, and a certified and licensed Athletic Trainer for twenty three years. I have been employed by Indiana University since 1985 as an athletic trainer and physical therapist. In addition, I have hospital, extended care facility, and clinical experiences as a physical therapist and athletic trainer. As I have extensive experience in a multitude of work environments, I feel that I am well qualified to express 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,

Wendeline K. Poppy, ATC, LAT, PT
Indiana University Athletic Department
1001 E. 17th St.
Bloomington, IN 47408

Submitter : **Dr. michael bishop** **Date: 08/30/2007**

Organization : **Dr. michael bishop**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

michael bishop, d.c.

Submitter : **Miss. Jana Mannino** **Date: 08/30/2007**

Organization : **Stoney Creek High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am currently an Athletic Training Intern working at a clinic and high school for the next 15 weeks. I am doing this as a graduation requirement and in order to gain better experience in the world of Athletic Training before I enter the working world. I have worked very hard the past 4 years at Central Michigan University to make it to this point and will be sitting for my certification boards in less than 3 months. I am very concerned about that changes that could potentially be made and how it could affect my job opportunities after I graduate.

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

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

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

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

Sincerely,
Jana Mannino (Athletic Training Intern)

Submitter : **Dr. Jim Konvicka** **Date: 08/30/2007**

Organization : **Dr. Jim Konvicka**

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 : **Mr. Jason Erlandson** **Date: 08/30/2007**

Organization : **Sports Medicine Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Jason Erlandson, MS, ATC. I am a certified athletic trainer working at a local high school contracted through a sports medicine clinic. I have been working as a certified athletic trainer since 2002.

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

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

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Sincerely,

Jason Erlandson,MS,ATC

Submitter : **Racheal Lawler** **Date: 08/30/2007**

Organization : **Huntsville Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Racheal Lawler. I am a licensed, certified athletic trainer practicing in the state of Alabama. I have been in this profession for over 10 years. I am currently employed by Huntsville Hospital. I have seen on a personal level how my profession directly and positively affects people s lives on a daily basis. I hope that you read the following words with an open mind. 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 havc not received the proper and usual vetting, I am more concerned that thesc 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 cxperience, and national certification exam ensure that my patients reccive quality health care. State law and hospital medical professionals have deemed me qualificd to perform these services and these proposed regulations attempt to circumvcnt those standards.

The lack of access and workforce shortagc 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 treatmcnt 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,
Racheal Lawler, ATC/L

Submitter : **Dr. Randall Stange** **Date: 08/30/2007**

Organization : **Stange Chiropractic Clinic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

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

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

Sincerely,

Randall P. Stange, D.C.

Submitter : **Dr. Randolph Freeman** **Date: 08/30/2007**

Organization : **Anesthesia Associates of Belleville, Ltd.**

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)

Dcar 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 recognizcd 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 arcas 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 ensurc 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. ann dawidczyk **Date:** 08/30/2007

Organization : Cytyc Corporation

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-12205-Attach-1.DOC

12205

CYTYC

Via Electronic Submission
August 24, 2007

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

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

Dear Mr. Kuhn:
Cytyc Corporation appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") Medicare Physician Fee Schedule proposed rule for fiscal year 2008, published in the Federal Register on July 12, 2007 (CMS-1385-P, Federal Register, Vol. 72, No. 133).

Cytyc Corporation, a medical device company, provides therapeutic and screening technologies for multiple areas of health and is particularly focused in women's health. In the area of therapeutics, Cytyc manufactures the MammoSite Radiation Therapy System (RTS) the most widely used method of breast brachytherapy to treat breast cancer. Additionally, Cytyc manufactures the ThinPrep Pap Test, the most widely used cervical cancer screening test. As an industry leader in women's health, Cytyc is focused on ensuring that issues impacting women's health and certain cancer therapies and diagnostics are given appropriate consideration in the formation of federal health care and reimbursement policy.

2008 Update of the Conversion Factor and the Sustainable Growth Rate
The proposed rule indicates that payment rates for physicians' services will be reduced by 9.9% for 2008. Such a drastic reduction will impact continued provider participation in the Medicare program. At a time where the number of Medicare beneficiaries is growing substantially, access to providers and services is crucial. We acknowledge annual review of the conversion factor according to the sustainable growth rate (SGR) formula is required by law. Nonetheless, CMS must recognize that the reductions under the SGR system forecasted for 2008 and subsequent years will limit provider participation. Cytyc does not support the proposed 9.9% reduction and recommends that CMS replace the Sustainable Growth Rate in 2008 with an alternate annual update system that more accurately reflect actual increases in physician practice costs.

Clinical Laboratory Issues
Cytyc offers diagnostic testing for cervical cancer with the ThinPrep test which has been shown to increase the detection of pre-cancerous cells, and Cellient™ Automated Cell Block System which can aid the pathologist with more diagnostically useful cell blocks. Payment for many of the diagnostic tests for cervical cancer is made under the clinical laboratory fee schedule.

CMS proposes a new reconsideration process relating to the basis for and the amount of payment for any new clinical laboratory test for which a new or substantially revised HCPCS code is assigned on or after January 1, 2008. We commend CMS for proposing a reconsideration process for use in future new lab test payment determinations. The reconsideration process as describe would allow the necessary dialogue to ensure adequate pricing is set for new tests. Cytyc urges CMS to establish payment amounts at the national limitation amount (NLA) of the new tests on the Clinical Laboratory Fee Schedule to which the new tests are cross-walked. The NLA should replace carrier-specific amounts below the NLA for new tests. Carrier specific low rates would inhibit patient access.

Resource-Based Practice Expense Issues
First, with regards to the treatment of breast cancer, we wish to express our concerns about CMS's proposed changes in RVUs and the potential impact of significant reductions in practice expense values on access to cancer care. Under the new practice expense methodology, two (2) breast brachytherapy and two (2) HDR brachytherapy codes are slated to be significantly reduced over the four-year transition period. CPT codes 77781 and 77782 are the primary procedures reported for ovarian, breast and cervical cancer treatments. The proposed reductions in reimbursement may influence treatment decisions.

Breast brachytherapy, or partial breast irradiation, is a viable treatment option for many women receiving a lumpectomy. The most common brachytherapy method utilizes a balloon catheter and High Dose Radiation (HDR). CPT codes 19296 and 19297 are used for the placement of the balloon catheter in conjunction with HDR brachytherapy codes 77781 & 77782. Decreasing the length of a course of radiation therapy improves the quality of life for these women. Currently 20% of women with breast cancer are foregoing radiation therapy. Partial breast irradiation provides an opportunity for some women to receive radiation who may otherwise not be able to endure 7 weeks of whole beam radiation. By implementing the proposed payment changes, this rate may continue to increase.

Second, Cytyc supports the recommendations submitted by the Coalition of Advanced Brachytherapy in this area.

Third, Cytyc supports the CMS decision not to revise the 50% equipment usage assumption until adequate data has been collected on equipment costs.

Quality Indicators
Cytyc wishes to acknowledge CMS efforts to implement the PQRI and to thank CMS staff for providing a clear description of the process included in the Proposed Rule. Cytyc would request CMS include providers, device manufacturers and patient groups in the continued development of PQRI. Additionally, Cytyc would request CMS include an indicator for radiation therapy following breast conservation surgery as included in the inpatient quality indicators.

Data from multiple large randomized trials have demonstrated the addition of radiation after breast conserving surgery in patients with invasive breast cancer lowers the risk of local recurrence. Therefore, we commend CMS for including PQRI Measure #74 'Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery' under the PWRI program in 2007 and for proposing to continue it in 2008. We also commend CMS for proposing to include a screening mammography quality measure in 2008 from the AQA starter-set measures. As a manufacturer that provides technology for women faced with breast cancer, we believe including these quality indicators will help to ensure all Medicare beneficiaries with breast cancer are evaluated and offered the most appropriate technology. We request that CMS allow manufacturers of advanced therapies involved in the treatment of breast cancer to be involved in the development of the quality measures.

Recommendations
Cytyc respectfully requests that CMS consider an implement the following recommendations:

- ◊ Make final the proposed new reconsideration process relating to the basis for and the amount of payment for any new clinical diagnostic laboratory test
- ◊ Base payment for new tests included in the Clinical Laboratory Fee Schedule on the National Limitation Amount, replacing local carrier rates to avoid disparity in rates which may have an impact on patient access.
- ◊ Reconsider reductions in the proposed practice expense relative value units (RVUs) specific to 19296, 19297, 77781 and 77782. These proposed reduction combined with the forecasted reductions in the annual update factor will have an adverse impact on Medicare beneficiaries' access to proven treatment advanced technologies for the treatment of breast cancer.
- ◊ Work with the Congress, physicians and manufacturers on an alternate annual update system to replace the SGR system.

Cytyc supports the specific recommendations included in the ADVAMED and CAB comment letters.

Cytyc appreciates the opportunity to provide comments during this proposed rule period. Should you have any questions or need additional information, please do not hesitate to contact me at 508-263-8961 or via email at ann.dawidczyk@cytyc.com.

Sincerely,

Ann Marie Dawidczyk
Senior Manager, Managed Care

cc: Margaret Eckenroad, Sr. Director Women's Health & Professional Relations

Submitter : **Mr. james putnam** **Date: 08/30/2007**

Organization : **Mr. james putnam**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. Celia Pate **Date:** 08/30/2007

Organization : Mrs. Celia Pate

Category : Private Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12207-Attach-1.TXT

CMS-1385-P-12207-Attach-2.DOC

#12207

Mrs. Celia C. Pate
3129 NW 21st St
Oklahoma City, OK 73107

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

To Whom It May Concern:

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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.

Celia C. Pate

Submitter : **Mrs. linda putnam** **Date: 08/30/2007**

Organization : **Mrs. linda putnam**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Submitter : **Mr. alex putnam** **Date: 08/30/2007**

Organization : **Mr. alex putnam**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Submitter : **Mr. mike hancock** **Date: 08/30/2007**

Organization : **Mr. mike hancock**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Submitter : Gregory Cowart **Date:** 08/30/2007

Organization : Gregory Cowart

Category : Other Health Care Professional

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 cnsure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increasc 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 I2-unit anesthesia service in 2008 will be rcimbursed 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.

Submitter : **Mrs. tamara hancock** **Date: 08/30/2007**

Organization : **Mrs. tamara hancock**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Lawrence Freund** **Date: 08/30/2007**

Organization : **Dr. Lawrence Freund**

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,

Lawrence Freund, D.O.

Diplomate, American Board of Anesthesiology
Diplomate, National Board of Echocardiography

Submitter : **Dr. Raymond Dufresne** **Date: 08/30/2007**

Organization : **Brown University, Dept. Dermatology**

Category : **Physician**

Issue Areas/Comments

Background

Background

in the early 1990's, i met local represents, reviewed and documented the mohs/surgery relationship; how and why it was disctinct, resulting in the 1991 decision. nothing has changed. the patient returned to the operating room, repeat vitals, preparation, anesthesia, new instruments etc. it is not like an excsion, where the patient is lying on the table, the closure following immediately following the excision. the waiting period is 0; mohs was always intended as a stand alone. in fact, under the proposed quidelines, if a complex repair is done, the first layer would be reduced by 1/2, less than the free standing second layer. this makes no sense;the mohs resection is not connected to the closure.

i saw the restricted access and aborations in the care of patients to skin cancer 20 years ago. i have also seen the improved care, easy access to a needed procedure, a less frequently diaster due to better cures and after 20k cases personally, a great safety record in mostly elderly patients.

these regulations will kill the best approach to the most common cancer. it is safe, highly effective, efficient, cost effective. The changes are a unprovoked attack on a 20 year agreement. I am glad i am approaching retirement, but it fear for the patients and my trainees will look to cosmetics rather than what is needed.

thank you,

Raymond G. Dufresne, Jr.,M.D.
Professor, Department of Dermatology, Brown
Director Dermatologic Surgery
Fellowship Director, American College Mohs Surgery

Submitter : **Miss. alexis hancock** **Date: 08/30/2007**

Organization : **Miss. alexis hancock**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Rosa Navarro** **Date: 08/30/2007**

Organization : **Michiana Anesthesia Care, P.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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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.

Rosa M. Navarro, MD

Submitter : **Ms. marge meinders** **Date: 08/30/2007**

Organization : **Ms. marge meinders**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Cathleen Brown** **Date: 08/30/2007**

Organization : **University of Georgia**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Cathleen Brown, PhD, ATC. I am a certified athletic trainer and teach in the undergraduate athletic training program at the University of Georgia.

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 and my students who treat patients after graduation.

As an athletic trainer, I am qualified to teach and 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 majority of my students are from Georgia, and most are from rural areas. They plan to return to their hometowns following graduation and provide treatment to the people who live there. 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,
Cathleen Brown, PhD, ATC

Submitter : **Mr. Joe Blair** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
___Joe Blair CRNA_____
Name & Credential
___1353 Curlew Rd_____
Address
___Dunedin, FL 34698_____
City, State ZIP

Submitter : **Dr. drew eldridge** **Date: 08/30/2007**

Organization : **Dr. drew eldridge**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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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. Gary Johnson** **Date: 08/30/2007**

Organization : **Athletic Advantage Inc.**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a recent college graduate working in a physical therapy clinic, and I recently sat for my NATA cerification exam.
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,

Gary Johnson

Submitter : Mr. Robert Black **Date:** 08/30/2007

Organization : Mr. Robert Black

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

August 30, 2007

To whom it may concern:
I am employed at Indiana University a member of the Big Ten conference where I serve as the athletic trainer for several athletic teams. I received my masters degree in sports medicine from IU and am currently nearing completetion of a doctoral degree in higher education adminstration. I am certified by the National Athletic Trainers Association Board of Certification and licenced in the state of Indiana.

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 E. Black, MS, ATC, LAT

Submitter : **Mr. Neil Thompson** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Practitioner**

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:
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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,

Neil L Thompson, CRNA
243 Blake Court
Springfield, IL

Submitter : **Mr. Randall Mountcastle** **Date: 08/30/2007**

Organization : **Insight Imaging, LLC**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12224-Attach-1.DOC

#12224

INSIGHT IMAGING

August 30, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8015
Baltimore, MD 21244-8015

RE: Proposed 2008 Physician Fee Schedule
File Code CMS-1385-P

To Whom It May Concern:

The purpose of this letter is to comment on CMS' July 2nd 2008 Medicare Physician Fee Schedule Proposed Regulations that, among other topics, address IDTF Performance Standards, Purchased Test Provisions and Reassignment Rules.

Insight Imaging, LLC provides a diagnostic ultrasound service in five (5) states in the Southeast. Insight Imaging is owned by businessmen and has no physician owners. The Company's service is provided with technologically advanced equipment and highly qualified and experienced technologists in many areas where the quality of diagnostic services is inferior and/or access is limited. Unlike CT, PET and MRI imaging technologies, ultrasound is a much lower cost, portable technology that may be effectively and efficiently offered in the physician practice suite and supervised by the treating / ordering physician.

In-office ultrasound suppliers like Insight Imaging provide services in physician practices, many of which are located in rural, non-metropolitan areas in which the quality and convenience of diagnostic ultrasound is not available or limited.

Insight Imaging provides ultrasound service in the physician's practice facility under the direction, control and supervision of the on-site physician and physician staff. For Medicare beneficiaries, the convenience of on-site service is very important in determining whether the patient ultimately receives the ultrasound imaging study. In certain markets, alternative service outlets (e.g. hospital outpatient imaging departments and fixed imaging centers) may entail drives beyond a twenty (20) mile radius for patient treatment. In other markets, service delays of 10-14 days for the scheduling of an exam are not uncommon. These lengthy drive times and scheduling delays do not exist with on-site, imaging services.

We appreciate the opportunity to provide commentary on the following rules as proposed by CMS:

1901 Roxborough Road, Suite 200 • Charlotte, North Carolina 28211 • 704.525.7005 • Fax 704.525.6250 • insightimagingllc.com

I. IDTF Performance Standards

A. Liability Insurance – § 410.33(g)(6)

The liability insurance requirement made effective January 1, 2007 is a positive standard that raises the quality bar for all IDTFs. We support CMS' proposals to: i) delete the requirement that the liability policy list the serial numbers of all diagnostic equipment as this will increase administrative burden on IDTFs and MACs, and (ii) clarify that the liability policy must provide coverage at each location of at least $300,000 "per incident". We recommend that liability policy details be reflected in the 855B Medicare Enrollment Application and that material changes to this policy would require notification to the MAC according to the same thirty (30) day notice period as that required for changes in ownerships, location, general supervision, and adverse legal actions rather than adopting the requirement for the MAC to be a named certificate holder. We expect that insurance underwriters will be reluctant to add MACs as certificate holders as it may raise questions regarding government indemnification or payment rights that are not warranted.

B. Enrollment Changes – § 410.33(g)(2)

We agree with CMS' proposal to require that changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the designated fee-for-service contractor on the Medicare enrollment application within thirty (30) calendar days of the change and that all other changes to the enrollment application must be reported within ninety (90) days.

C. Beneficiary Questions & Complaints – § 410.33(g)(8)

We do not agree with CMS' proposal to expand performance standard # 8 to require not only that the IDTF answer beneficiaries' questions and respond to their complaints but that the IDTF create and maintain on file at the physical site of the IDTF (or home office for mobile units) documentation of these interactions with beneficiaries. This documentation provision will place additional administrative and enforcement burdens on IDTFs and MACs, respectively, which will likely decrease the services available to program beneficiaries by the IDTFs.

D. Supervising Physician - § 410.33(b)(1)

We agree with CMS' proposal to delete the existing, very broad requirement that the supervising physician is responsible for "the overall administration and operation of the IDTFs... and for assuring compliance with applicable regulations." We believe that the supervising physician should be responsible for quality-related oversight where he/she is more capable of positively impacting the operation of the IDTF.

§ 410.33(b) Supervising physician. We recommend that CMS move to a diagnostic equipment threshold limit instead of an IDTF site limit since, as proposed – "Each supervising physician must be limited to providing supervision to no more than three IDTF sites." -- portable/mobile providers would be unfairly treated relative to fixed

based operators. The language as written seems to provide a maximum threshold of three (3) portable/mobile ultrasound units operating under one supervising physician. It is unclear how many ultrasound units would be allowed to operate under the three (3) fixed IDTF sites as the maximum number of units at each facility is unspecified by CMS in the proposed rules. Supervision restrictions should be based upon patient volume, which is more closely related to the volume of equipment involved as opposed to the number of IDTF sites. An ultrasound unit threshold per supervising physician would be more precise and prevent any unnecessary disparity in the treatment between portable/mobile and fixed IDTFs. A maximum ultrasound unit threshold of fifteen (15) per supervising physician would be advisable. It may also be necessary to state more clearly in this section that CMS intends this threshold limit to apply to "general" supervision and not "direct" or "personal" supervision.

E. Enrollment Date – § 410.33(i)

We recommend that CMS provide for an effective date that is retroactive for a period of time no greater than sixty (60) days to limit Medicare's exposure to long periods of time between billable activity and enrollment and to provide adequate time for the IDTF to complete the necessary paperwork. Practically speaking, the IDTF must meet all of the requirements of the Medicare Program for providing service (purchase of equipment, employment of technologist, staffing of supervising physician, etc.) before providing the first exam. Once this requirement is met, adequate time is required to accurately and fully complete the 855B. If the IDTF were unable to provide exams and bill for these during this period, the IDTF would be detrimentally impacted financially by incurring expenses to meet requirements of the Medicare Program without potential Medicare revenue. Limiting the retroactive date to sixty (60) days would seem to protect the Medicare program and provide for an ample amount of time for the IDTF to complete the full 855B. An unintended consequence of CMS' proposed rule will be an increase in hurriedly submitted enrollment applications and a resulting increase in administrative burden on MACs due to the processing costs of incomplete enrollment applications. This rule should also account for enrollment delays due to MAC processing delays that are not the fault of the enrollee.

F. Prohibition on Sharing – § 410.33(g)(15)

We understand that CMS is concerned about the sharing of space between fixed IDTF providers and other physician providers. Our experience as a portable IDTF provider does not lend us any specific knowledge to provide thoughtful commentary on this prohibition of sharing as it relates to fixed IDTFs.

We do, however, believe that CMS needs to clarify whether it is drawing a distinction between "mobile" and "portable" providers of service in its solicitation of commentary on a broader application of this "prohibition on sharing" in future CMS rule-making. It is our understanding from form 855B that a mobile provider of service actually performs the diagnostic service within a mobile trailer or transportable unit, and that a portable provider of service actually transports its diagnostic equipment into the physicians practice to provide service. Recognizing this particular distinction, Insight is a portable provider of service and, by

definition, must share space, equipment and staff with the physician provider in order to perform exams. Therefore, we request that portable IDTF providers be excluded from this prohibition of sharing as the inability of portable providers to share space, equipment and staff of a physician provider during the episodes of service to the practice would prevent entirely the provision of portable IDTF service, the most cost effective and convenient delivery method for imaging procedures for patients and the Medicare Program. Therefore, we recommend that portable IDTF providers be excluded from future rulemaking along these lines. Also the prohibition on sharing staff cannot be extended to the supervising physician, as that party will likely never be a full-time employee of the IDTF, and will likely always be employed by his or her own physician practice.

II. Anti-Markup Provisions

A. § 414.50 Purchased Diagnostic Test Rule

To provide some perspective of our Company's service, Insight makes use of vans that transport ultrasound technology and technologists to the office of each primary care physician practice (PCP). In a typical situation, each PCP enters into a one (1) year written agreement with Insight to lease ultrasound technology and a technologist one day each week (or some other predetermined block of time of no less than four (4) hours) for use at the PCP primary practice location. The PCP pays a set daily charge for the equipment and technologist that does not vary with referrals. The PCP supervises the technologist and includes him on its medical malpractice policy. The PCP bills Medicare for the TC. The PC is referred to an outside radiologist who bills and collects for the PC.

A simple reading of proposed regulation section 414.50 would seem to imply that in any diagnostic test billed by a physician, the PDT anti-markup billing rules apply if only one condition exists; i.e., the PC or TC is performed by an "outside supplier". An outside supplier is defined as "someone other than a full-time employee of the billing physician or medical group." Under the Insight facts, it would appear that the leased ultrasound technologist could fit the definition of "outside supplier" since the PCP would not be a full-time employer of the technologist.

We have had conversations with CMS (and have consulted with others who have as well) and have been told that Section 414.50 was not intended to apply to Insight or arrangements like the above because there is no purchased test under our facts. We understand that this conclusion was reached because Section 414.50 was intended to address situations like abusive path labs where physicians had a separate "centralized building" off-site from their traditional professional practice where they exclusively provided path lab services with part-time employees. The off-site path lab service was not integrated into the PCP practice and provided no access or other benefits to patients of the PCP traditional practice. Our ultrasound services are provided directly in the PCP primary office where the PCP provides its traditional professional services. The service is also integrated into the PCP practice as it provides accessible and convenient care for the benefit of PCP patients. The PCP has capital risk for the ultrasound technology (its lease payments to Insight are set in advance for set periodic block time visits that do not vary with the

volume or value of referrals) and has liability risk for the technologist. In other words, the PCP is clearly performing the test and not purchasing the test.

We recommend that the language of Section 414.50 exclude from the proposed regulation services that are performed by the PCP as outlined above, even if the technologist is not a full-time employee of the PCP. This clarification may also be accomplished by CMS language indicating that Section 414.50 only applies when the diagnostic service is provided in a centralized building outside of the physician's primary office site where he provides his professional services.

A failure to clarify the language of this proposed regulation to allow for the service as provided by Insight Imaging would have a detrimental impact on patients, physicians and the Medicare Program in the form of: 1) reduced access to lower cost, diagnostic imaging especially for elderly patients and patients in rural areas; 2) increased utilization of higher tech, higher cost fixed-based imaging modalities; 3) reduced quality of imaging where physicians choose to purchase equipment and provide service on their own and are not subject to IDTF standards; and 4) increased potential for greater utilization of imaging where physicians choose to purchase equipment and provide service on their own and where the incentive to cover these larger fixed costs is greater.

B. 42 C.F.R. § 424.80 (d) -Reassignment to an entity under an employer-employee relationship or under a contractual arrangement

We do not believe that we need to address the proposed language of Section 424.80 since it only applies to reassignments of either the Technical Component or Professional Component, as we do not have reassignments in our proposed facts. However, if the proposed regulation revised definition of "entity" ultimately allows global billing of the Professional Component and Technical Component by the PCP for off-site interpretations, then it would seem that the same clarifying language suggested for Section 414.50 -- "...only applies when the diagnostic service is provided in a centralized building outside of the physician's primary office site where he provides his professional services." -- would also be required for Section 424.80.

C. Elimination of Stark "On-Site" Interpretation Requirement

We support CMS' proposed rules changing the definition of "entity" that effectively exempt the purchased or reassigned interpretation from the on-premises requirements of the Stark in-office ancillary services exception. We believe that the addition of the Anti-Markup provisions to the Professional Component are an effective way to prevent any potential program abuse and improves the administration of the billing of reads to allow more efficiency in the provision of service for the provider (no movement of demographic information between physicians), for the patient (one bill), and for the Medicare program (efficiencies resulting from processing a single global bill).

Conclusion – General Comments on Value of Diagnostic Ultrasound

Diagnostic ultrasound is a clinically effective, low cost, low tech imaging modality. High tech imaging which includes CT, MRI, PET and nuclear imaging is on average three (3) times as expensive as ultrasound. Regulations, proposed or otherwise, that limit providers from offering this low cost modality to physicians inherently leads to the use of higher tech/higher cost imaging modalities offered by hospitals or other fixed providers. By way of one example, Insight serves a small rural hospital an hour's drive from Nashville, TN. If it were not for the ultrasound service that Insight offers in this area, the hospital's only imaging alternative was CT, a higher cost modality. There are numerous examples of the value of ultrasound as a cost effective substitute or alternative imaging tool to other higher cost modalities which greatly benefits patients, providers and CMS.

Private commercial insurance companies have begun to institute pre-qualification/pre-verification standards to control the growth in the use of imaging technologies. In most all of the instances currently present in the marketplace, these standards have been directed at high tech imaging. Low tech imaging, and more specifically diagnostic ultrasound, has been excluded from these new rules because the modality is significantly less expensive and offers physicians a first alternative to diagnose pathology that is much more cost effective. We believe that CMS should give serious consideration to avoiding any future rulemaking that would limit physician and patient access to these low tech imaging modalities and would result in greater cost to the Medicare program.

We hope that CMS finds the above commentary to the July 2nd Proposed Regulations helpful and informative. We appreciate the opportunity to comment to insure that the Medicare Program delivers the maximum amount of clinical and financial value to all stakeholders -- patients, providers, physicians, CMS and taxpayers.

Sincerely,

INSIGHT IMAGING, LLC

Randall W. Mountcastle

Randall W. Mountcastle
CFO

Submitter : **Mrs. kara eldridge** **Date: 08/30/2007**

Organization : **Mrs. kara eldridge**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Gregory Macchio** **Date: 08/30/2007**

Organization : **Michiana Anesthesia Care, P.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
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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.

Gregory J. Macchio, MD

Submitter : **Dr. Philip Lebowitz** **Date: 08/30/2007**

Organization : **Montefiore Medical Center**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Philip Lebowitz, MD

Submitter : **Dr. James Bowen** **Date: 08/30/2007**

Organization : **Nash Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter

Submitter : **Mrs. Rachelle McLees** **Date: 08/30/2007**

Organization : **Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Office of the Administrator
Center for Mediere & Medicaid Services
Dcpartment of Health and Human Services
P.O. Box 8018
Baltimorc, 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 thc Centers for Medicare & Medicaid Services proposal to boost the valuc of anesthesia work by 32%. Under CMS' proposed rule Medicare would increase the anesthesia conversion factor by 15% in 2008 compared with current lcvcls.
(72 FR 38122, 7/12/2007) If adopted, CMS' proposal would help to ensure that Certified Registered Nurse Anesthetists as Medicare Part B providers can continue to providc Medicarc beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.
First, as the American Association of Nurse Anesthetists 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, cffcctive Jaqnuary 2007. However, the value of anesthesia 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 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 anestheties 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,

Rachelle Dyess McLees CRNA, MSN, APN
6964 Riverwood Drive
Knoxville, TN 37920

Submitter : Dr. Michael James **Date:** 08/30/2007

Organization : Thoracic Cardiovascular Institute

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

RE: CMS 1385 P; Proposed Physician Fee Schedule and other Part B Payment Policies for CY2008.
Coding additional codes from 5-year review

Dear Mr. Kuhn:

As a physician who provides echocardiography services to Medicare patients and others in the mid Michigan area, I am writing to object to CMS s proposal to bundle Medicare payment for color flow Doppler (CPT Code 93325) into all echocardiography base services. This proposal would discontinue separate Medicare payment for color flow Doppler effective on January 1, 2008, on the grounds that color flow Doppler has become intrinsic to the performance of all echocardiography procedures.

In conjunction with two-dimensional echocardiography, color Doppler typically is used for identifying cardiac malfunction (such as valvular regurgitation and intracardiac shunting), and for quantitating the severity of these lesions. In particular, color Doppler information is critical to the decisionmaking process in patients with suspicion of heart valve disease and appropriate selection of patients for valve surgery or medical management. In addition, color flow Doppler is important in the accurate diagnosis of many other cardiac conditions.

CMS s proposal to bundle (and thereby eliminate payment for) color flow Doppler completely ignores the practice expenses and physician work involved in performance and interpretation of these studies. While color flow Doppler can be performed concurrently or in concert with the imaging component of echocardiographic studies, the performance of color flow Doppler increases the sonographer time and equipment time that are required for a study; in fact, the physician and sonographer time and resources involved have, if anything, increased, as color flow Doppler s role in the evaluation of valve disease and other conditions has become more complex. The sonographer and equipment time and the associated overhead required for the performance of color flow Doppler are not included in the relative value units for any other echocardiography base procedure. Thus, with the stroke of a pen, the CMS proposal simply eliminates Medicare payment for a service that (as CMS itself acknowledges) is important for accurate diagnosis and that is not reimbursed under any other CPT code.

Moreover, CMS is incorrect in assuming that color flow Doppler is intrinsic to the provision of all echocardiography procedures. I understand that data gathered by an independent consultant and submitted by the American College of Cardiology and the American Society of Echocardiography confirm that color flow Doppler is routinely performed in conjunction with CPT code 93307. However, these data, which were previously submitted to CMS, also indicate that an estimated 400,000 color flow Doppler claims each year are provided in conjunction with 10 echocardiography imaging codes other than CPT Code 93307, including fetal echo, transesophageal echo, congenital echo and stress echo. For many of these echocardiography base codes, the proportion of claims that include Doppler color flow approximates or is less than 50%. More recent data submitted by the ASE in response to the Proposed Rule confirms that this practice pattern has not changed over the past several years.

For these reasons, I urge you to refrain from finalizing the proposed bundling of color flow Doppler into other echocardiography procedures, and to work closely with the American Society of Echocardiography to address this issue in a manner that takes into account the very real resources involved in the provision of this important service.

Sincerely yours,

Michael J. James, DO
Thoracic Cardiovascular Institute

Submitter : Christopher Feeney **Date:** 08/30/2007

Organization : Shore Spine & Sport Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1385-P-12231-Attach-1.DOC

#12231

To: CMS

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

RE: **Physician Self-Referral Issues**.

I am a physical therapist in private practice in NJ. I, as a physical therapist, own my own physical therapy clinic. However, I must compete (unfairly) with physician-owned physical therapy clinics. Physician-ownership of physical therapy allows the physicians to refer for profit.

Good medical practice and good business practices are not the same thing. The number one reason physician's own physical therapy clinics is to increase revenue. Under physician ownership, there is tremendous incentive for physicians to abuse Physical Therapy services. This is bad for patients and costs payors.

I strongly support physical therapy services be removed from permitted services under the in-office ancillary exception. This is good for CMS, consumers and independent physical therapy practitioners.

Thank you.

Chris Feeney, PT
Brielle, NJ 08730

Submitter : **Ms. anne rodman** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
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Sincerely,
__ANNE RODMAN, CRNA_____
Name & Credential
__295 e. valley forge rd..
Address
___king of prussia, pa 19406_____
City, State ZIP

Submitter : **Dr. John Preston** **Date: 08/30/2007**

Organization : **The University of Tennessee**

Category : **Other Health Care Provider**

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:

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Sincerely,

John C. Preston, CRNA, DNSc, APN
10065 Delle Meade Drive
Knoxville, TN 37931

Submitter : **Mr. Junji Shinohara** **Date: 08/30/2007**

Organization : **University of Toledo**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an athletic training doctoral student in the University of Toledo. I am also providing athletic service to student athletes in a local Toledo city high school.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care.

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,

Junji Shinohara, MS, ATC, LAT

Submitter : Ms. Judith Cahill **Date:** 08/30/2007

Organization : Academy of Managed Care Pharmacy

Category : Association

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Section 101 of the Medicare Modernization Act (MMA) requires prescription drug plan (PDP) sponsors to establish electronic prescription drug programs to provide for electronic transmittal of certain information to the prescribing provider and dispensing pharmacy and pharmacist. There is no requirement that prescribers or dispensers implement e-prescribing, however, prescribers and dispensers who electronically transmit prescription information for covered drugs for Medicare Part D beneficiaries are required to comply with any applicable final standards that are in effect. 'Computer-generated' faxes fall within the definition of 'electronic media' for e-prescribing, meaning entities transmitting computer-generated faxes are required to comply with all applicable e-prescribing standards. CMS stated in its November 7, 2005 final rule that entities that transmit prescriptions by means of computer-generated facsimile were exempted from the requirement to use the adopted National Council for Prescription Drug Programs (NCPDP) SCRIPT standard - the foundation standard adopted for the exchange of new prescriptions, changes, renewals, cancellations and certain other transactions between prescribers and dispensers. CMS now proposes to eliminate this exemption effective one year after the effective date of the final CY 2008 physician fee schedule.

The Academy supports the removal of the exemption on electronic faxes as one incentive to increase the use of electronic prescribing by prescribers and dispensers. Prescribers who already have the necessary systems in place but have not activated the e-prescribing service should easily be able to implement electronic prescribing using SCRIPT transactions.

AMCP is concerned that those prescribers who do not yet have SCRIPT-compliant systems in place, especially those in small offices and rural practices, may be affected adversely by the financial burden required in converting their practices to electronic prescribing. Our concern is that the cost to purchase new systems and the disruption in workflow that may ensue during training will delay their acquisition of SCRIPT-compliant systems. The Academy believes that the date for eliminating the exemption should be no sooner than April 1, 2009, the date by which the final e-prescribing standards become effective rather than the one year after the final rule becomes effective. This will allow more time to obtain, install and be trained on the SCRIPT-compliant systems.

While the advantages of electronic prescribing are many, including fewer medication errors and reductions in health care costs, in order to speed the transition to full electronic prescribing, additional incentives may need to be provided to both prescribers and dispensers. Such incentives could take the form of additional reimbursement for electronic prescriptions, subsidies for hardware, software and training, etc. In addition to economic incentives, CMS should implement comprehensive, uniform nationwide standards which would apply to electronic prescribing for all prescriptions, not just Medicare Part D. CMS should continue to work with the Drug Enforcement Administration to create standards for electronic prescribing of controlled substances.

CMS-1385-P-12235-Attach-1.PDF

#12235

AMCP Academy of Managed Care Pharmacy

CELEBRATING AMCP'S 20th ANNUAL MEETING
APRIL 16-19, 2008 • MOSCONE WEST CONVENTION CENTER • SAN FRANCISCO, CA •

August 30, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: File Code CMS-1385-P

Dear Sir/Madam:

The Academy of Managed Care Pharmacy (AMCP) is pleased to have the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Medicare Program; Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; Proposed Rule.

AMCP is a national professional association of pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to achieve positive patient outcomes. The Academy's 5,000 members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit.

100 North Pitt Street
Suite 400
Alexandria, VA 22314

800 827 2627 | 703 683 8416
Fax 703 683 8417
www.amcp.org

AMCP Academy of Managed Care Pharmacy

CELEBRATING AMCP'S 20th ANNUAL MEETING
APRIL 16-19, 2008 • MOSCONE WEST CONVENTION CENTER • SAN FRANCISCO, CA •

PROPOSED ELIMINATION OF EXEMPTION FOR COMPUTER-GENERATED FACSIMILIES

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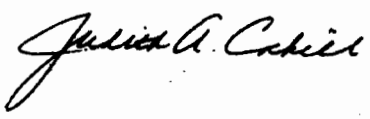
AMCP appreciates the opportunity to comment on the Medicare Program; Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; Proposed Rule. If you have any questions regarding our comments or wish additional information, please contact me at (703) 683-8416 or jcahill@amcp.org.

Sincerely,



Judith A. Cahill
Executive Director

Submitter : Ms. **Date:** 08/30/2007

Organization : Ms.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

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

Dear Mr. Weems,
I am a physical therapist in Middletown, Ohio. I have been practicing for 17 years as an outpatient orthopedic therapist. For the first five years I worked in a private practice that was owned by two physical therapists. Since then I have been employed by Middletown Regional Hospital. I work in the Sports Medicine and Physical Therapy Department.
The purpose of my letter is regarding physician self- referral issues. I wish to comment on the July 12 proposed 2008 physician fee schedule rule, particularly regarding the issue surrounding physician self- referral and in office ancillary services exception.
I have experienced first hand how abusive physician self referral can be. As stated above, I have been with the hospital for the last 12 years. My previous boss, a PT, left our practice to start a private practice in Middletown that is physician owned by a local orthopedic surgeon group. Initially our referrals from this group of doctors dropped from 70% to 10%. Our practice was in jeopardy for several years. We have survived due to caring, hardworking PT s and PTA s who have the patients well-being, function, and goals in mind at all times.
Also, we know from patient reports that the physicians and their support staff push their patients to attend therapy at their clinic. Patients share direct quote statements from them such as, Here is a prescription for our therapy clinic. You need to go there. You will get the best care there . This will happen even if it is a previous patient of ours who wants to return to our clinic. It is the patient's choice to attend therapy where they wish to. If the patient does not demand to go elsewhere for PT, they end up in the physician s clinic. This often occurs with the elderly population because they do not question the doctor, thinking the doctor knows best .
We also have had multiple reports from patients that they are not happy with the PT care they receive there. They have too many patients at one time. They do not receive individualized care. They are left on their own to do exercise. They are treated by an aide, not a licensed individual. The average treatment time is 2-3 hours for what should take one hour maximum. To sum it up, they feel like a number.

These comments reinforce to me that physician owned PT practices are unethical and have strong potential for fraud and abuse of the patients. I believe the bottom line for these practices is money. Both the physicians and physical therapists are lining their pockets. But what about the well being of the patient and where is the quality of care? It is not a concern for these types of practices.
The in-office ancillary services exception has created a loophole that allows physician owned PT practices to thrive. Physical therapists are supposed to be autonomous healthcare professionals, musculo-skeletal experts. We do not need direct physician supervision to administer PT services. It is detrimental for our profession, but more importantly the patient is not receiving the care they deserve.
In closing, thank you for your attention to this matter. Please help stop fraudulent abuse of our Medicare system. I can be reached at our Middletown location if you have any questions

Sincerely,

Margo E. Cox

CMS-1385-P-12236-Attach-1.TXT

#12236

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

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

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I have experienced first hand how abusive physician self referral can be. As stated above, I have been with the hospital for the last 12 years. My previous boss, a PT, left our practice to start a "private practice" in Middletown that is physician owned by a local orthopedic surgeon group. Initially our referrals from this group of doctors dropped from 70% to 10%. Our practice was in jeopardy for several years. We have survived due to caring, hardworking PT's and PTA's who have the patients' well-being, function, and goals in mind at all times.

Also, we know from patient reports that the physicians and their support staff push their patients to attend therapy at their clinic. Patients share direct quote statements from them such as, "Here is a prescription for our therapy clinic. You need to go there. You will get the best care there". This will happen even if it is a previous patient of ours who wants to return to our clinic. It is the patient's choice to attend therapy where they wish to. If the patient does not demand to go elsewhere for PT, they end up in the physician's clinic. This often occurs with the elderly population because they do not question the doctor, thinking "the doctor knows best".

We also have had multiple reports from patients that they are not happy with the PT care they receive there. They have too many patients at one time. They do not receive individualized care. They are left on their own to do exercise. They are treated

by an aide, not a licensed individual. The average treatment time is 2-3 hours for what should take one hour maximum. To sum it up, they feel like a number.

These comments reinforce to me that physician owned PT practices are unethical and have strong potential for fraud and abuse of the patients. I believe the bottom line for these practices is money. Both the physicians and physical therapists are lining their pockets. But what about the well being of the patient and where is the quality of care? It is not a concern for these types of practices.

The "in-office ancillary services" exception has created a loophole that allows physician owned PT practices to thrive. Physical therapists are supposed to be autonomous healthcare professionals, musculo-skeletal experts. We do not need direct physician supervision to administer PT services. It is detrimental for our profession, but more importantly the patient is not receiving the care they deserve.

In closing, thank you for your attention to this matter. Please help stop fraudulent abuse of our Medicare system. I can be reached at our Middletown location if you have any questions

Sincerely,

Margo E. Cox

Submitter : **Mr. Jason Schwartz** **Date: 08/30/2007**

Organization : **Middletown Regional Hospital**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist manager in a community hospital. I have spent my entire career with the same hospital (6 years). The practice arena has changed significantly in the past 6 years as competition has significantly increased in our area. Unfortunately, much of this competition has eliminated fair competition and a choice for patients in regards to their physical therapy treatment.

The purpose of this letter is to document some personal Physician Self-Referral Issues as it relates to the practice of physical therapy in my area. In the Cincinnati area, nearly all orthopaedic surgery groups own their own physical therapy practice. This is wrong for patient care for a variety of reasons, a few of which I would like to outline. The potential for abuse is great with over utilization of services to generate a profit for the physicians. The main advantage for the physicians is purely monetary. It completely eliminates choice for patients as they are not aware they can attend physical therapy at a clinic of their choice. Patients often go where they are told even if the information their physician provides them is not accurate. Most, if not all of these Physicians do not disclose to the patients the fact that they have a financial interest in the physical therapy clinic. Therefore, patients are not given a choice regarding their care and eliminating competition. Patients will not choose a physical therapist based on skill, expertise, experience, etc, but based purely on where the physician recommends and in many cases insists they attend.

For this reason, there needs to be specific mention of physical therapy not being included under the list of Designated Health Services (DHS) furnished under the in-office ancillary services exception.

The original intent of the in-office ancillary services exception was to include services that could be provided in a physician s office that might not otherwise be provided, such as a primary care physician with a practice in a rural area. The very liberal interpretation of this exception has allowed the spread of Physician Owned Physical Therapy Services (POPTS) throughout the United States and in Southwest Ohio. Due to the repetitive nature of physical therapy services, it is no more convenient to provide physical therapy within a physician s office than a private clinic or a hospital-based outpatient clinic.

It has been my personal experience that patients are also referred to the hospital environment for physical therapy services that have less desirable Medicare or Medicaid HMOs. It is a shame that patients are chosen by these POPTS groups based on their financial status and not based on need for services.

Thank you for your time and consideration,

Jason Schwartz PT, MPT, MBA, CSCS
Site Coordinator
Middletown Regional Hospital
Sports Medicine and Physical Therapy
(513) 420-5014
jason.schwartz@middletownhospital.org

CMS-1385-P-12237-Attach-1.DOC

12237

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : Dr. SHIVA SALE **Date:** 08/30/2007

Organization : CCF

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

#12238

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mrs. Sarah Johnstone** **Date: 08/30/2007**

Organization : **Middlebury Union High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12239-Attach-1.DOC

12239

Dear Sir or Madam:

I am a certified athletic trainer working in the Addison County Supervisory Union for Middlebury Union High School in Vermont. I am responsible for the prevention, management, and reahbilitation of all injuries and illnesses sustained by our student athletes; and the resulting administrative duties. I received my B.S. in Kinesiology: Athletic Training from the University of New Hampshire in 2005. I am nationally certified and licensed by my state's department of professional regulations.

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,

Sarah Johnstone, ATC

Submitter : Mr. Matthew Smith **Date:** 08/30/2007

Organization : University of South Florida

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Matthew Smith. I graduated from The University of Alabama and I am now working a Graduate assistantship with the University of South Florida Track and Field and Football team. I am going to receive a masters in exercise science in May of 2009. I am a member of NATA and I am a certified athletic trainer. 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,

Matthew Smith, ATC/LAT

Submitter : **Dr. John McAuliffe** **Date: 08/30/2007**

Organization : **Nash Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Sharon Tiefenbrunn MD FAAD **Date:** 08/30/2007

Organization : The American Society for Mohs Surgery

Category : Health Care Professional or Association

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

The American Society for Mohs Surgery would like to express its concern with the change to the MMPR for the Mohs codes, 17311 and 17313. Our letter is attached.

CMS-1385-P-12242-Attach-1.TXT

#12242

August 29, 2007

The Honorable Herbert Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Washington, DC 20201
Phone: 202-690-6726
E-mail: herb.kuhn@cms.hhs.gov

Re: CMS 1385-P: 2008 Medicare Fee Schedule
Coding - Multiple Procedure Reduction Rule for Mohs Surgery

Dear Acting Administrator Kuhn:

As President of the American Society for Mohs Surgery, a medical specialty organization representing over 850 Mohs Surgeons, I would like to thank you for the opportunity to comment on the proposed change in the exempt status of Mohs surgery codes 17311 and 17313 from the Multiple Procedure Reduction Rule (MPRR). We are concerned that the proposed rule would represent a significant reversal of CMS's own longstanding exemption of the Mohs codes from the MPRR. This change would result in increased medical costs, increased recurrences of skin cancer, and increased complications following surgery.

Legal and procedural issues regarding Mohs Surgery and the proposed change in the MPRR have been addressed in a joint letter from the American Academy of Dermatology, American Society for Dermatologic Surgery, American College of Mohs Surgery, and the American Society for Mohs Surgery. I understand that a face to face meeting with representatives from these societies is scheduled. The purpose of this communication is to discuss the impact that the proposed rule would have on the treatment of skin cancer, and the resulting increased costs, patient inconvenience, and reversal of prior gains in cure rates and quality measures that would occur.

Exemption of Mohs from the MPRR since 1991 has resulted in an evolution of skin cancer care that has had positive impact on patient outcomes and cost effectiveness. The past 16 years have seen higher cure rates, fewer complications, better functional outcomes, and movement of services out of the O.R. to the physician's office or other outpatient setting, resulting in significant cost savings. Instead of having a skin cancer widely excised in the O.R. under general anesthesia and a skin graft placed, resulting in disfigurement, loss of function and an increased risk of complications, patients are treated by dermatologists who have acquired skills in accurate, margin-controlled excision (MOHS), with a cure rate of 96% to 99%, followed, usually on the same day, with a flap, linear repair, or graft. Dermatologists have enthusiastically acquired great expertise in both Mohs Surgery and the flaps required to achieve the best possible outcome to the surgical cure of skin cancer. This has been enabled by the MPRR exemption for Mohs that has allowed full payment for Mohs and repair of the first lesion on the same day.

The reversal of this rule may encourage separation of the services of extirpation and repair, moving reconstruction back into the hands of other surgical specialists who are accustomed to using general anesthesia and the O.R. to perform their cases. This would result, not in the cost savings anticipated, but would have the opposite effect, a significant increase in costs. It would also cause inconvenience to our patients, loss of time from work, increased postoperative complications from delay in repair of the Mohs-created surgical defect, and increased risks of general anesthesia and hospital acquired infections.

CMS has suggested that there are efficiencies in performing Mohs surgery on two lesions on the same day. This issue was addressed in 1991, at which time CMS concluded that Mohs surgeries are clearly separate procedures in a series of procedures. In 2006 Mohs codes were changed to 17311 and 17313 to reflect Mohs Surgery performed at different anatomic sites. The technical requirements of the procedure, however, remained the same as the 17304 procedure. Since a large part of the Mohs procedure itself involves pathology services, viz. mapping, creating frozen sections, and interpreting them, and as these pathology services must be performed separately for each separate Mohs case (each separate lesion) , treatment of two lesions on the same patient on the same day results in procedures that are largely separate. Pre- and post- service work is a minimal component of the Mohs procedure. Therefore, the second Mohs procedure performed on the same day should be exempt from the MPRR.

The July 2004 CPT Assistant article also reviewed the rationale behind the MPRR exemption: "The rationale for this policy is that for many surgical procedures some of the work of a procedure is not repeated when two or more procedures are performed. For these procedures the intraservice work is only 50% of the total work, while the other 50% represents pre- and post-service work that overlaps when multiple procedures are performed on the same patient on the same date of service. For Mohs surgery, however, greater than 80% of the work is intraservice work that does not overlap when two or more procedures are performed. The pathology portion of Mohs surgery constitutes a large portion of this total and also is not reduced with multiple procedures. The pre-service and post-service work values are small because there is a zero-day global period. Together there is very little overlap or reduction in work when two or more tumors are treated on the same patient on the same day. Therefore, Mohs surgery codes are exempt from the use of modifier 51."

Mohs and the first repair also are distinct and separate procedures. The surgeon achieves very few efficiencies by doing these on the same day. The Mohs procedure must be completed in its entirety before the repair is begun. This requires the surgeon to wait while the frozen tissue sections are being prepared before he can read the sections, determine if the tumor has been cleared, and then begin the repair. Repair requires re-rooming of the patient, repositioning of the patient, re-prepping, re-draping, re-anesthetizing and, in most cases, opening a new pack of sterilized surgical instruments for the repair.

Mohs surgery has been proven to be a cost-effective treatment for skin cancer. The payment policies that have been in place for the past 16 years have resulted in an evolution of excellence in the treatment of skin cancer. Rising costs reflect an epidemic of skin cancer in an aging population; the cost of care does not reflect lack of value. As the epidemic of skin cancer expands, we hope CMS will maintain economic policies that promote excellent, convenient, and cost efficient care which will benefit our patients and our nation as a whole.

In closing, I wish to thank you again for the opportunity to comment on an issue that is critically important to our members and the over 1 million patients with skin cancer whom we serve. Should you require additional information, please do not hesitate to contact Novella Rodgers at execdirasms@aim.com. I appreciate your attention to this important matter.

`Sincerely,

Sharon F. Tiefenbrunn, M.D.
President
cc : Terrence Kay, Director, Hospital and Ambulatory Policy Group, Centers for Medicare and Medicaid Services
Amy Bassano, Director, Practitioner Services Division, Centers for Medicare and Medicaid Services
Diane Baker, MD, President, American Academy of Dermatology
David G. Brodland, MD, President, American College of Mohs Surgery
Allistaire Carruthers, M.D, President, American Society for Dermatologic Surgery

Volume 39, Issue 5, Pages 698-703 (November 1998)Top of Form

Bottom of Form
Mohs micrographic surgery: A cost analysis????
Top of Form
Joel Cook, MDa, John A. Zitelli, MDb
Bottom of Form
Accepted 20 July 1998
Abstract
Background: The incidence of skin cancer is increasing significantly, and many people have declared the increase an epidemic. It was estimated that 900,000 to 1.2 million cases of nonmelanoma skin cancer occurred in the United States in 1994. With increasing pressure to deliver cost-effective medical care, physicians must understand the cost and value of the various methods to treat skin cancer. Objective: Our purpose was to define the true cost of treating a series of skin cancers with the Mohs micrographic technique and compare our costs with calculated estimates of the costs to treat the same cancers with traditional methods of surgical excision. Methods: A group of 400 consecutive tumors was selected. The cost of treatment in the reference group included diagnosis, Mohs micrographic surgery, reconstruction (if applicable), follow-up, and the cost to treat disease recurrence. These costs were then compared with traditional methods of surgical excision: excision with permanent section margin control, excision with frozen section margin control, and excision with frozen section margin control in an ambulatory surgical facility. For cost comparisons, it was assumed that all tumors in the comparison groups would be excised with standard surgical margins and the resultant surgical defects would be reconstructed with the simplest method possible. The costs of diagnosis, excision, pathology, reconstruction, and the cost to treat disease recurrence were then calculated and compared with the costs of treating the lesions with Mohs micrographic surgery. Results: Our calculation of costs documents that Mohs micrographic surgery is similar in cost to office-based traditional surgical excision and less expensive than ambulatory surgical facility-based surgical excision. The average cost of Mohs micrographic surgery was $1243 versus $1167 for excision with permanent section margin control, $1400 for excision in the office with frozen section margin control, and $1973 for excision with frozen section margin control in an ambulatory surgical facility. Analysis based on

anatomic location yielded similar results. Conclusion: Mohs micrographic surgery is a method of surgical excision with high intrinsic value that is cost-effective in comparison to traditional surgical excision. (J Am Acad Dermatol 1998;39:698-703.)

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I am an advocate AGAINST physician owned physical therapy services. They are constructed as revenue makers for physicians. These businesses are not in the best interest of the patient. I have witnessed poor quality of care in these systems. They are detrimental toward the autonomy practice of the physical therapy profession. I ask that the stark laws be amended to end the practice of physician owned physical therapy services.

Submitter : **Dr. Matthew Morgan** **Date: 08/30/2007**

Organization : **None**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.

Very Sincerely,

Matthew Morgan, M.D.

Submitter : **Dr. John McAuliffe** **Date: 08/30/2007**

Organization : **Nash Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,

Name & Credential
_Stephen G. Stupik CRNA_____
Address
_184 Millham St. Marlboro, MA 01752_____
City, State ZIP

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am currently a physical therapist in an outpatient orthopaedic clinic in central Ohio. I have been practicing as a licensed therapist for the past 5 years, all of which has taken place in similar outpatient settings. Over the course of my practice, I have become familiar with many of the physicians in this region, as well as other physical therapy practices and referral patterns. For this reason, I am writing to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception.

I strongly support the removal of physical therapy from the permitted services under the in-office ancillary exception, due to the potential for fraud and abuse to occur within physician-owned physical therapy clinics. Physicians in these practices have an obvious financial incentive to refer patients to the practice in which they have ownership, and to overutilize those services for their financial gain. One example of this arrangement I have witnessed in this area is a large orthopedic physician group that for a number of years has leased space within the building that they own to a separate physical therapy corporation. Many patients were referred to this corporation in the past; recently, however, this physician group opened their own physical therapy practice under the central location exception directly across the street. Now, they refer all of their patients to their own clinic. Realistically, although patients are aware of the other options, they have chosen the physician that they believe will provide them the best care. So naturally, they will also want to choose the physical therapy clinic that comes most recommended by this same physician. In addition, the fact that Medicare requires a physician referral in order for beneficiaries to receive services only adds to this situation.

A significant problem is the potential for patients to receive substandard care by only pursuing treatment from the physician-owned therapy clinic. For example, there may be a therapist across the street who specializes in treatment for the spine, and has extensive experience in this area, while the therapists in the physician-owned practice specialize only in injuries of the extremities, or even more likely, are new grads. The physician will still be incentivized to send this patient to his own clinic, rather than to someone else who could provide the best possible treatment.

Another point to mention is the potential for physician-owned practices to use unlicensed personnel, or non-physical therapist personnel, and still bill under physical therapy codes. This situation most certainly leads to substandard care, as well as a need for prolonged services when the patient does not improve as quickly as they would under the care of an actual physical therapist. The tendency for overutilization of services by these practices only adds to the more national problem of rising healthcare costs.

Thank you very much for considering my comments on this issue.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems 08/30/07
Administrator- Designate
Centers for Medicare and Medicaid Services
Attention: CMS- 1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

Dear Mr. Weems,
I have been practicing outpatient physical therapy in Ohio for nine years. Also filling in as needed in other treatment settings for both my current employer and other health care systems in southwestern Ohio. I am presently employed by Middletown Regional Hospital (MRH) and have been for the last six years
The purpose of my letter is regarding physician self- referral issues. I wish to comment on the July 12 proposed 2008 physician fee schedule rule, particularly regarding the issue surrounding physician self- referral and in office ancillary services exception.
Middletown is rather small, with limited options in specialty medical services. Prior to my joining the staff at MRH a large portion of our referrals (66%) came from the orthopedic group in town. The manager of our department at the time partnered with this group and subsequently referrals have declined to 16% (2007 thus far).I have heard from patients who have come to our department after attending therapy at our competition that the personalized care they receive in our clinic is a welcome change from the lack of attention/aide directed service our competition offers.
Though patients should be permitted to seek care where they desire, I have heard from my patients that physicians in the orthopedic practice mentioned above have instructed them to attend therapy at their affiliated clinic even after they have expressed a desire to come to our establishment due to both prior good experiences and being employed by the hospital (with better insurance coverage at our location)!
Secondarily, I have had the opportunity to work in Cincinnati on a PRN basis with one of the large orthopedic groups via a contract health care company. I was surprised at what I would consider abusive numbers of therapy sessions. Where as I might see an average knee scope between 6 and 10 sessions, patients were being seen 2-3 times a week for 3-4 months routinely at this location! Privately, therapists employed by this group let me know they were strongly encouraged to maintain a number of units per patient as well as keep patients in therapy as long as possible. Schedules were over booked in order to bill as many units as possible with little regard for personalized care.

Both of these experiences have led me to believe that physician owned PT practices are unethical and have strong potential for fraud and abuse of the patients. I believe the bottom line for these practices is money, both for the physician owners and kickbacks for therapists to encourage billing more units.
Care for the patients both medically and financially has been obviously lacking in both of these examples.
The in-office ancillary services exception has created a loophole that allows physician owned PT practices to thrive. Where as ancillary services such as x-ray or lab work may be appropriate and provide quicker and cheaper care, allowing physical therapy to fall under this exemption is in my experience not only inappropriate but has the potential to decrease patient care and increase costs.
In closing, thank you for your attention to this matter. Please help stop fraudulent abuse of our Medicare system. I can be reached at our Middletown location if you have any questions

Sincerely,

Stephen I. Woodward

Submitter : Mrs. Lou Ann Mayfield **Date:** 08/30/2007

Organization : AANA

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
_Lou Ann Mayfield,CRNA
Name & Credential
5434 Marina Club Drive_____
Address
_Wilmington,N.C. 28409_____
City, State ZIP

Submitter : Ms. **Date:** 08/30/2007

Organization : Ms.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist in private practice in Kentucky. I have been in private practice for the past 15 years. In these 15 years I have seen the negative effects that allowing physical therapy to bc a designated health service (DHS) under the in-office ancillary services exception have had on the profession, patients rights to choose, and care.

I have witnessed private practice closings, in part due to the inability to 'compete' for patients who are refered only to the in-office services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. I have seen a decline in referrals from long term sources once a physician owned practice was established upward to 90-95 percent. I have experienced in the home health setting, when homebound status no longer applies and the patient needs to transition to an outpatient facility, a prohibition of the patient going anywhere but the physician office for these services. This in irregardless of convenience or choice of the patient. By eliminating physical therapy as a DHS furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutilization of physical therapy services, enhance the quality of care and provide a level playing field for which providers can operate and maintain their business.

Thank you for this opportunity to comment.

Sincerely,

Rebecca Rebitski P.T.

Submitter : **Mr. John Anderson** **Date: 08/30/2007**

Organization : **Milwaukee Bucks**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is John Anderson. I am the Assistant Athletic Trainer/Assistant Strength and Conditioning Coach for the Milwaukee Bucks of the National Basketball Association. I received my undergradate degree from Arizona State University and my masters degree from the University of Oregon. I have certifications from the National Athletic Trainers Association, National Strength and Conditioning Association, and National Academy of Sports Medicine.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

John J. Anderson, MS, ATC, CSCS, PES, CES

Submitter : **Dr. Michael Nestor** **Date: 08/30/2007**

Organization : **Ashland Anesthesia, PSC**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I strongly support the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. This isn't a selfish request on my part, as my contract with the hospital where I practice helps with financial supplements to the anesthesia budget. But I'm concerned about the overall anesthesia services stability nationwide, for current patient access to medical care, and this will include concern for myself as a future Medicare patient, since I'll retire in about 4-5 years.

The current payment of $16.19 per unit for anesthesia services is too low to cover the cost of employment of anesthesia personnel without hospital supplementation of income. This situation arises anywhere there is a high proportion of government payors, which is common in small rural hospitals, as well as in large university centers and "county" hospitals. These are the hospitals that can least afford to supplement the anesthesia budget, a supplementation that can be in the range of 1-2 million dollars per year, that is, up to 30-40% of the anesthesia yearly budget in some cases. This is a contributor to a shortage of anesthesia providers in smaller, more remote hospitals, leading to the recruiting of even more expensive locum tenens (temp help) providers.

Twenty years ago the Medicare payment for anesthesia was about $22.00 per unit, and since then the employed CRNA income demands have quadrupled, which has become a major contributor to the anesthesia budget deficit.

To insure that patients have continued 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 of about $4.00 per unit, offsetting a calculated 32% work undervaluation, as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Ms. Carolyn Zollar **Date:** 08/30/2007

Organization : American Medical Rehabiliation Providers Assoc

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

These comments are submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA). AMRPA is the national voluntary trade association which represents over 550 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and a number of outpatient rehabilitation service providers. Many, if not most, of our members provide outpatient therapy services either through the outpatient departments of hospitals or though outpatient clinics, Comprehensive Outpatient Rehabilitation Facilities (CORFs), or rehabilitation agencies. We have reviewed the proposed rule in-depth and our comments follow.

CMS-1385-P-12253-Attach-1.PDF

#12253

Kathleen Yosko, MS, MBA
President and CEO
Marianjoy Rehabilitation Hospital
AMRPA Chairman of the Board

American Medical Rehabilitation Providers Association

August 29, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

cc: 445-G Hubert H. Humphrey Building
200 Independence Ave. S.W.
Washington, DC 20201

Delivered by Courier and Electronically

Ref: CMS –1385-P, 72 F. R. 133, July 12, 2007 - Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Ms. Norwalk:

These comments are submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA). AMRPA is the national voluntary trade association which represents over 550 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and a number of outpatient rehabilitation service providers. Many, if not most, of our members provide outpatient therapy services either through the outpatient departments of hospitals or though outpatient clinics, Comprehensive Outpatient Rehabilitation Facilities (CORFs), or rehabilitation agencies. We have reviewed the proposed rule in-depth and our comments follow.

A. TRHCA—SECTION 101(b): — PQRI, pg 38197

The Tax Reform and Health Care Act of 2006 (TRHCA) created the Physician Quality Reporting Initiative (PQRI) under which eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services. The Act also directed CMS to publish proposed measures that would be appropriate for eligible professionals to use to

submit data on the quality of covered professional services furnished to Medicare beneficiaries in 2008. In addition, these measures must have been endorsed or adopted by the National Quality Forum (NQF) and the AQA Alliance (AQA). Eligible professionals include physical therapists (PTs), occupational therapists (OTs), and speech language pathologists (SLPs).

The rule proposes measures from seven categories for inclusion in the 2008 Physician Quality Reporting Initiative (PQRI). The proposed rule would also retain some of the 2007 PQRI measures to the extent that they have been NQF endorsed.

1. **Addressing a Mechanism for Submission of Data on Quality Measures Via a Medical Registry or Electronic Health Record, pg 38203**
   The rule proposes the use of registries which professionals would use to report data to CMS in 2008 and discusses 5 different registry options that the agency plans to explore in 2008. CMS stated in the rule that it will test one or more of these options in 2008. CMS does not discuss nor propose a way to allow professionals who are paid by FIs (such as professionals in hospital outpatient departments, SNFs, and CORFs) to participate in the PQRI. AMRPA is concerned that CMS has not addressed this issue, thereby denying the many PTs, OTs, and SLPs who practice in these settings an opportunity to receive the bonus payment. We do not believe the TRHCA statute or history intended to exclude these professionals. CMS did not make provision for payment of these professionals who practice in these settings for July 1, 2007 to December 31, 2007 either. AMRPA recommends that CMS remedy this problem in this rule.

   Comments and Recommendation
   There are two ways this problem may be resolved. One option is that all eligible professionals would report their quality measures to the providers in which they practice using their National Provider Identifier. The providers would serve as registry and be responsible for verifying that the professionals meet the reporting requirements specified by CMS.

   Under a second option, we recommend that eligible professionals, PTs, OTs, SLPs, that report to the registries also provide the provider number for the hospital, SNF, or CORF, or wherever they practice. The registry must therefore be built to accept provider numbers as well as other data items. Once the registry information is reviewed and approved, payment can be approved and it can be sent to the provider. Or, the registry would forward the approved information directly to the fiscal intermediary for that provider, which will then send payment to the provider. We would be willing to work with CMS further on these issues.

B. Therapy Standards and Requirements, pg 38191
The rule would also require that persons furnishing physical and occupational therapy and speech language pathology services (PT, OT, SLP) to beneficiaries meet licensing, registration, and certification requirements in the state in which they practice, and that they complete an approved educational program for the services they are furnishing. It proposes, as well, to grandfather certain therapists and assistants with comparable

education and training and then requires that therapists who begin their practice after January 1, 2008 be licensed, certified, registered, or otherwise regulated as a type of therapist to be recognized by Medicare.

The proposed rule would also apply these new personnel qualifications to the inpatient rehabilitation hospital setting, among others. Specifically, it would cross reference the personnel qualifications for therapists in 42 CFR 484.4 (personnel qualifications) as updated by the proposed rule to the Medicare Condition of participation for Hospitals, Subpart D, Section 482.56 Condition of participation: Rehabilitation Services, as well as amend other regulations.

In addition, it proposes to clarify that hospitals' plans of care include physical therapy, occupational therapy, and speech language pathology plans of treatment. Specifically, according to the preamble to the proposed rule, it would require inpatient hospital services to include a plan of treatment consistent with the plan required for outpatient therapy services under Part B as part of the amendments to the Condition of participation referenced above, as well as other regulations. The physician review and certification of the therapy plan "is implied in the physician review and approval of a facility plan that includes therapy services." The rule also proposes to change the outpatient therapy certification requirements from 30 days to not to exceed 90 days, subject to several conditions.

Comments and Recommendations

1. ***Personnel Qualifications***
   Generally, we support the personnel qualifications as proposed and in applying them to the rehabilitation hospitals and units. However, we are concerned that there is no mention of the state practice acts. We are assuming that references to "licensed" would mean licensed pursuant to the state practice acts and that the services that constitute therapy services delineated therein would be incorporated by reference.

2. ***Application to Rehabilitation Hospitals and Units***
   In applying the proposed personnel qualifications to rehabilitation hospitals and units, we recommend that the proposal be amended, as stated above, to recognize the scope of state practice acts and all the services recognized as within the scope of skilled therapy services.

3. ***Application of Part B Therapy Services' Plan of Treatment Requirement to Inpatient Rehabilitation Hospitals and Units***
   Regarding plans of treatment, we examined 42 CFR 410.61 and the Medicare Benefits Policy Manual Section 220.1.2, Plans of Care for Outpatient Physical Therapy, Occupational Therapy, and Speech Language Pathology Services. It is unclear per the proposed rule which Part B requirements the hospitals and units would have to meet. We compared these to the IRF Exclusion Criteria 42 CFR 412.23 (b)(6) and the Medicare Benefit Policy Manual Section 110 regarding Inpatient Hospital Rehabilitation Care.
   The process of care in the inpatient setting is different from the outpatient setting in that patients are in a different stage of recovery regarding medical and functional

needs. Hence the scope, duration, and frequency of therapy services will differ. Inpatient rehabilitation hospitals and units traditionally provide an interdisciplinary plan of care which includes rehabilitation medicine, nursing, and other services and incorporates the three therapy services in the overall plan. Any additional paperwork implicit in a discipline specific plan of care in addition to an interdisciplinary plan and progress report is redundant and contrary to an interdisciplinary inpatient rehab approach to care We recommend that if there are any conflicts between any Part B policies on plan of treatment for therapy services with Part A requirements that the Part A requirements have precedent. These would include for example:

- Certification of the policy which is recognized in the proposed rule.
- Recertification
- Treatment began before the plan of care is in writing performed only by or supervised by the assessing therapists (MBPM Section 220.1.2)
- No requirements regarding timed codes, treatment time minutes due to different requirements (MBPM Section 220.1.2)
- Duration of weeks for plan of care stated in terms of weeks or visits when inpatients usually stay for shorter periods, possibly less than a week.
- Completion of additional forms: The plan of care is part of the chart under Part A. We understand that under Part B therapists have to complete a form 700. We do not support nor recommend that additional paperwork requirements be included in this proposal.
- We also recommend that the regulation be clear that any plan of treatment for therapy services can be integrated (as it is now) in the over plan of care created for every IRF inpatient.

Therefore, we recommend that 42 C.F.R. 482-56(b)(2) proposal be amended as follows:
"Such plan of treatment may be included in an overall plan of care for the patient. **The physical therapy, occupational therapy, or speech language pathology must be in accordance with a written plan of treatment that meets the requirement of paragraph (b)(3)(i) through (b)(3)(iv) of this section."**

4. ***Other Comments: " Incident to Services"***
We are concerned that as CMS is seeking to make certain personnel qualifications applicable in multiple settings that it also addresses the issue of delivery of services "incident to" physician services. We recommend that similar requirements be provided by appropriately licensed, registered, or certified individuals.

C. CORF Issues, pg 38171

The rule will also make extensive changes in the CORF Conditions of Participation which include:

1. Adding a new subpart to reflect changes in CORF payment methodology,
2. Requiring services to relate directly to the patient's rehabilitation plan of care,
3. Removing coverage for drugs and biologicals,
4. Revising the definition of physician services, respiratory services, social services, psychological services and nursing services,
5. Revising the definition of supplies, equipment and appliances, and

6. Paying for services in the home where payment is not otherwise paid for under the home health benefit.

Comments and Recommendations

1. Outpatient Therapy Certification Requirements (pg 38193). We recommend that the proposed change in certification requirements (from 30 days to 90 days) should also apply to CORFs. The proposed rule excludes CORFs from the settings affected by the change in certification requirements despite CMS's stated position that "therapy services should be provided according to the same standards and policies in all settings,"

   According to CMS, adjusting the first CORF recertification interval from 60 to 90 days would allow the physician to approve a plan of care that represents the clinically appropriate length of treatment, discourage routine 60-day plans, encourage professional determination of an appropriate length of treatment at the time of the initial certification, reduce the administrative burden on providers, suppliers, physicians, and Medicare contractors, and provide an appropriate timeline for monitoring the necessity of continuing therapy services.

   Therefore, we recommend that CMS amend 42 C.R.F. 424.27 so that recertification must occur every 90 days after beginning treatment in a CORF.

2. Changes in CORF Services
   We have several recommendations about a number of the CORF proposals. We believe the proposals to curtail payment for drugs and biologicals, revise the definition of social and psychological services, and revise the definition of supplies, equipment, and appliances are contrary to the CORF statute. We do not support the proposed rule in that the statute is clear that CORF services are to mirror those services available under the inpatient hospital benefit. We also do not support the change of grouping psychological and social services. We do however support the proposal regarding payment for CORF services in the home. These issues are discussed in greater detail below.

   Specifically,

   a. Drugs and Biologicals (pg 38175). We disagree with CMS's proposal to remove drugs and biologicals as a CORF service. When enacting the original CORF legislation, Congress intended to create a new type of outpatient facility that could provide all of the services required by a patient in a coordinated fashion. The patient's ability to obtain all rehabilitation services at a CORF was intended to provide patients an alternative to the difficulty of obtaining the same comprehensive set of services from multiple providers, in a coordinated fashion. By law, these services are designated as CORF services and CMS does not have authority to eliminate these services via the rule making process. CMS's concern over its inability to detect any duplicative billing is not cause for the agency to, in effect, rewrite the law and remove drugs and biologicals from the scope of CORF services. We urge CMS to find an alternative strategy to achieve its objectives without removing coverage of this longstanding benefit.

b. Payment for CORF Services (pg 38176). We believe that CMS should separately pay CORFs for CORF physician services.

Prior to 1999, CORFs were reimbursed for the cost of CORF physician services as a result of the cost-based payment methodology. Specifically, medical director costs and other costs associated with CORF physician services were included on the facility cost report and CORF payments were based on those costs. However, with introduction of the new payment methodology in 1999 CORFs were no longer reimbursed for CORF physician services even though these services are required by statute and CMS regulations. The non-facility PFS payments for CORF services (i.e., physical therapy, occupational therapy, SLP, respiratory therapy, nursing and social/psychological services) fail to fairly compensate the CORF for services provided by a CORF physician that are administrative in nature or otherwise involve the coordination of each patient's comprehensive plan of care, such as consultation with and medical supervision of non-physician staff, patient case review conferences, utilization review, and the review of the therapy plan of treatment.

CMS's position that the "administrative costs associated with the provision of [CORF physician services] are incorporated into payment amounts established under the PFS through the PE RVUs" is inaccurate. Although these payment levels may be defensible for physician office settings and other non-facility settings, they are inappropriately low for the CORF setting where by law the level of required administrative physician activity (i.e., CORF physician services) is greater than in a physician office. In essence, CMS is proposing to reimburse a CORF as if it were equivalent to a physician office, completely ignoring the costs associated with operating as the specialized facility clearly envisioned by Congress. Since there is no facility payment for these services, we urge CMS to develop appropriate codes with associated fees (similar to G0128, the code used for covered nursing services provided in a CORF setting) for required CORF physician services.

We will be happy to meet with CMS to discuss any of the above comments. If you have any questions about these recommendations, please contact Carolyn Zollar at czollar@13x.com or 202-223-1920.

Sincerely

Joseph P. Caroselli

Joe Caroselli
Chairman
AMRPA Outpatient Rehabilitation Services Task Force

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12254-Attach-1.DOC

#12254

September 13, 2007

Re: Stark III Proposal

Mr. Donald H Romano:

Over the past five years as a medical sales representative, I have witnessed unethical business conduct due to physician ownership in surgical laser devices.

Surgical lasers have become a large avenue in which the "per click" concept applies. It has been my experience that when a physician purchases a laser asset solely or enters into a joint venture partnership to supply laser rental services within a hospital setting the patient is not given all adequate information on the different types of treatments available, hospitals pay higher rates and equipment is sub-par or below industry standards.

Unfortunately, patients and hospitals are caught in the middle therefore unable to receive services for surgical lasers at fair market value. Fewer RFP's (Request for proposal) are seen in the market place today because hospitals are being forced to lease from the physician owned L.L.C... If a hospital chooses not to use a physician owned L.L.C. then they risk loosing patients to the competing hospital across town that will gladly except the physician owned L.L.C. As a result, hospitals and patients are receiving services at much higher rates and technology that is typically sub-par.

Further more, I have seen an overall increase in laser utilization, not because it's the right treatment for patients, but merely a means to produce significant substantial revenues for private practice physicians. I strongly believe if this trend is not corrected the medical community could suffer financially and patients will continue to receive sub-par treatments.

Sincerely,

Concerned Medical Sales Representative

Submitter : **Mr. Dean Kirkwood** **Date: 08/30/2007**

Organization : **dean kirkwood anesthesia**

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,

M. Dean Kirkwood, CRNA

305 NE 6th St. PMB 550
Grants Pass, OR 97526

Submitter : **Miss. Bethany Storck** **Date: 08/30/2007**

Organization : **University of Tennessee**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

August 30, 2007

Dear Sir or Madam:
I am a certified athletic trainer working at The University of Tennessee, Knoxville, TN. I work with athletes at the Division I level. I received my Bachelor of Scienee degrec in Kinesiology: Athletic Training from the University of New Hampshire in Durham, NH. I am currcntly pursuing my Master of Science degree in Tennesscc. I was certified by the Board of Certification in 2006 and am currently licensed to practice athletic training in New Hampshire and Tennessee.

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 aecess 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 elinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Bethany Storck, ATC/L

Submitter : **Matthew Bracken** **Date: 08/30/2007**

Organization : **Healtherapy Partners**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a licensed and certified athletic trainer currently employed through a physical therapy clinic to provide prevention, treatment, and rehabilitation services to nearly 700 athletes on 38 different teams at a high school located in Toledo Ohio. I learned the skills needed to perform these tasks at the University of Utah in there Athletic Training Education program. During this time I worked in several different settings including collegiate athletics, high schools, and physical therapy clinics. I am currently pursuing a Masters degree from the University of Toledo. The skills I learned at my undergrad prepared me to sit and pass the National Board of Certification Exam that everyone must pass before become an athletic trainer. In addition to this, I then obtained state licensure in Ohio in order to work as an athletic trainer in that state.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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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,

Matthew Bracken, ATC, LAT

Submitter : **Mr. Steve Broughton** **Date: 08/30/2007**

Organization : **MBI Solutions, Inc.**

Category : **Other Health Care Provider**

Issue Areas/Comments

Ambulance Services

Ambulance Services

August 29, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008.

Dear Ms. Norwalk:

MBI Solutions, Inc., based in Kettering Ohio provides billing services for the ambulance providers throughout the State of Ohio and Virgina. The proposed rule would have a direct negative impact on our operations and the ability to effectively provide emergency transport services to Medicare beneficiaries. We believe this proposed rule will inappropriately provide incentives to seek signatures from patients who are in need of medical care and under mental duress. Additionally, this proposed rule could have a negative impact on wait times in the emergency department, impacting ambulance operations and the operations of emergency departments throughout the country. We therefore submit the following comments in objection to the proposed rule.

In summary, here are the points we would like you to consider:
? Beneficiaries under duress should not be required to sign anything;
? Exceptions where beneficiary is unable to sign already exist and should not be made more stringent for EMS billing;
? Authorization process is no longer relevant (no more paper claims, assignment now mandatory, HIPAA authorizes disclosures);
? Signature authorizations requirement should be waived for emergency encounters.

We understand that the proposed rule was inspired by the intention to relieve the administrative burden for EMS providers. However, the relief being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services, hospitals and their billers, and would result in shifting the payment burden to the patient if they fail to comply with the signature requirements at the time of transport. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for emergency ambulance services.

Sincerely,

Steve Broughton
Chief Executive Officer

#12261

MANDEL THERAPY GROUP

8842 Route 90 • King Ferry, NY 13081
PH: (315)364-7570 • FAX: (315)364-8016

66 Central Street • Moravia, NY 13118
PH: (315)497-1390 • FAX: (315) 497-1391

August 30, 2007

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, MD 21244-8018

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008: Proposed Rule

Dear Mr. Weems:

Please allow me to introduce myself. I am a physical therapist with multiple practices in New York State. I have been practicing physical therapy for over 15 years and have enjoyed lending a helping hand in the community.

At this time I would like comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. I would like to urge you to remove the practice of physical therapy from the in-office ancillary services exception. The potential for fraud and abuse exists whenever physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to over utilize those services for financial reasons. By eliminating physical therapy as a designated health service furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, over utilization of physical therapy services under the Medicare program, and enhance the quality of patient care. Therefore, please protect physical therapy by removing PT from the in-office ancillary services exception.

Recognizing that you are a very busy individual, I would like thank you for taking the time for consideration of this matter.

Sincerely,

Dana Mandel PCS, PT

Submitter : **Ms. Michelle Vande Berg** **Date: 08/30/2007**

Organization : **Ursinus College**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Michelle Vande Berg and I am employed at Ursinus College in Collegeville, PA. My roles at Ursinus are many as I serve as a Certified Athletic Trainer, Strength and Conditioning Specialist, as well as a Course Instructor for the college. Here at Ursinus, and in previous employment venues, I have served as the 'first link' to my patients for appropriate medical care as well as a 'bridge back to full activity'. As a result, 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, during their times away from college atheltics, (winter and summer breaks, etc.).

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,
Michelle Vande Berg MS, A.T.,C., CSCS

Submitter : **Mr. Morgan Simpson** **Date: 08/30/2007**

Organization : **Citizens Memorial Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am a licensed athletic trainer and Director of Citizens Memorial Hospital Outpatient Sports Medicine Center in Bolivar, Missouri. As a licensed health care professional I provide physical medicine and rehabilitation services to injured athletes in southwest Missouri. Our physical rehabilitation services to patients are a perfect example of how athletic trainers are more than capable of treating injured athletes in an outpatient setting and returning them to functional and pain-free recreational sport activities.

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.
As a licensed athletic trainer, I've been treating athletes with injuries for 14 years and I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My health care education, clinical experience, and national board of certification exam ensure that my patients receive the highest quality of health care. Since 1990, the AMA has recognized us as allied health care professionals. You should also know I have a 98% patient satisfaction rate for my services in our outpatient physical rehabilitation department. Missouri state law and my hospital medical professionals have deemed me qualified to perform the physical medicine and rehabilitation services. However, your proposal will possibly dissolve our outpatient department, put essential healthcare professionals out of work and put patients at risk for poor treatment by physical therapists who are not educated to treat athletic related injuries. Over my years of practice I've had hundreds of referrals from physicians because they know the injured athletes will receive the highest quality of care and effective treatment from a qualified health care professional.

The lack of access and workforce shortage to fill therapy positions is widely known throughout healthcare. It is irresponsible for CMS, which should 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, PART 482, 485, & 491.

Sincerely,

MorganSimpson,AT Licensed AthleticTrainer

Director,
CitizensMemorialHospital Outpatient Sports Medicine Center

cc:
Senator ClaireMcCaskill
Representative
Roy Blunt

Submitter : Dr. RICHARD COLAVITA **Date:** 08/30/2007

Organization : ANESTHESIA CONSULTANTS OF NEW JERSEY

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 support for the proposal to inerease anesthesia payments under the 2008 Physician Fee Schedule. CMS has recognized that anesthesia services are undervalued, 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. Most physician services, either for a procedure or office visit, are valued for the complexity of the procedure. Anesthesia services have a component of complexity in the base unit charge, but most of our services are related to our time spent with the patient without regard to the complexity of the service performed or the patient's underlying condition. Medicare payment for anesthesia services stands at just $16.19 per unit, half the value paid 20 years ago. 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. Our nation's seniors are living longer, and will continue to need anesthesia services, and it is imperitive that the practice of anesthesia remains an attractive choice to medical school graduates.

In an effort to rectify this 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.

Respectfully,

Richard Colavita, M.D.

Submitter : **Mr. Joe Mayfield** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
_Joe D. Mayfield, CRNA_____
Name & Credential
_5434 Marina Club Drive _____
Address
_Wilmington, NC 28409_____
City, State ZIP

Submitter : Katherine Svedman **Date:** 08/30/2007

Organization : American Society for Dermatologic Surgery

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12266-Attach-1.DOC

#12266

ASDS
American Society for Dermatologic Surgery

August 28, 2007

The Honorable Herbert Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Washington, DC 20201

Re: CMS 1385-P: 2008 Medicare Fee Schedule
Coding – Multiple Procedure Reduction Rule for Mohs Surgery

Dear Acting Administrator Kuhn:

As President of the American Society for Dermatologic Surgery (ASDS), a medical specialty organization representing over 4700 dermatologic surgeons, including the vast majority of those performing Mohs micrographic surgery, I would like to thank you for the opportunity to comment on the proposed change in the exempt status of Mohs surgery codes 17311 and 17313 from the Multiple Procedure Reduction Rule (MPRR).

We are concerned that the proposed rule, which would be a significant reversal of CMS' own longstanding exemption of the Mohs codes from the MPRR, may represent a misunderstanding of the separate and unique nature of Mohs surgery relative to other procedures on the same day. The result would be an inappropriate application of the MPRR that will have a negative impact on Medicare beneficiaries' access to timely care, with a potential increase in risk and cost.

Back in 1991, CMS determined that the Mohs codes were indeed separate and distinct procedures, for which an exemption from the Multiple Procedure Reduction Rule was appropriate. CMS stated at that time that Mohs surgeries "are a series of surgeries which, while done on the same day, are done at different operative sessions and are clearly separate procedures in a series of procedures...They will be paid separately with no multiple surgery reductions." We believe this determination by CMS was correct, and note that the exemption has been maintained ever since.

At the request of CMS in the 2006 five-year review of the Mohs codes, we worked with AMA CPT/AMA RUC to develop two new base codes, 17311 and 17313, to reflect Mohs surgery on different anatomic sites. The new codes differed only in the specification of anatomic site. Although new codes were created, there were and have been no changes in the "technical elements of the procedure" that should alter CMS' original determination that exemption was appropriate. The AMA CPT/AMA RUC review of the new codes and descriptors did not change the characteristics that qualified the new 17311 and 17313 codes for inclusion on the modifier -51 exemption list. While the old Mohs surgery code was deleted with the adoption of the new codes, the nature of the procedure has not changed, nor should the exempt status of the new codes change.

The basis for CMS's original exemption related to an examination of the procedure itself. Mohs surgical excision of a skin cancer includes meticulous excision of the tumor and complete histopathologic examination of the margins. The excision of tumors is completed in stages, such that each stage must be completed in entirety prior to subsequent stages or repair. Each stage consists of rooming the patient, discussing, positioning, anesthetizing, prepping, draping, excising, dressing, mapping, inking, processing, and interpreting the histopathology; stages are repeated until tumor margins are clear.

5550 Meadowbrook Drive, Suite 120 Rolling Meadows, IL 60008 Tel. 847-956-0900 Fax. 847-956-0999 www.asds.net

Treatment of multiple tumors at the same time requires each component be completed for each tumor. The patient waits during the processing and interpretation portions of the procedure. Repair procedures following Mohs tumor excision require that all the same steps be undertaken again (except the tissue processing and interpretation), usually with new instrumentation and often in different rooms. As such, each Mohs tumor excision is performed in a completely separate operative session from every other tumor excision and from any repair procedure. There is minimal overlap in work from one stage to the next, from excision to repair, or between Mohs excision of two separate tumors at the same time.

Mohs surgery includes both surgical and pathological components; the inherent requirements for both account for the minimal overlap between Mohs excision of two separate tumors at the same time and between Mohs excision and a subsequent repair. Because of these dual components of surgery and pathology, 80% of the work of Mohs code 17311 is intra-service work (78% for 17313), with little pre- or post-service work. Such valuation was examined and approved by the RUC. The large amount of intra-service work, in addition to the fact that the Mohs tumor excisions are performed at separate operative sessions from repairs, differentiate the Mohs codes from other surgical codes. Because of the large pathology component of the Mohs codes, which must be completed in its entirety for each tumor independently and before contemplating repair, the "efficiencies" referred to in the proposed rule are not realized for Mohs surgery, even for treatment of two tumors on the same date. **It is inappropriate to subject these codes to the MPRR for efficiencies which don't exist.**

Additionally, approximately half the physician work of the Mohs codes represents work related to histopathology. As with all pathology codes, work of interpreting one block or specimen is completely independent of interpretation of other specimens; as such, exemption of pathology codes is appropriate, and they traditionally have not been subject to multiple surgery reduction. **Application of the MPRR to the Mohs codes would be incongruous with the appropriate exemption of other pathology codes.**

In determining characteristics of codes appropriate for exemption from the MPRR, the AMA CPT/AMA RUC Modifier -51 Workgroup identified various criteria. In addition to CMS longstanding exemption and the large amount of intra-service work referred to above, which meet two of the criteria, Mohs surgery codes are used both as adjunct codes

and as stand-alone codes. Although usually used as adjunct codes with separate repair codes, in 10-30% of cases, depending on the surgeon, wounds created by Mohs excision
are allowed to heal by second intention, with no repair procedure performed. This is particularly true for defects in concave areas such as the alar crease, medial canthus, and conchal bowl, in addition to sites off the face and less noticeable areas, such as the posterior pinna. **Such adjunct and stand-alone use meets a third criterion for exemption.**

We are concerned that the application of the MPRR to the Mohs codes will decrease Medicare beneficiaries' access to timely care and potentially increase complications and costs. In approximately 10% of cases, more than one Mohs excision is performed on the same date. This is most likely for patients with multiple tumors, who tend to be older patients and those patients at high risk due to immunosuppression from organ transplantation, chemotherapy, medication, etc. These are also the patients at greatest risk for metastasis from squamous cell carcinoma and subsequent morbidity and mortality. Application of the MPRR will delay treatment for these high-risk patients and increase the risk of subsequent complications.

Application of the MPRR to the Mohs codes may also affect repair patterns, with potential increases in cost. Reduced reimbursement for the lower-valued code, whether Mohs tumor excision or the associated repair, will make it less cost-effective for surgeons to excise and reconstruct cancers on the same day. This will likely result in an increase in referral by Mohs surgeons to other surgeons for reconstruction. Such referrals would most often be to plastic surgeons, facial plastic surgeons, or oculoplastic surgeons, most of whom operate in the hospital or in ambulatory surgery centers, where the cost of reconstruction is greater than that of the Mohs surgeon practicing in less expensive facilities. **The increased cost of repair will offset potential cost savings of the MPRR.**

ASDS
American Society for
Dermatologic Surgery

There are many reasons for the increase in utilization of the Mohs codes, including an increasing number of skin cancers, which currently affect over one million Americans and are projected to affect one in five Americans in their lifetimes. At the same time, there is an increasing number of surgeons trained in the Mohs technique utilizing the codes. While application of the Multiple Procedure Reduction Rule could appear to be a cost-savings measure and tempting to apply to Mohs surgery, it is inappropriate by previous CMS decision and current RUC policy, as I have detailed previously. Mohs surgery is a separate and distinct procedure from other procedures performed on the same day and for which no significant gain in efficiencies exists when performed with other procedures.

Application of the reduction will negatively impact care and unnecessarily put patients at risk without generating significant cost savings. We urge CMS to amend the Proposed Rule and permanently restore the exemption from the Multiple Procedure Reduction Rule to the Mohs codes 17311 and 17313.

Thank you again for the opportunity to comment on an issue that is critically important to our members and the skin cancer patients we serve. Should you require additional information, please do not hesitate to contact Lisle Poulsen, ASDS Advocacy and Socioeconomic Affairs Manager, at lpoulsen@asds.net or (847) 956-9125. I appreciate your attention to this important matter.

Sincerely,

Alastair Carruthers, FRCPC
President

cc: Terrence Kay, Director, Hospital and Ambulatory Policy Group, Centers for Medicare and Medicaid Services
Amy Bassano, Director, Practitioner Services Division, Centers for Medicare and Medicaid Services
Diane Baker, MD, President, American Academy of Dermatology
David G. Brodland, MD, President, American College of Mohs Surgery
Sharon Tiefenbrunn, MD, President, American Society for Mohs Surgery
Katherine J. Svedman, Executive Director
Lisle Poulsen, Advocacy and Socioeconomic Affairs Manager
Ronald A. Henrichs, CAE, Executive Director and CEO, American Academy of Dermatology
Georganne Dixon, Executive Director, American College of Mohs Surgery
Novella Rodgers, Executive Director, American Society for Mohs Surgery

Submitter : Mr. Lyle Kelsey **Date:** 08/30/2007

Organization : Oklahoma Board of Medical Licensure & Supervision

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-12267-Attach-1.DOC

#12267

August 23, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-1850

Re: CMS-1385-P
THERAPY STANDARDS AND REQUIREMENTS

Dear Sir or Madam:

The Oklahoma State Board of Medical Licensure and Supervision submits the following comments on the proposed rules changing the definition of "physical therapist" in Section 484, Title 42 of the Code of Federal Regulations. The proposed rules are part of the 2008 Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 2008, found in Volume 72 of the Federal Register, published on July 12, 2007.

Under subsection (i)(B) and (ii)(B) of the proposed definition of "physical therapist" an applicant would need to have "[p]assed the National Examination approved by the American Physical Therapy Association." We strongly suggest that CMS rely on state licensure and that the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist" be deleted from the final rule. At the very least, the Centers for Medicare and Medicaid Services ("CMS") should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We, along with all of the other state boards of physical therapy examiners, have already adopted a national qualifying exam for physical therapists, the National Physical Therapy Examination ("NPTE"). The Federation of State Boards of Physical Therapy ("FSBPT") develops and administers the NPTE in close collaboration with the state boards. Working together, we have developed a national passing score. The FSBPT has done an outstanding job of meeting our needs. Likewise, the NPTE has been a valuable tool in screening physical therapist applicants. Through the NPTE, we have been able to successfully filter applicants. In turn, we, as a policing body, have been able to protect the public by ensuring that only qualified therapists are licensed care for our citizens.

CMS should not usurp the states' function of licensing physical therapists and other professionals. Health care professional credentialing and licensing is a classically state function. Licensing and credentialing are the domain of the states. CMS' proposal would inappropriately transform a state function into a federal function. There is no justification for this action, and CMS should prevent it by removing the proposed rule.

CMS respects states' rights and state licensure for other health care professions, and it should continue to do so with respect to physical therapists. For example, CMS' regulations define a physician as a "doctor of medicine ... legally authorized to practice medicine and surgery by the State in which such function or action is performed." 42 C.F.R. § 484.4 (2006). Likewise, a registered nurse is defined as "[a] graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing." 42 C.F.R. § 484.4. Establishing requirements that are different than what the states require for licensing PTs would be inconsistent with not only the rights of the states, but also CMS' own standards.

Moreover, the federal government should not impose an additional burden on the states, particularly since its stated desire for a national examination already satisfied and its other stated goals would not be better met by the burden it proposes to impose. The proposed unfunded mandate could result in the development of a second exam, which would create confusion and more work for the states, without benefit. Our resources are already limited and stretched.

In the preamble to the proposed regulations, CMS says that it is seeking uniformity. The fact of the matter is that uniformity and consistency across the nation and across provider settings already exists. State licensing requirements apply to physical therapists without regard to where they practice. All states accept CAPTE accreditation. All states accept the NPTE and have adopted the same passing score. No federal regulation is required.

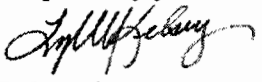
In fact, the proposed regulations would likely defeat CMS' own goal of uniformity. If, for example, the APTA were to approve a different exam than the NPTE, which the regulations would permit it to do, physical therapists, patients, including Medicare and Medicaid beneficiaries and recipients, and others could face substantial confusion and interruption of service. As a state board of physical therapy examiners, we would continue to have authority to select an exam of our choice for licensing purposes. However, under the proposed rule, a physical therapist would have to pass a second exam approved by the APTA to qualify for Medicare reimbursement. Thus, patients might be forced to change physical therapists as they become Medicare or Medicaid eligible, and the current uniformity and continuity of standards across the country would be lost. Thus, the proposed rules undermine CMS' ambition for uniformity of standards.

CMS and the federal government should not empower an advocacy group, like the APTA, to establish an examination or any qualifications for professionals to provide healthcare services to patients. The APTA's mission is to advocate and promote the profession. As a licensing body, our mission is to ensure that physical therapists are qualified to provide physical therapy services and are authorized to do the work for which they are trained. The FSBPT, the organization to which we look for the national licensing exam, was created to eliminate, protect against and prevent the inherent conflict of interest that the APTA would have if it were to have authority over the examination and credentialing processes. Even the APTA recognized this conflict of interest problem two decades ago when it created the Federation of State Boards of Physical Therapy. CMS must not allow this conflict of interest to become a rule.

The Oklahoma Board of Medical Licensure and Supervision strongly urges CMS to require only state licensure. Most importantly, CMS should remove the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist." At a minimum, CMS should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We appreciate the opportunity to comment on the proposed rules regarding physical therapist and physical therapy assistant qualification requirements.

Respectfully yours,



Lyle Kelsey,
Executive Director
Oklahoma State Board of Medical
Licensure and Supervision

Submitter : **Dr. Michael Friedman** **Date: 08/30/2007**

Organization : **Dr. Michael Friedman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

1209 Larail Dr
Columbia, MO 65203

August 30, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)
Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

As a physician, I take pride in participating in the care of our Medicare recipients. However, under the current Medicare Fee Schedule the expenses incurred providing the care exceed the reimbursement. In many hospitals this situation has put our seniors in the middle of strained relations between anesthesia providers and hospital administrators. I am thankful CMS is taking the steps to correct this untenable situation.

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.

Sincerely,

Michael J. Friedman, MD

Submitter : **Mrs. Eileen Sweigert** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Eileen P. Sweigert, CRNA
2515 Settlement Circle
Lancaster, PA 17601

Submitter : **Mr. Jay Gallegly** **Date: 08/30/2007**

Organization : **Mr. Jay Gallegly**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jay Gallegly and I am new to the Athletic Training Profession. I received my undergraduate degree from Lindenwood University in Saint Charles, Missouri. I am currently working on my Masters of Science in Health and Kinesiology at the University of Texas at Tyler. Along with going to Graduate School, I work as an Athletic Trainer in a rural east Texas town. I am the main health care provider for the schools athletes and my duties include preventing, recognizing, managing and rehabilitating injuries that result from physical activity.

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,

Jay Gallegly, ATC, LAT

Submitter : Ms. Erica Sherer **Date:** 08/30/2007

Organization : AANA

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Erica Sherer MSN CRNA
607 Country Club Road
York, PA 17403

Submitter : **Mr. Jess Hoyman** **Date: 08/30/2007**

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
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Baltimore, MD 21244 8018 ANESTHESIA SERVICES
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Sincerely,

Jess G Hoyman II CRNA,MS
319 Coppersmith Lane
Strasburg,PA,17579

Submitter : **Dr. David Whalley** **Date: 08/30/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

Background

Background

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.

David G Whalley MD

Submitter : Mrs. tracey butler **Date:** 08/30/2007

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
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Baltimore, MD 21244 8018 ANESTHESIA SERVICES
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Sincerely,

Tracey Butler, ms, CRNA
1518 marietta avenue
Lancaster Pa 17603

Submitter : **Miss. Kathleen Feuerbach** **Date: 08/30/2007**

Organization : **Edgewater High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:
I work as a Secondary School Athletic Trainer in a very populated urban area of Florida. My work hours are not your typical 9am-5pm job, there are many days that I work well over the contracted 7.5hrs per day in order to provide the best physical medicine and rehabilitative services to our athletes. I am required by law to maintain my licensure and certification with 75 continuing education units in three years. For your information the public can access The Board of Certification at bocatc.org or 877 262-3926 as well as the National Athletic Trainers' Association at nata.org or 214 637-6282 to have an overview of how extensive the credential process is for an Athletic Trainer. Besides the professional standards my job consists of making sure all of our athletes are medically cleared to participate in all sports. Statistically our school has 2300 students and many of them roughly 1200 tryout for an extracurricular activity including our ROTC program all need a pre-participation physical. I work alone with a part-time Athletic Trainer contracted to our school by a physical medicine company. If the proposed changes to CMS-1385-P are ratified the quality of the health care to our student athletes will be severly compromised. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitative facility.
Sincerely,
Kathleen Feuerbach, ATC

Submitter : **Catherine Maltais** **Date: 08/30/2007**

Organization : **Duke University Eye Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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.

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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,

Catherine Maltais, CRNA
35 Rookridge Lane
Manson, NC 27553
katiemaltais@earthlink.net

Submitter : Mr. Dwight McDonnell **Date:** 08/30/2007

Organization : University of Missouri

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

August 30, 2007

Dear Sir or Madam:

I am an athletic trainer at the University of Missouri. In Missouri we have nearly 700 licensed athletic trainers, with over half of them working in the clinical setting with outreach to high schools. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Dwight Eric McDonnell, M.Ed., ATC, LAT

Submitter : **Mrs. nancy Klombers** **Date: 08/30/2007**

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
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Sincerely,
Nancy M Klombers, CRNA
5064 Hill Road
Mohnton PA 19540

Submitter : **Dr. Kizhakepat Sukumaran** **Date: 08/30/2007**

Organization : **Vally Anesthesia**

Category : **Physician**

Issue Areas/Comments

ASP Issues

ASP Issues

Please take ation as soon as possible

Submitter : **Ms. Marianne Devlin** **Date: 08/30/2007**

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
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Sincerely,
Marianne Devlin, CRNA,MSNA
105 Topland Drive
Lancaster, Pa 17601

Submitter : **Dr. Brent Amble** **Date: 08/30/2007**

Organization : **Marshfield Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Thank you for reading this letter. I am an athletic trainer in the Sports Medicine Department at Marshfield Clinic in Eau Claire, WI. I have received a B.S. Degree in Athletic Training from UW-LaCrosse, a M.S. Degree in Management from Silver Lake College, and a Ph.D. in Health Administration from Warren National University.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Sincerely,

Brent Amble, Ph.D, ATC

Submitter : Dr. Carol Campbell **Date:** 08/30/2007

Organization : UTHSCSA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. PREMJIT SARANGI** **Date: 08/30/2007**

Organization : **Dr. PREMJIT SARANGI**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Submitter : Dr. Jefri Williams **Date:** 08/30/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

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Submitter : **Mr. Matthew Johnson** **Date: 08/30/2007**

Organization : **Hannibal Anesthesia Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Matthew Johnson, MBA, CASC
Administrator
Hannibal Anesthesia Associates
98 Medical Drive
Hannibal, MO 63401

Submitter : **Shannon Pirmann** **Date: 08/30/2007**

Organization : **Genesis Medical Center - Illini Campus**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Shannon Pirmann. I am a Certified Athletic Trainer for outpatient rehabilitation services at Genesis Medical Center - Illini Campus in Silvis, Illinois. I also provide athletic training services to United Township High School in East Moline, Illinois. I have been practicing as an athletic trainer for 6 years, with the last 4 in my current position. I earned a Bachelor's degree in Sports Medicine from North Park University in Chicago, Illinois and a Masters degree in Physical Education (Athletic Administration) from Loras College in Dubuque, Iowa. I am a current member of the National Athletic Trainers Association. I also carry Athletic Training licensure in both Illinois and Iowa.

In my current employment setting, I am able to practically apply what I learned in my undergraduate and graduate studies to provide assistance to patients of all ages in physical therapy in treatment and documentation. Following evaluation by a Physical Therapist, I assist patients in administration of appropriate exercise form and techniques, gait, instruction and use of assistive devices and braces, and massage. I also have formal training in the use and application of modalities such as ultrasound, electrical stimulation, hot packs, and cold packs.

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,
Shannon E. Pirmann, MA, ATC, LAT

Submitter : **Mrs. Kimberly Brandtonies** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Kimberly Brandtonies, CRNA
Name & Credentials

Address:
2041 Harvest Drive
Mechanicsburg, PA 17055

Submitter : **Amy Barrall** **Date: 08/30/2007**

Organization : **Saint Vincent Center for Sports and Restorative Me**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I am a certified athletic trainer working in a rural high school. I have 6 years of experience in the high school, collegiate, professional athletic settings, as well as hospital experience. 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,

Amy Barrall, MEd, ATC

Submitter : **Dr. Damon Dozier** **Date: 08/30/2007**

Organization : **UMMC**

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.

Damon Dozier, MD

Submitter : **Mr. William Sevening** **Date: 08/30/2007**

Organization : **San Antonio Spurs**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Will Sevening and I am the Head Athletic Trainer For the San Antonio Spurs. I have a BS in Biology and MS in Sports Medicine. I am also a certified member of the NATA and a certified and licensed member in the state of Texas.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for the rehabilitation in hospitals and faeilities proposed in 1385-P. While I am concerned that these proposed changes to the hospitals 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 patients receive quality health care. State laws and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to cicumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is IRRESPOSIBLE 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 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,
Will Sevening B.S., M.S., ATC,LAT
Head Athletic Trainer
San Antonio Spurs

Submitter : matt saylor **Date:** 08/30/2007

Organization : matt saylor

Category : Other Health Care Professional

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.
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,

Matt Saylor, CRNA
697 South Shire Lane
Farmington, Utah
84025

Submitter : Lawrence Mroz **Date:** 08/30/2007

Organization : Lakewood Fire Department

Category : Local Government

Issue Areas/Comments

Ambulance Services

Ambulance Services

See attachment

CMS-1385-P-12292-Attach-1.DOC

#12292

14601 MADISON AVENUE • LAKEWOOD, OHIO 44107-4303
Lawrence E. Mroz, Fire Chief

Division of Fire
216-529-6655
FAX 216-226-9963
www.ci.lakewood.oh.us
fire@lakewoodoh.net

August 28, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008.

Dear Ms. Norwalk:

Our organization provides emergency ambulance services to the communities which we serve. The proposed rule would have a severely negative direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. In addition, we believe this proposed rule will inappropriately provide incentives to seek signatures from patients who are in need of medical care and under mental duress. Additionally, this proposed rule would have a negative impact on wait times in the emergency room impacting our operations and the operations of emergency rooms throughout the country. We therefore urgently submit comments on ills of the proposed rule.

In summary, here are the points we would like you to consider:

- Beneficiaries under duress should not be required to sign anything;
- Exceptions where beneficiary is unable to sign already exist and should not be made more stringent for EMS;
- Authorization process is no longer relevant (no more paper claims, assignment now mandatory, HIPAA authorizes disclosures);
- Signature authorizations requirement should be waived for emergency encounters.

We understand that the proposed rule was inspired by the intention to relieve the administrative burden for EMS providers. However, the "relief" being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and the hospitals and would result in shifting the payment burden to the patient if they fail to comply with the signature requirements at the time of incident. Accordingly, we urge CMS to

abandon this approach and instead eliminate entirely the beneficiary signature requirement for emergency ambulance services.

Current Requirement

When the beneficiary is physically or mentally incapable of signing, the industry has been following the requirements listed in the CMS Internet Only Manual, Pub. 100-02, Chapter 10, Section 20.1.2 and Pub. 100-04, Chapter 1, Section 50.1.6(A) (3) (c). These sections allow for a representative of the ambulance provider or hospital to sign on behalf of the beneficiary when the patient is unable to sign, document that the beneficiary was unable to sign, the reason and that no one could sign for the beneficiary.

The proposed rule directly conflicts with the existing rule. It requires that the provider representative sign **contemporaneously** with the transport and **seek an additional signature** from the hospital in the event a patient is unable to sign.

BENEFICIARY UNDER DURESS SHOULD NOT BE REQUIRED TO SIGN ANYTHING

Emergency ambulance providers have no admission department and no registration desk. The same individuals responsible to providing medical care and transportation to the hospital are also responsible for fulfilling the administrative functions. All EMS encounters are emergency in nature and medically necessary ambulance transports in particular are stressful events on patients.

CMS has recognized this modified its rules for obtaining Advance Beneficiary Notice and Acknowledgement of HIPAA Privacy Notices, creating exceptions that do not require ambulance crews to interrupt their care to seek a signature from a patient under their care.

In fact, CMS has deemed that all emergency encounters put the patient under great duress. Under such duress, patients would sign anything in order to get the care they require. Therefore, any signature obtained in an emergency situation cannot be relied upon.

Yet the proposed rule is so burdensome on ambulance crews that they will have every incentive to obtain a patients signature even though the patient is under mental duress. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

EXCEPTIONS WHERE BENEFICIARY IS UNABLE TO SIGN ALREADY EXIST AND SHOULD NOT BE MADE MORE STRINGENT FOR EMS

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. The proposed exception essentially mirrors the existing requirements that the beneficiary is unable to sign and that no authorized person was available or willing to sign on their behalf, while adding additional documentation requirements. Therefore, we believe that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed sub-division (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, we do not object to the requirement that an ambulance provider obtain documentation of the date, time and destination of the transport. Nor do we object to the requirement that this item be maintained for 4 years from the date of service. However, we do not see any reason to include these in the Regulation, as they are already required and standard practice.

The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. Our organization **strongly objects** to this new requirement as:

- Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.
- Hospital personnel will often refuse to sign <u>any</u> forms when receiving a patient.
- If the hospital refuses to sign the form, it will be the beneficiary that will be responsible for the claim.
- The ambulance provider or supplier would in every situation now have the additional burden in trying to communicate to the beneficiary or their family, at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.
- Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ER Admitting Record, etc.

We also strongly object to the requirement that ambulance providers or suppliers obtain this statement from a representative of the receiving facility *at the time of transport*. Since the proposed rule makes no allowances for the inevitable situations where the ambulance provider makes a good faith effort to comply, but is ultimately unable to obtain the statement, we believe this requirement imposes an excessive compliance burden on ambulance providers and on the receiving hospitals. Consider what this rule requires—the ambulance has just taken an emergency patient to the ER, often overcrowded with patients, and would have to ask the receiving hospital to take precious time away from patient care to sign or provide a form. Forms such as an admission record will become available at a later time, if CMS wants them for auditing purposes in addition to the trip transport that will already include date, time and receiving facility.

<u>AUTHORIZATION PROCESS IS NO LONGER RELEVANT (NO MORE PAPER CLAIMS, ASSIGNMENT NOW MANDATORY, HIPAA AUTHORIZES DISCLOSURES)</u>

<u>Purpose of Beneficiary Signature</u>

a. <u>Assignment of Benefits</u> -The first purpose of the beneficiary signature is to authorize the assignment of Medicare benefits to the health care provider or supplier. However, assignment of covered ambulance services has been mandatory since April 2002. Furthermore, 42 C.F.R. §424.55(c), adopted November 15, 2004 as part of the Final Rule on the Physician Fee Schedule (67 Fed. Reg. 6236), eliminated the requirement that beneficiaries assign claims to the health care provider or supplier in those situations where payment can only be

made on an assignment-related basis. Therefore, the beneficiary's signature is no longer required to effect an assignment of benefits to the ambulance provider or supplier.

CMS recognized this in the Internet Only Manual via Transmittal 643, by adding Section 30.3.2 to Pub. 100-04, Chapter 1. As a result, the beneficiary signature is no longer needed to assign benefits of covered ambulance services.

b. Authorization to Release Records - The second purpose of the beneficiary signature is to authorize the release of medical records to CMS and its contractors. However, the regulations implementing the HIPAA Privacy Rule, specifically 45 C.F.R. §164.506(c) (3), permit a covered entity (e.g. an ambulance provider or supplier) to use or disclose a patient's protected health information for the covered entity's payment purposes, without a patient's consent (i.e. his or her signature). Therefore, federal law already permits the disclosure of medical records to CMS or its contractors, regardless of whether or not the beneficiary's signature has been obtained.

Signatures Not Required for ABN's for Emergency Transports

The Third Clarification of Medicare Policy regarding the Implementation of the Ambulance Fee Schedule states that Advanced Beneficiary Notifications only be issued for non-emergency transports. The ABN's which require beneficiary signature "may not be used when a beneficiary is under great duress" which would include emergency transports. Would not the requesting of a Medicare Beneficiary's signature for any other reason during an emergency transport be less duress?

Signature Already on File

Almost every covered ambulance transport is to or from a facility, i.e. a hospital or a skilled nursing facility. In the case of emergency ambulance transports, the ultimate destination will always be a hospital. These facilities typically obtain the beneficiary's signature at the time of admission, authorizing the release of medical records for their services *or any related services*. The term "related services", when used by hospitals and SNFs, can mean more than only entities owned by or part of the facility. The term already includes physicians providing services at the facility. We believe that ambulance transport to a facility, for the purpose of receiving treatment or care at that facility, constitutes a "related service", since the ambulance transports the patient to or from that facility for treatment or admission. Therefore, we believe a valid signature will be on file with the facility. Additionally, for those transports provided to patients eligible for both Medicare and Medicaid, a valid signature is on file at the State Medicaid Office as a product of the beneficiary enrollment process.

Electronic Claims

It is also important to note that, as a result of section 3 of the Administrative Simplification Compliance Act and the implementing regulations at 42 C.F.R. §424.32, with very limited exceptions (e.g. providers or suppliers with less than 10 claims per month), ambulance suppliers must submit claims electronically. Thus, the beneficiary does not even sign a claim form. When submitting claims electronically, the choices for beneficiary signature are "Y" or "N". An "N" response could result in a denial, from some Carriers. That would require appeals to show that,

while the signature has not been obtained, an alternative is accepted. As a result, many Carriers allow a "Y", even though the signature was not actually obtained, if one of the exceptions is met.

While this may be a claims processing issue, since you are now looking at the regulation, this would be a good time to add language indicating that the signature requirement will be deemed to be met if one of the exceptions to the requirement exists.

Program Integrity

It is important for CMS to realize that, for every transport of a Medicare beneficiary, the ambulance crew completes a trip report listing the condition of the patient, treatment, origin/destination, etc. AND the origin and destination facilities complete their own records documenting the patient was sent or arrived via ambulance, with the date. Thus, the issue of the beneficiary signature should not be a program integrity issue.

SIGNATURE AUTHORIZATIONS REQUIREMENT SHOULD BE WAIVED FOR EMERGENCY ENCOUNTERS.

Conclusion

Based on the above comments, it is respectfully requested that CMS:

- Amend 42 C.F.R. §424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that "good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported".
- Amend 42 C.F.R. §424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
- Amend 42 C.F.R. §424.36(b) (5) to add "or ambulance provider or supplier" after "provider".

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

Thank you for your consideration of these comments.

Sincerely,

Lawrence E. Mroz
Chief, Division of Fire

Thomas J. George
Mayor, City of Lakewood

Submitter : **Kevin Maltais** **Date: 08/30/2007**

Organization : **Maria Parham Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

As a CRNA working in a rural hospital in Henderson, NC; I see how desperately Maria Parham Medical Center needs an increase in reimbursement for Anesthesia Services.
We can not continue to provide service under the current payments. MPMC pays out double than it takes in for its Anesthesiologists and Nurse Anesthetists. We have cut back 25% in personnel in the last year and still lose money. We can not maintain staffing if we lower salaries and benefits.
Rural America needs Anesthesia Services and we are bearing the brunt of lower payments from all payers, lack of insurance of our patients and illegal aliens using our services.
All payers follow Medicare s lead, we need you to approve an increase in Medicare payments and values for Anesthesia Care.
Thank You,
Kevin Maltais, CRNA
35 Rookridge Lane
Manson, NC 27553
kmaltais@bigfoot.com

CMS-1385-P-12293-Attach-1.PDF

#12293

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.

- 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,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Ms. Barbara Callahan** **Date: 08/30/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear CMS:
I am a nurse anesthetist in a rural area of which approx. 30% of our patients are medicare. I am writing as a member of the AANA to support the CMS proposal to boost the valuation of anesthesia services by 32%. This would increase the anesthesia conversion factor by 15% in 2008 as compared with current levels. (72 FR 38122, 7/12/2007). The increase is vital for several reasons: 1. Studies by Medicare Payment Advisory Commission (medpac) and others have shown that most Medicare B reimbursements are at or above 80% of private market rates while anesthesia services are reimbursed at 40% or less of private market rates. 2. Anesthesia reimbursement rates have been slipping behind inflation rates and this correction would bring rates closer in line with inflation increases. 3. 36,000 CRNA's provide 27,000,000 anesthetics per year mainly in rural and underserved areas and fair medicare reimbursement is important in continuing to provide quality anesthesia services to these areas. I support the agency's acknowledgement that anesthesia payments have been undervalued and strongly support the proposal to adjust the valuation to bring payments in line with inflation and other medical services. Thank you for your work on behalf of this fair proposal.
Barbara Callahan CRNA

Submitter : Mr. Todd Semla **Date:** 08/30/2007

Organization : The American Geriatrics Society

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12295-Attach-1.DOC

#12295

THE AMERICAN GERIATRICS SOCIETY

THE EMPIRE STATE BUILDING, 350 FIFTH AVENUE, SUITE 801, NEW YORK, NY 10118 TEL: (212) 308-1414 FAX: (212) 832-8646

LINDA HIDDEMEN BARONDESS
Executive Vice President

August 31, 2007

Herb Kuhn
Acting Director
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1385-P: Medicare Program: proposed Revisions to Payment Policies Under the Physician Fee Schedule, and other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions

Dear Mr. Kuhn,

The American Geriatrics Society (AGS), an organization of nearly 6,800 geriatrics healthcare professionals who are specially trained in the management of care for frail, chronically ill older patients, appreciates the opportunity to provide comments on the proposed physician fee schedule for CY 2008.

Background

Geriatricians are physicians who are board certified in family medicine or internal medicine and who complete additional fellowship training in geriatrics. Geriatricians serve as both primary care providers and consultants to other primary care providers on the sickest patients in Medicare, serving these patients across the full care continuum. The patients of geriatricians are often medically complex, chronically ill, and frail because of a combination of physical, mental and social ailments. Geriatric medicine promotes wellness and preventive care in older persons, with emphasis on care

management and coordination, frequently involving a team of health care professionals. The care management and coordination helps patients maintain functional independence in some cases and decrease the rate of decline in others, thus improving their overall quality of life.

Specific Comments:

The AGS has the following specific comments on the proposed fee schedule rule for 2008. The order of comment reflects the order presented in the proposed rule.

However, AGS priorities are, in order:

1. Fix the flaws of the SGR methodology and avert a dramatic payment cut that will impair the physician care network for the most frail and complex Medicare patients;
2. Apply budget neutrality provisions to work RVUs through adjustments in the conversion factor and not to the work RVUs themselves through a "work adjuster." This more accurately implements the correction of the E/M valuations accomplished at the most recent five year review;
3. Do not substitute pay for reporting programs for fee schedule annual updates because the latter reflect real practice cost trends;
4. Address the undervaluation of Home Visit and Domiciliary Visit care; and
5. Adjust PE RVUs administratively so that they can be reallocated in a budget neutral manner across other services in the fee schedule.

"Resource-Based PE RVUs"

AGS strongly believes that a guiding principle behind resource-based PE RVUs should be that they reflect actual relative costs of services and do not create an incentive to over utilize any services. CMS proposed a 70% usage assumption in the past based on data supplied by Abt Associates. However, it implemented an assumption of 50% usage for capital equipment which is not based on any empiric data, including survey data. Most observers believe the 50% assumption to be low for the actual use of capital equipment by the typical provider. The higher Medicare practice expense payments resulting from this assumption incentivize over-use. CMS could take a position that is both data driven and policy driven, i.e. that the fee schedule should pay for capital equipment based on an assumption of reasonable efficiency. We do not believe that 50% usage is reasonably efficient. We recommend that CMS propose and implement an equipment usage assumption that is more reasonable than 50%.

Further, we request that before finalizing any changes to the equipment use percentage, CMS explain and demonstrate the redistributive effects of such a change. Without that kind of discussion, AGS does not believe it is possible to provide helpful comments to CMS on such a proposal. For example, if CMS is going to consider increasing the utilization percentage of specialty-specific equipment that costs more than $500,000,

AGS would like to know whether the redistributive effects of such a proposal would be among codes performed by that specialty or whether the effects would be across specialties. Specifically we would like to understand the effects of such a proposal on evaluation and management ("E/M") services.

Lastly, we request that CMS revise its equipment utilization percentage before Congress acts legislatively so that the redistribution of PE RVUs is budget neutral. If Congress acts on this issue then it is possible that any reductions in PE RVUs could be considered "savings" and those RVUs could be taken out of the system.

"Medicare Telehealth Services"

AGS supports CMS' proposal to add CPT Code 96116, Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report, to the list of telehealth services. CPT code 96116 is a new code that replaced 96115 in 2006 as part of revisions to the neuron/psychological tests codes. Before this renumbering took place, CPT code 96115 (the predecessor to 95116, as described) was on the telehealth services list. Therefore, AGS considers this to effectively be a restoration of the status of CPT 96115. Because the descriptor for 96116 seems to require that the service be provided "face-to-face" we request that CMS clarify that "face-to-face" services may qualify as telehealth services.

AGS also supports adding subsequent hospital care codes (CPT 99231-99233) to the list of telehealth services when they are reported to describe follow-up services to an inpatient consultation. There are a number of clinical scenarios where treating physicians will request the opinion of a geriatrician (e.g., regarding evaluation of falling spells or suitability for nursing home placement) but none is available in the hospital and a telehealth consultation would be required. CMS correctly notes that the deletion of the "Follow-up Inpatient Consultation" codes which used to be on the list of telehealth services before those codes were deleted from CPT has created the need to add subsequent hospital care codes to the list of telehealth services when those codes describe follow up inpatient consultation care. We recommend that CMS create a special modifier that would be appended to CPT codes 99231-99233 when appropriate to report the furnishing of follow-up inpatient consultation care via telehealth.

"Coding-Additional Codes from 5-Year Review"

AGS requests that CMS discontinue use of the work adjuster it established in CY 2007 as a means to budget neutralize the work RVUs increases for E/M services. The work adjuster has had the unintended consequence of significantly harming payments for specialties whose patient population is predominantly Medicare beneficiaries. For

example, almost all of the patients seen by home care physicians are Medicare beneficiaries. Therefore, home care physicians have not only seen their request for an increase in home visit work RVUs denied by the RUC but it has actually seen a 10% decline due to the work adjuster. This year, the work adjuster has been proposed to increase due to the revaluation of anesthesia work and certain other codes. This will amount to another decrease in payment for home care physicians who cannot offset this decrease by performing services whose work values have increased. AGS believes that continuing the work adjuster at the proposed 12% will have a devastating effect on home care. Therefore, AGS requests that CMS remove the work adjuster and make the work revaluations due to the 5 year review budget neutral through adjusting the conversion factor.

AGS also requests that CMS reconsider its proposal to accept the RUC recommendation to not increase the work value for home visit codes. AGS believes that the home care physicians made a compelling case that the home visit work values should remain "relatively" the same with respect to office visit codes as they did before the five year review.

Because there were limited reference codes available for the five year review, the Home Care codes were used for magnitude estimation. However, in spite of this, the RUC rationales for the E/M recommendations do not always rely upon the Home Care codes. But their use as reference services made it impossible for the RUC to seriously consider any revisions in Home Care valuations as it would potentially undermine a portion of the foundation of the five year review recommendations for E/M services. Additionally, the Home Care codes had recently been considered appropriate for cross-walking the valuations for Domiciliary Care codes.

Consequently, it was inevitable that the RUC would find no compelling evidence that the Home Care codes were mis-valued and it would not even consider data regarding valuations. We believe the relationship between Domiciliary Care and Home Care codes and other E/M codes that existed prior to the five year review were reasonable. But more significantly we believe that CMS should consider the data presented by the American Academy of Home Care Physicians and it should ask the RUC to review these data. The RUCs comments will provide useful information to CMS so that CMS may deliberate as to whether Home Care and Domiciliary Care codes remain correctly valued.

At no point during the five year review was it suggested that the Home Care codes presented a rank order anomaly with the other E/M services at their previous valuation. Unfortunately, in spite of this fact, the results of the five year review have created a series of rank order anomalies and have had the unintended consequence of creating a serious problem for one group of physicians - home care physicians.

A growing volume of home care services are being provided by teams who dedicate their practices entirely to patients requiring home care, not by individual clinicians who perform a very limited number of home care services for select long-term patients of their office based practices. Because we believe the highest quality home care is being

provided by organized teams dedicated to this service, it is detrimental to the care of these most vulnerable patients to allow this matter to go unaddressed. Agreeing to our previous recommendation of using the conversion factor for budget neutrality adjustments instead of a work adjuster only will ameliorate part of the problem for these dedicated professionals. That is not enough. Therefore, we also recommend that CMS review the home care visit valuations and ask the RUC to assess the current valuations and submit recommendations to CMS specifically addressing whether the current valuations of home care visits may be a rank order anomaly that warrants reassessing the work values.

Alternatively, or in addition to RUC review, CMS may wish to convene a refinement panel to assess this situation. Lastly, we encourage CMS to use this opportunity to review its practice expense policy related to time and resources unique to home care. A quality demonstration project may be appropriate to sustain this safety net resource and measure the care provided.

"Update"

Although not officially part of the proposed rule, AGS wishes to register its objections to the 10% negative update that will take effect unless Congress takes legislative action. Part of the reason for the 10% negative update is CMS' refusal to remove the increasing cost and utilization of drugs out of the calculation of the sustainable growth rate. We believe CMS has the administrative discretion to take such action and we recommend that it do so, even though it has refused to do so for the past 5 years.

"Therapy Standards and Requirements"

AGS supports the CMS proposal to eliminate the 30 day recertification requirement for physical therapy services. We agree with CMS that such a requirement does not affect the duration for which physical therapy is provided. Furthermore, performing the recertification at 30 day intervals is an unnecessary administrative burden and the requirement actually results in unnecessary patient visits to the certifying physician.

Removing this requirement will allow physicians to certify the length of treatment that is medically necessary. We agree that physicians should document the need for ongoing physical therapy in the medical record, as appropriate. However, we request that CMS clarify that it is not implementing any new documentation requirements that would be a "substitute" for the certification.

"Exemption to Foundation Standard Requirements for Computer Generated Facsimiles"

AGS understands that this exemption was created because not all e-prescribing standards have been issued; many physicians were using computer generated fax technology in connection with e-prescribing and that the cost of complying with the e-prescribing standard was a significant issue.

The CMS proposal appears to be in response to the continued use of computer generated fax technology and a perceived lack of movement by physicians to comply with the e-prescribing standards.

Although the proposal would not take effect until one year after the effective date of the CY 2008 PFS final rule, we urge CMS to move even more slowly. AGS has members that do e-prescribing, internal to their electronic health record, with facsimile transmittal and we believe that many of those members would simply go back to paper prescriptions if they were forced to comply with the e-prescribing standard at significant cost. At a minimum CMS should do a survey of physicians to determine the costs of compliance with the standard and continue the exemption until the cost is low enough for most physicians to make the necessary changes.

To the extent that this form of e-prescribing improves patient care, removal of the exemption would be an administration action that could negatively affect patient care.

"TRHCA-Section 101(b): PQRI"

AGS believes it is too early to comment on the success or failure of the program and will comment on the program after it has obtained input from its members who are participating in CY 2007. We do support funding the infrastructure necessary for quality reporting and improvement as well as the general principles that are the basis for PQRI; these include: physician involvement in measure development, promoting quality measurement as a routine activity in patient care and recognizing that a pay for volume (i.e., service) system inadequately promotes and rewards the care many beneficiaries need.

AGS agrees that quality should be measured as long as the measures are valid and reflect the care being provided. It also supports the development of an infrastructure that allows valid measurement of quality. AGS does not believe that its members are currently being rewarded for the care they provide to Medicare beneficiaries and it does not know whether PQRI will provide a valid measurement of, or reward for, quality.

However, the PQRI is not, and should never be considered, a substitute for a negative update to the conversion factor. Receiving a 1.5% bonus while losing 12% of the other 98.5% of a provider's reimbursement is not a reasonable trade-off, nor is it adequate to support access to care or investing in the infrastructure necessary to improve quality.

The use of electronic health records and data registries in PQRI or any quality measurement program has the potential to simplify the administrative burden of data collection and facilitating those efforts should be supported.

Conclusion

We hope to work with CMS on the development of the final rule. If you should have questions or comments on this letter, please contact Paul Rudolf our Counsel at 202-775-5731.

Sincerely,

Todd P. Semla

Todd P. Semla, MS, PharmD, AGSF
President
American Geriatrics Society

Submitter : **Jonathan Linkous** **Date: 08/30/2007**

Organization : **American Telemedicine Association**

Category : **Other Association**

Issue Areas/Comments

Medicare Telehealth Services

Medicare Telehealth Services

See attached coments

CMS-1385-P-12296-Attach-1.DOC

#12296

American Telemedicine Association

RE: Regulation CMS-1385-P - Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 Reply Comments of the American Telemedicine Association Regarding Medicare Telehealth Services

Contact Information:

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These comments are provided by ATA in response to the proposed regulations for Medicare Telehealth Services issued by CMS in the July 12, 2007 Federal Register (pages 38143-38145).

Subsequent Inpatient Visits 99231-233

ATA requested CMS to add "subsequent hospital care" codes since the previous "subsequent inpatient consultation" codes were deleted. CMS declined to approve the request since the "subsequent hospital care" codes are broader and include services for acutely ill patients. The Agency stated a lack of comparative analyses showing the efficacy of using telemedicine for acute cases. The ruling stated "We continue to have concerns about using a telecommunications system as a substitute for the on-going (in person) evaluation and management (E/M) of a hospital inpatient. Therefore, we propose to not add subsequent hospital care as described by HCPCS codes 99231 through 99233 to the list of Medicare telehealth services" (p.38144). However, CMS requested comments about providing telehealth reimbursement for "subsequent hospital care for telehealth only when the codes are used for follow-up inpatient consultation (and not for inpatient visits)."

Two scenarios were described to CMS in ATA's original request to re-establish Subsequent Inpatient Visits – the first scenario including patients admitted to a rural or remote inpatient hospital or critical access hospital, both eligible originating sites, by an attending physician and followed by the same attending physician, who subsequently consulted with a specialist for the care of the patient and the second scenario involving an attending or admitting physician who sees the patient in-person for the initial visit, and provides subsequent care via telemedicine including after-hours and weekend unscheduled visits. The comparison *is not* between in-person care, versus care via telemedicine, the comparison ***is when no other care is available***. ATA can provide information stating that there are equivalencies between in-person and telemedicine encounters, but it is ipso facto evident that in such cases telemedicine is better than ***no*** care. Studies have been conducted that indicated care is better than no care when provided for in-person care, and clearly show that appropriate, timely care provides better clinical outcomes than no care at all.

In the past, CMS has added several CPT codes to the list of approved Medicare telehealth codes without evidence submitted to show that telemedicine does not alter the diagnosis, and that patients and providers are satisfied with telehealth encounters. Two such sets of codes are the dialysis codes approved in 2004, and the psychiatric diagnostic interview examination (as described by CPT code 90801) added to the list of Medicare telehealth services in CY 2003. "To date, Medicare expenditures for telehealth services have been extremely low. For instance, in CY 2006, the total Medicare payment amount for telehealth services (including the originating site facility fee) was approximately $2 million. The addition of CPT code 90801 in 2003 resulted in an increase in Medicare payment amounts of approximately $100,000 in CY 2006. In its own words, CMS has stated "moreover, previous additions to the list of Medicare telehealth services have not resulted in a significant increase in Medicare program expenditures." (p. 38216)

The process of requiring Class 2 evidence for addition of subsequent inpatient care as well as the denied neurodevelopment testing codes, does not meet the need of CMS to identify cost-savings strategies with implementation of new CPT codes, nor does it allow for a comparison of when no care is available versus providing care via telehealth. The system simply does not fit. CMS itself has not adhered to the process in adding previous CPT codes in 2003 and 2004. With the federal government using telehealth throughout the Veteran's Administration Health system as well as Indian Health Services, and with the strong application of telemedicine in military operations and health care organizations, the public continues to be denied the benefits of access to care through telehealth due to a process for approval that does not fit the current environment nor the situation in which telehealth is most valuable, when ***no*** care exists.

ATA continues to request the addition of subsequent hospital care for subsequent inpatient visits 99231-99233. ATA provided substantial information to CMS in the original CPT code request for addition of services showing that in the instance where NO services were available, critical specialty services were able to be provided to rural and remote patients through the use of telemedicine. The first situation in which codes 99231-99233 would be used is when no services are available and where telemedicine can be used to provide such specialty services. The availability of a tertiary care trauma surgeon, a neurologist for both initial and follow-up stroke evaluation, a psychiatrist for initial assessment and prescriptive safety orders, an infectious disease provider, or a cardiologist can all be accomplished over telemedicine when no one of these specialties are available on-site. The first issue is not one of replacing on-site services, the issue is putting a specialist and a generalist together in the most critical period, the acute phase, when diagnostic and interventional decisions can decrease cost and improve clinical outcomes. The golden hour of trauma and the window of opportunity for stroke are two such examples where the addition of a specialist to the diagnostic decision tree ultimately improves clinical outcomes.

Telemedicine networks throughout the country are starting to target telestroke care. In areas where local stroke care specialists are not available, telemedicine can link an emergency department or ICU physician with a specialist in a stroke treatment center. This consultation provides an opportunity for administration of thrombolytic drugs within the short therapeutic time window associated with ischemic stroke. The University of Maryland Medical Center used a triplexed integrated services digital network line providing a 30-frames-per-second video link to St Mary's Hospital >100 miles away. The system uses a pan, tilt, and zoom camera with

remote site control, allowing 2-way, real-time, audiovisual communication and CT image transfer. In this study, a retrospective review was conducted of all acute stroke consultations provided to St Mary's Hospital between 1999 and 2001. Fifty consultations were reviewed. Of the 50, 23 were attempted through telemedicine linkage, and 27 were by traditional telephone conversation, followed by transfer. Of the 23 telemedicine consultations, 2 were aborted because of technical difficulties. Of the patients evaluated by traditional means, 1 of 27 (3.8%) received intravenous rtPA; 5 of 21 (23.8%) received rtPA after telemedicine consultation. No patients experienced complications. In conclusion, telemedicine consultation provided treatment options not previously available at the remote hospital. Administration of rtPA during telemedicine consultation was feasible and safe, and the system was well received. In some cases coding for such services may be considered part of emergency room or outpatient services. However, in many other cases where the patient has been admitted, such services are in-patient care. Lack of reimbursement for such telemedicine services will hinder widespread adaptation of this promising technology for remote acute stroke treatment.

CMS has stated they continue to have concerns about using a telecommunications system as a substitute for the on-going (in person) evaluation and management (E/M) of a hospital inpatient and with the acuity of hospitalized patients. Patients seen in the emergency department typically have a higher acuity, are more precarious in their physical state, and many times do not have a diagnosis. Hospitalized patients have been seen and admitted by an on-site physician and have a preliminary diagnosis. Emergency patients do not. Yet, CMS reimburses for care delivered via telemedicine to emergency patients. We provide the following study as evidence that if the needs of higher acuity emergency patients can be met through telemedicine, we also believe that hospitalized patients' needs can also be met. In a study by Handschu et. al.[1], acute stroke care was evaluated. In acute stroke care, rapid but careful evaluation of patients is mandatory but requires an experienced stroke neurologist. Telemedicine offers the possibility of bringing such expertise quickly to more patients. This study tested for the first time whether remote video examination is feasible and reliable when applied in emergency stroke care using the National Institutes of Health Stroke Scale (NIHSS). A multimedia tele-support system for transfer of real-time video sequences and audio data was used. The remote examiner could direct the set-top camera and zoom from distant overviews to close-ups from the personal computer in his office. Acute stroke patients admitted to our stroke unit were examined on admission in the emergency room. Standardized examination was performed by use of the NIHSS (German version) via telemedicine and compared with bedside application. In this pilot study, 41 patients were examined. Total examination time was 11.4 minutes on average (range, 8 to 18 minutes). None of the examinations had to be stopped or interrupted for technical reasons. Unweighted [kappa] coefficients ranged from 0.44 to 0.89; weighted [kappa] coefficients, from 0.85 to 0.99. The study concluded that *remote examination of acute stroke patients with a computer-based telesupport system is feasible and reliable when applied in the emergency room*; inter-rater agreement was good to excellent in all items.

Since these early tests, the use of telemedicine for treating stroke patients has expended throughout the globe. At the Partners Telestroke Center in Boston, MA they have successfully

[1] LaMonte, Marian P. MD, MSN; Bahouth, Mona N. MSN, CS, CRNP; Hu, Peter MSE; Pathan, Mohammed Y. MD; Yarbrough, Karen L. MS, CS, CRNP; Gunawardane, Ruwani MD; Crarey, Patrick MD; Page, Wesley MD. Telemedicine for Acute Stroke: Triumphs and Pitfalls. Stroke. 34(3):725-728, March 2003.

used telemedicine to provide 24 hour acute "stroke expertise-on-demand" to a number of hospitals in Massachusetts. Their services are used by local hospitals to fulfill state and federal laws requiring such services for all emergency rooms. Similar services are starting to be used in many other hospitals and medical centers in the United States, Canada, the UK, Scandinavia and other parts of the world. According to a study performed at the Henry Ford Hospital in Detroit "Telemedicine for stroke has the promise to become a key revolutionary component of an integrated health-care delivery system. It can link rural hospitals and under-resourced urban hospitals with regional acute stroke centers of excellence, enhancing standardized streamlined care throughout a system's care facilities. It may be important to link isolated lower stroke volume hospitals to a larger stroke network." [2]

In some instances, not allowing these codes to be used can result in blocking Medicare patients from receiving these services, reversing previous Congressional and CMS policy and flying in the face of over 15 years of experience, federal investments and supportive research. For cases such as the use of telemedicine for early assessment of stroke patients and providing inpatient care where specialist services are not otherwise available, such a decision denying coverage will inevitably lead to additional early deaths.

With respect to cost, there is data showing that costs associated with hospitalizations in the acute management of the patient when specialty services are available via telemedicine go down. In a study conducted by the University of California at Davis, the objective of the research was to examine the fiscal impact of telemedicine consultations for acutely ill and injured children in a rural setting using pediatric intensive care unit (ICU) telemedicine. One hundred seventy-nine acutely ill and injured infants and children were cared for in the Mercy Redding ICU from April 2000 to April 2002. Data were gathered from these patients, including 47 patients who received 70 pediatric ICU telemedicine consultations during the same time period. Transport and hospital costs avoided were calculated for patients who received telemedicine consultations (Group 1) and for those not transferred due to the availability telemedicine consultations (Group 2), estimated to be one-half of the 179 patients (Group 2). The revenue generated in the rural ICU based on the ability to keep these patients was also determined. An estimated annual cost savings of $172,000 and $300,000 for transport and inpatient care was demonstrated for Group 1 and Group 2, respectively. Additionally, this program resulted in generating $186,000 and $279,000 of inpatient revenue annually for the two groups at the rural hospital. The cost of this program was approximately $120,000 per year. Given the substantial financial savings, support for underserved rural programs, and significant funds kept in the rural community, this may serve as a viable model for providing care to acutely ill and injured infants and children.[3]

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[2] "Telestroke" The Application of Telemedicine for Stroke, Steven R. Levine, MD Mark Gorman, MD, Center for Stroke Research & Henry Ford Stroke Program, Henry Ford Hospital & Health Science Center, Detroit, Mich, *Stroke.* 1999;30:464-469

[3] James P. Marcin, Thomas S. Nesbitt, Steven Struve, Craig Traugott, Robert J. Dimand. Telemedicine Journal and e-Health. 2004, 10(supplement 2): S-1-S-5. doi:10.1089/tmj.2004.10.S-1. Telemedicine Journal and e-Health. Financial Benefits of a Pediatric Intensive Care Unit-based Telemedicine Program to a Rural Adult Intensive Care Unit: Impact of Keeping Acutely Ill and Injured Children in Their Local Community

Neurobehavioral Status Exam and Neuropsychological Testing

ATA asked for approval of codes relating to both types of services. CMS approved neurobehavioral status exams (HCPCS code 96116) as an eligible telehealth service. However the Agency stated: "We believe that neuropsychological testing services are category 2 services because, as explained further below in this section, the roles of and interaction among the physician or practitioner at the distant site and beneficiary at the originating site are not similar to existing telehealth services." CMS added: "the information submitted was not sufficient to enable us to determine whether the use of a telecommunications system would affect the diagnosis or treatment plan as compared to a face-to-face delivery of neuropsychological testing services" (p. 38144). Therefore, CMS did not propose to add the service has asked for evidence where such services could be provided effectively using telemedicine, opening the door for a positive decision later.

The codes are used to report "the services provided during testing of the cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures". Testing includes administering such tests as the MMPI and WAIS, Developmental Screening Test II, Early Language Milestone Screen, etc. Typically, these tests are administered by a trained technician without the physician or provider present, under the general supervision requirements (Jun 23, 2006, CMS Manual System, Pub 100-02 Medicare Benefits Policy, sec 80). Physicians who will use 96116 to provide a neuropsychological exam will determine, as a result of that exam, which tests are appropriate for the patient. The tests are then typically administered by a technician who reports the results in a standardized fashion to the provider. In the telehealth example, there are many tests which are easily carried out via telehealth. Memory tests, visual recognition, language and other visual or verbally oriented tests can be easily administered via telehealth. For those tests that require in-person assistance, the telepresenter would assist, as they do in other consultations and visits already approved.

In a study by Cullum et. al. (2006)[4] the researchers studied whether or not videoconferencing could be used to administer neurocognitive assessments. The researchers administered a battery of common neuropsychological tests to persons with mild cognitive impairment or mild to moderate Alzheimer's disease. The Mini-Mental State Exam (MMSE) and the Clock Drawing Test were administered to patients aged 83 to 95 and compared in-person (face-to-face) with videoconferencing examination. The testing administered by videoconferencing was successfully completed in all cases, and there was close agreement with test findings when administered face-to-face. Telecognitive testing was well tolerated by all participants (p. 389).

Alberta Hospital Ponoka[5] was the site of a study where the feasibility of administering neuropsychological tests via videoconferencing was compared to face-to-face testing. Participants all over the age of 60 without neurological or psychiatric disturbance were tested under two experimental conditions – face-to-face and via videoconference at 336 or 384 kbps.

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[4] Cullum CM, Weiner MR, Gehrmann HR, Hynan LS. (2006). Feasibility of Telecognitive Assessment in Denentia. *Assessment* Vol 13, p. 385-390.

[5] Hildebrand R, Chow H, Williams C, Nelson M, Wass P. 2004. Feasibility of neuropsychological testing of older adults via videoconferen e: implications for assessing the capacity for independent living. *J Telemedi Telecare*, 10(3), 130-4.

Memory and learning, letter fluency, expressive word knowledge, reasoning, verbal attention, and visual-spatial processing were tested. Scores for expressive word knowledge were similar in the two test conditions.

In addition, there are several studies on the reliability of conducting neuropsychological testing over standard telephone, voice prompting, and computer technologies. Without the examiner present, patients complete neuropsychological testing effectively. Interactive voice response technology was used via POTS to measure cognitive function traditionally measured by a clinician or in paper-and-pencil formats.[6]

Telephone word-list recall was tested in a rural aging and memory study.[7] Word lists included the standardized telephone interview of cognitive status (TICS) and two newly developed lists. Results indicated that there were no differences in comparing the TICS and the two newly developed lists. This study, although not comparing in-person to telephone testing, does demonstrate that a standard does exist for telephonic neuropsychological testing, and that the introduction of video-conferencing to the equation will only enhance the accuracy and validity of testing.

And finally, with respect to telephonic testing, in a test of the reliability using a telephone interview procedure for cognitive, function, and behavioral scales in an elderly population with normal aging and dementia, researched performed assessments on patients both in-person and over the telephone. Results indicate that a telephone format is a reliable procedure for obtaining the assessment modalities studied.[8]

A web-based screening tool for monitoring cognitive status was tested in a study by Erlanger et. al.[9] Testing occurred over time to give neuropsychologists a better picture of an individual's cognitive status that a single point in time test. The study used screening batteries that could be administered online in a secure, supervised environment. Two neurocognitive test protocols were developed that were web-based and included components of standardized tests. The cognitive subsets were a number recall test, a number sequencing test, a memory cabinet 1 and 2 test, an incident learning 1 and 2 test, a response direction 1 and 2 test, a animal decoding test, and a symbol scanning test. Data from the study indicated that the four CSI factors had acceptable psychometric properties with regard to reliability and their correlation with traditional tests measuring similar cognitive function. Again, these tests were administered via computer.

ATA believes that again, addition of neuropsychological testing codes will have little budgetary impact, as previously demonstrated by the addition of 90801, and that evidence exists that many if not all neuropsychological testing can occur via telemedicine with reliable and valid results,

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[6] Mundt JC, Geralts DS, Moore HK. 2006. Dial "T" for testing: technological flexibility in neuropsychological assessement. *J Telemed Telecare*. Jun;12(3):317-23.

[7] Hogervorst E, Bandelow S, Hart J Jr, Henderson VW. Telephone word-list recall ested in the rural aging and memory study: two parallel versions for the TICS-M. *Int J Geriatr Psychiatr 2004 Sep;19(9):875-80.*

[8] Monteiro IM, Boksay I, Auer SR, Torossian C, Sinaiko E, Reisberg B. Reliability of routine clinincal instruments for the assessment of Alzheimer's disease administered by telephone. *J Geriart Psychiatry Neurol.* 1998 Spring;11(1):18-24.

[9] Erlanger DM, Kaus T, Bros D, Freeman J, Feldman D, Festa J. 2002. Development and validation of a web-based screening tool for monitoring cognitive status. *J Head Trauma Rehabi.* Vol 17(4):48-476

particularly in the environment with a telepresenter is with the patient. **With much interaction between health care providers and patients occurring over the telephone and through the use of computers, as well as substantial research showing the efficacy of such services, there is no plausible reason not to move forward with approval of 96118 and 96118.**

Submitter : **Dr. Poornima Paramesh** **Date: 08/30/2007**

Organization : **Dr. Poornima Paramesh**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Support: CMS-1385-P - Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies; Revisions to Payment Policies for Ambulance Services for CY 2008

CMS-1385-P-12297-Attach-1.DOC

#12297

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,
Dr. Poornima Paramesh

Submitter : **Ms. Sheena Woodard** **Date: 08/30/2007**

Organization : **Georgia State University**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer and graduate student at Georgia State University in Atlanta, GA.

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,

Sheena M. Woodard, ATC, MS

Submitter : **Mrs. Brittany Byrd** **Date: 08/30/2007**

Organization : **AANA**

Category : **Nurse**

Issue Areas/Comments

Background

Background

Offiec of the Administrator
Centers for Medicare & Medicaid Scrvices
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 Medieare & 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 benefieiaries 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 healtheare 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 privatc 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 rcimbursed 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 rcquiring 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,
Brittany Byrd, SRNA
3610 Nebraska Avenue
Nashville, TN 37209

Submitter : **Dr. Devan Bhagat** **Date: 08/30/2007**

Organization : **Hospital for Special Surgery**

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.

Devan D. Bhagat, MD
Hospital for Special Surgery

Submitter : **Date: 08/30/2007**

Organization :

Category : **Occupational Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Commenting on physician owned therapy practices and referral for profit.

I am an OT at a hospital based outpatient hand therapy clinic. In previous years we have been a thriving hand clinic supporting hours for 4 therapists. In the past 4 years 2 arca physician practices have opened their own therapy practices. Initially we were offered positions in their clinics however we declined concerned about the ethics of such a practice. Since this time we have seen a great decline in our business with little to no referrals from these same physicians. Today we have 3 therapists working only 20 hours each.

My concern regarding physician owned therapy practices is what I perceive to be unethical referral of patients to the physician's own therapy practice where they might recieve more therapy visits than they would if they were referred elsewhere. When the physician stands to benefit financially from prescribing therapy visits there is great risk of fraud and abuse. At times we have seen a patient for a family practice physician who then referred the patient for consultation with an orthopaedic specialst. The patient has then been told that they needed to attend therapy at that physician's office so the doctor could have better communication with the therapist. Prior to the doctor having his/her own practice there were never any complaints about communication with our therapy practice. Some patients have had to pay higher co-pays to attend therapy at the physician's office increasing their health care costs. Often we hear about patients that were offered no choice but to attend therapy at the physician's office and were not advised of the added cost. Another situation that we see is Medicare patients who are told that they must attend therapy at the physician's office. After the patient has used up all of their allowed therapy visits at this nonhospital based clinic then they are referred to our clinic where we must charge them (Medicare) for another evaluation. There is no continuity of care nor regard for the patient's own personal cxpense.

I feel that Medicare needs to investigate this practice of physician owned therapy because by its very nature it lends itself to fraud and abuse. It seems to me that it is a conflict of interest when the more therapy a doctor prescribes for his patient the more money he/she makes.

Submitter : **Dr. Winston Mark** **Date: 08/30/2007**

Organization : **Colquitt Chiropractic, LP**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimore, Maryland 21244-8018

Rc: "TECHNICAL CORRECTIONS"

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

By limiting a Doctor of Chiropractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources, seniors may choose to forgo X-rays and thus, needed treatment. If treatment is delayed, illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 30, 2007
Mr. Kerry N. Weems
Administrator Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule
Dear Mr. Weems:
I am a physical therapist who co-owns a private practice in Florence, AL, a small city in the northwest corner of the state. The clinic is relatively small, where we average about 25 patients per day. This is my 2nd year in private practice, although I spent time as a staff therapist, clinical director, and administrator for a large rehab company over the past 5 years.
The purpose of this letter is to express my concerns regarding Physician Self-Referral Issues. I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral exception. My comments are intended to highlight the wrongful nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.
My initial concern is that physicians have an inherent financial incentive to refer patients to the practices they have invested in, and to overutilize those services. I have witnessed this myself not only with PT services, but diagnostic services as well. Physicians are in a very influential position, and can often sway patients into an in-office ancillary service that may not be medically necessary.
The issue that I feel most strongly about is the fact that the in-office ancillary services exception has created a loophole that has resulted in the expansion of physician-owned arrangements that provide physical therapy services. Based on what I ve experienced, this type of arrangement decreases the quality of physical therapy care given to your patients. Physicians have a captive referral base of physical therapy patients in their offices, therefore, the need to provide superior care to sustain business is not warranted. This noncompetitive environment creates mediocrity, and your patients do not receive the service they deserve. In addition, I think you will find that the patients/therapist/day ratio will increase substantially, further decreasing the value of the physical therapy service provided.
In closing, I would like to thank you for considering my comments, and thank you for allowing our profession s voice to be heard concerning this matter.

CMS-1385-P-12303-Attach-1.DOC

#12303

September 13, 2007

Mr. Kerry N. Weems
Administrator – Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

Dear Mr. Weems:

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My initial concern is that physicians have an inherent financial incentive to refer patients to the practices they have invested in, and to overutilize those services. I have witnessed this myself not only with PT services, but diagnostic services as well. Physicians are in a very influential position, and can often sway patients into an "in-office ancillary service" that may not be medically necessary.

The issue that I feel most strongly about is the fact that the "in-office ancillary services" exception has created a loophole that has resulted in the expansion of physician-owned arrangements that provide physical therapy services. Based on what I've experienced, this type of arrangement decreases the quality of physical therapy care given to your patients. Physicians have a captive referral base of physical therapy patients in their offices, therefore, the need to provide superior care to sustain business is not warranted. This noncompetitive environment creates mediocrity, and your patients do not receive the service they deserve. In addition, I think you will find that the patients/therapist/day ratio will increase substantially, further decreasing the value of the physical therapy service provided.

In closing, I would like to thank you for considering my comments, and thank you for allowing our profession's voice to be heard concerning this matter.

Submitter : **Mr. Kris Tarlton** **Date: 08/30/2007**

Organization : **AANA**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

August 30, 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,

Kris Tarlton, CRNA
909 East 5th
Hoisington, Kansas
67544

Submitter : **Mr. Chad Bergman** **Date: 08/30/2007**

Organization : **San Antonio Spurs**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,
My name is Chad Bergman. I am the Assistant Athletic Trainer for the San Antonio Spurs. I am writing today to voice my opposition to the therapy standards and rcquiremcnts in regards to the staffing provisions for rehab in hospitals and facilties proposed in 1385-P.
As an athletic trainer I am qualified to perform physical medicine and rehab services, which you know is not the same as physical therapy.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the rccommcndations of those professionals that are tasked with overseeing the day-to-day health care needs of patients. I respectfully request that you withdraw the proposed changes related to hopitals, rural clinics, andany Medicare Part A or B hospital or rehab facility.

Sincerely,
Chad Bergman, ATC

Submitter : **Andy McGill** **Date: 08/30/2007**

Organization : **University Orthopaedic Clinic**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached letter with comments.

CMS-1385-P-12306-Attach-1.DOC

#12306

UOC
University Orthopaedic Clinic & Spine Center

H. CHESTER BOSTON, JR., M.D. ★● Δ ❑
Spinal Disorders
Surgery of the Spine ▲

JOHN P. BUCKLEY, M.D. ★● ○ ❑
Arthroscopic &
Orthopaedic Surgery
Surgery of the Hand &
Upper Extremity ▲

STEPHEN T. IKARD, M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Total Joint Replacement ▲

DONALD S. SCOTT, M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Work Related Injuries

L. SCOTT ATKINS, JR., M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Knee & Shoulder Surgery

JAMES T. BARNETT, JR., M.D. ■
Physical Medicine &
Rehabilitation

WILLIAM C. STANDEFER, JR., M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Sports Medicine ▲

FREDERICK S. GRAHAM, M.D. ■
Physical Medicine &
Rehabilitation
Interventional Spine Procedures ▲

BRIAN S. CLAYTOR, M.D.
Spinal Disorders
Surgery of the Spine ▲

DONNA S. WOOD
Chief Executive Officer

OFFICES
305 Bryant Drive, East
P.O. Box 2447
Tuscaloosa, AL 35403

400 Bryant Drive, East
Tuscaloosa, Alabama 35401

Northport Medical Plaza
2702 Hospital Dr., Suite 101
Northport, Alabama 35476

Phone: (205) 345-0192
(800) 218-4UOC (4862)
Tuscaloosa Fax: (205) 345-7341
Northport Fax: (205) 333-9935

www.univorthoclinic.com
Email: uoc@dbtech.net

OTHER LOCATIONS
Bibb Medical Associates
Centreville, Alabama

Fayette Medical Associates
Fayette, Alabama

August 29, 2007

Via Electronic Submittal to CMS
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

RE: CMS 1385-P
In Office Ancillary Services Exemption

Dear Sir or Madam:

Thank you for the opportunity to comment regarding whether changes are necessary pertaining to the PHYSICIAN SELF-REFERRAL PROVISIONS.

I am a licensed physical therapist in the state of Alabama who has chosen to work for an orthopaedic physician practice. Our physical therapy services are only offered to patients who are referred by the physicians in this practice. I find that this arrangement is highly beneficial to the patient because we are able to see patients the same day that physical therapy is prescribed, access the complete medical file and history of the patient and have greater interaction with the referring physician regarding the patient's care.

Once physical therapy is prescribed, the patient can choose where to receive their physical therapy services. Many patients prefer the convenience of having their physical therapy at the same location of their physician's office. This is not an arrangement that encourages abuse. Therapy services should continue to qualify for the in office ancillary services exception.

The views expressed by a national letter-writing campaign promoted by the American Physical Therapy Association are not representative of the opinions of the majority of physical therapists.

Sincerely,

Andrew McGill, PT, ATC

Submitter : Dr. Lawrence Elliott **Date:** 08/30/2007

Organization : South County Heart Center

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

I am writing on behalf of my group. I feel that the MTWA is avery important tool to determine a patient's risk of sudden cardiac death.
We use this test to determine which patients will benefit most from an implantable cardioverter defibrillator.(ICD) I understand that the Medicare Practice Formaula significantly decreases physician payment for MTWA reimbursement. The "equipment usage assumption" of 50%is inacurate, which results in an inappropriate payment for physicians. We only use this test for specific high risk patients, who meet the criteria, and will benefit form this analysis. We use the test only when indicated, not 50% of the time. I feel that CMS should use the actual usage rate when available, to pay for this valuable technology..

Submitter : Mr. Walter Blase **Date:** 08/30/2007

Organization : Atlanta Hawks NBA Team

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-12308-Attach-1.DOC

#12308

Dear Sir or Madam:

My Name is Walter Blase, I am the Head Athletic Trainer for the Atlanta Hawks NBA Team. I am a certified Athletic Trainer, through the NATA, and have a Bachelors of Science degree in sports medicine from Winona State University, and a Masters of Science Degree from Syracuse University. I also hold credentials from the NASM, as a (CES) Corrective exercise specialist, and (PES) Performance enhancement specialist. As well as being certified strength and conditioning specialist through the NSCA

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,

Walter R. Blase, M.S. ATC, CSCS, PES, CES

Submitter : Mr. Donald Beckley **Date:** 08/30/2007

Organization : Middle Tennessee School of Anethesia

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

If this proposal is approved, it will help to correct the value of anesthesia services which have long been undervalued and have slipped behind inflation adjustments!

Submitter : **Mrs. Joanna McClarey** **Date: 08/30/2007**

Organization : **Audrain Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Joanna McClarey and have been a Certified Athletic Trainer since 1991. I have an B.A. from Grinnell College (1989) and a M.S. from Indiana University (1991). I have worked in a combination role since 1991 providing care to community athletes and assisting in outpatient clinic. Currently I reside in a rural area of Missouri. Over the past two years I have seen a drastic change in the level or care I have been allowed to provide persons in the clinic due to insurance issues.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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Sincerely,

Joanna McClarey, ATC M.S.

Submitter : **Dr. Brandy Conrad** **Date: 08/30/2007**

Organization : **Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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 : Mr. JP Hamilton **Date:** 08/30/2007

Organization : Ocoee High School - Orange Co. Public Schools

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer in Ocoee, FL working as a full time teacher/athletic trainer in the secondary school 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.

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Sincerely,

JP Hamilton, MS, ATC, LAT
Ocoee High School
1925 Ocoee Crown Point Parkway
Ocoee, FL 34761
407-905-3000 ext 4107
hamiltj@ocps.net

Submitter : **Dr. Jeffrey Edelman** **Date: 08/30/2007**

Organization : **Analytical Pathology Services**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 30, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in a small private pathology group which is currently dealing intensely with the issue of self referral of prostate biopsies by urologists.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,

Jeffrey Edelman M.D.
11133 Dunn Rd.; Pathology Dept.
St. Louis MO 63136

Submitter : EMily Smith **Date:** 08/30/2007

Organization : University Orthopaedic Clinic

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see comments in letter.

CMS-1385-P-12315-Attach-1.DOC

#12315

UOC
University Orthopaedic Clinic & Spine Center

H. CHERRIE BOSTON, JR., M.D. ★● △ ❑
Spinal Disorders
Surgery of the Spine ▲

JOHN P. BUCKLEY, M.D. ★● ○ ❑
Arthroscopic & Orthopaedic Surgery
Surgery of the Hand & Upper Extremity ▲

STEPHEN T. IKARD, M.D. ● ❑
Arthroscopic & Orthopaedic Surgery
Total Joint Replacement ▲

DONALD S. SCOTT, M.D. ● ❑
Arthroscopic & Orthopaedic Surgery
Work Related Injuries

L. SCOTT ATKINS, JR., M.D. ● ❑
Arthroscopic & Orthopaedic Surgery
Knee & Shoulder Surgery

JAMES T. BARNETT, JR., M.D. ■
Physical Medicine & Rehabilitation

WILLIAM C. STANDEFFER, JR., M.D. ● ❑
Arthroscopic & Orthopaedic Surgery
Sports Medicine ▲

FREDERICK S. GRAHAM, M.D. ■
Physical Medicine & Rehabilitation
Interventional Spine Procedures ▲

BRIAN S. CLAYTOR, M.D.
Spinal Disorders
Surgery of the Spine ▲

DONNA S. WOOD
Chief Executive Officer

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www.univorthoclinic.com
Email: uoc@dbtech.net

OTHER LOCATIONS
Bibb Medical Associates
Centreville, Alabama

Fayette Medical Associates
Fayette, Alabama

August 29, 2007

Via Electronic Submittal to CMS
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

RE: CMS 1385-P
In Office Ancillary Services Exemption

Dear Sir or Madam:

Thank you for the opportunity to comment regarding whether changes are necessary pertaining to the PHYSICIAN SELF-REFERRAL PROVISIONS.

I am a licensed physical therapist in the state of Alabama who has chosen to work for an orthopaedic physician practice. Our physical therapy services are only offered to patients who are referred by the physicians in this practice. I find that this arrangement is highly beneficial to the patient because we are able to see patients the same day that physical therapy is prescribed, access the complete medical file and history of the patient and have greater interaction with the referring physician regarding the patient's care.

Once physical therapy is prescribed, the patient can choose where to receive their physical therapy services. Many patients prefer the convenience of having their physical therapy at the same location of their physician's office. This is not an arrangement that encourages abuse. Therapy services should continue to qualify for the in office ancillary services exception.

The views expressed by a national letter-writing campaign promoted by the American Physical Therapy Association are not representative of the opinions of the majority of physical therapists.

Sincerely,

Emily Smith, PT

Emily Smith, P.T.

△ CERTIFIED AMERICAN BOARD OF SPINE SURGERY
❑ DIPLOMATE OF THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY (A.B.O.S.)
● FELLOW OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
▲ POST RESIDENCY FELLOWSHIP TRAINING
★ FELLOW OF THE AMERICAN COLLEGE OF SURGEONS
○ MEMBER AMERICAN SOCIETY FOR SURGERY OF THE HAND
■ DIPLOMATE OF THE AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION

Submitter : **Dr. Karrin Stoehr** **Date: 08/30/2007**

Organization : **Twin Cities Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,
Dr. Karrin Stoehr

Submitter : **Dr. Jacques YaDeau** **Date: 08/30/2007**

Organization : **Hospital for Special Surgery**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Jacques YaDeau, MD, PhD

Submitter : **Haley Blackwell** **Date: 08/30/2007**

Organization : **University Orthopaedic Clinic, PC**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached comments.

CMS-1385-P-12318-Attach-1.DOC

#12318

UOC
University Orthopaedic Clinic & Spine Center

H. CHESTER BOSTON, JR., M.D. ★● △ ❑
Spinal Disorders
Surgery of the Spine ▲

JOHN P. BUCKLEY, M.D. ★● ○ ❑
Arthroscopic &
Orthopaedic Surgery
Surgery of the Hand &
Upper Extremity ▲

STEPHEN T. ILKARD, M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Total Joint Replacement ▲

DONALD S. SCOTT, M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Work Related Injuries

L. SCOTT ATKINS, JR., M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Knee & Shoulder Surgery

JAMES T. BARNETT, JR., M.D. ■
Physical Medicine &
Rehabilitation

WILLIAM C. STANDEFER, JR., M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Sports Medicine ▲

FREDERICK S. GRAHAM, M.D. ■
Physical Medicine &
Rehabilitation
Interventional Spine Procedures ▲

BRIAN S. CLAYTOR, M.D.
Spinal Disorders
Surgery of the Spine ▲

DONNA S. WOOD
Chief Executive Officer

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Fayette, Alabama

August 29, 2007

Via Electronic Submittal to CMS
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

RE: CMS 1385-P
In Office Ancillary Services Exemption

Dear Sir or Madam:

Thank you for the opportunity to comment regarding whether changes are necessary pertaining to the PHYSICIAN SELF-REFERRAL PROVISIONS.

I am a licensed physical therapist assistant in the state of Alabama who has chosen to work for an orthopaedic physician practice. Our physical therapy services are only offered to patients who are referred by the physicians in this practice. I find that this arrangement is highly beneficial to the patient because we are able to see patients the same day that physical therapy is prescribed, access the complete medical file and history of the patient and have greater interaction with the referring physician regarding the patient's care.

Once physical therapy is prescribed, the patient can choose where to receive their physical therapy services. Many patients prefer the convenience of having their physical therapy at the same location of their physician's office. This is not an arrangement that encourages abuse. Therapy services should continue to qualify for the in office ancillary services exception.

The views expressed by a national letter-writing campaign promoted by the American Physical Therapy Association are not representative of the opinions of the majority of physical therapists or physical therapy assistants.

Sincerely,

Haley Blackwell

Haley Blackwell, P.T.A.

△ CERTIFIED AMERICAN BOARD OF SPINE SURGERY
❑ DIPLOMATE OF THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY (A.B.O.S.)
● FELLOW OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
▲ POST RESIDENCY FELLOWSHIP TRAINING
★ FELLOW OF THE AMERICAN COLLEGE OF SURGEONS
○ MEMBER AMERICAN SOCIETY FOR SURGERY OF THE HAND
■ DIPLOMATE OF THE AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Provider**

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.

? 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,

James A. Chervoni, MSN, CRNA
Name & Credential
8424 Mannington Place
Address
Converse, TX 78109
City, State ZIP

Submitter : **Chris Boyle** **Date: 08/30/2007**

Organization : **University Orthopaedic CLinic, PC**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

PLease see attached comments.

CMS-1385-P-12320-Attach-1.DOC

#12320

UOC

University Orthopaedic Clinic & Spine Center

H. CHERRY BOSTON, JR., M.D. ★● △ ❑
Spinal Disorders
Surgery of the Spine ▲

JOHN P. BUCKLEY, M.D. ★● ○ ❑
Arthroscopic &
Orthopaedic Surgery
Surgery of the Hand &
Upper Extremity ▲

STEPHEN T. IKARD, M.D. ● ❑
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Interventional Spine Procedures ▲

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Spinal Disorders
Surgery of the Spine ▲

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August 29, 2007

Via Electronic Submittal to CMS
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

RE: CMS 1385-P
In Office Ancillary Services Exemption

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Sincerely,

Chris Boyle, PT, ATC

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❑ DIPLOMATE OF THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY (A.B.O.S.)
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★ FELLOW OF THE AMERICAN COLLEGE OF SURGEONS
○ MEMBER AMERICAN SOCIETY FOR SURGERY OF THE HAND
■ DIPLOMATE OF THE AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION

Submitter : **Dr. Grover Mims** **Date: 08/30/2007**

Organization : **WFU Health Sciences**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Minerva Betancourt** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
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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).
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Sincerely,
_Minerva Betancourt, CRNA
2734 Evelyn Dr.
Apopka, Fl 32703

Submitter : **Mr. James Mackie** **Date: 08/30/2007**

Organization : **St Vincent's Medical Center**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 30, 2007

Centers for Medicare and Medicade Services

Dear Sir or Madam:

I have been an Athletic Trainer for 35 years working in a variety of settings, the last 15 years in the Hospital Out-patient Rehabilitation and High School outreach setting. I have a Masters degree, and have met annual continuing education requirements as a Certified Athletic Trainer. I am licensed to practice as an Athletic Trainer in Florida. 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,

Jim Mackie

James H. Mackie, M.Ed., ATC, LAT

Submitter : John Robison **Date:** 08/30/2007

Organization : University Orthopaedic CLinic, PC

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached comments

CMS-1385-P-12324-Attach-1.DOC

#12324

University Orthopaedic Clinic & Spine Center

H. CHESTER BOSTON, JR., M.D. ★● △ □
Spinal Disorders
Surgery of the Spine ▲

JOHN P. BUCKLEY, M.D. ★● ○ □
Arthroscopic &
Orthopaedic Surgery
Surgery of the Hand &
Upper Extremity ▲

STEPHEN T. HARD, M.D. ● □
Arthroscopic &
Orthopaedic Surgery
Total Joint Replacement ▲

DONALD S. SCOTT, M.D. ● □
Arthroscopic &
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Work Related Injuries

L. SCOTT ATKINS, JR., M.D. ● □
Arthroscopic &
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JAMES T. BARNETT, JR., M.D. ■
Physical Medicine &
Rehabilitation

WILLIAM C. STANDEFFER, JR., M.D. ● □
Arthroscopic &
Orthopaedic Surgery
Sports Medicine ▲

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Physical Medicine &
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Interventional Spine Procedures ▲

BRIAN S. CLAYTOR, M.D.
Spinal Disorders
Surgery of the Spine ▲

DONNA S. WOOD
Chief Executive Officer

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August 29, 2007

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The views expressed by a national letter-writing campaign promoted by the American Physical Therapy Association are not representative of the opinions of the majority of physical therapists.

Sincerely,

John Robison, DPT

Submitter : **Dr. Meenoo Agarwal** **Date: 08/30/2007**

Organization : **Dr. Meenoo Agarwal**

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

Rc: CMS-1385-P

Anesthcsia 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 othcr 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 ensurc 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 : **Sandy Stanard** **Date: 08/30/2007**

Organization : **University Orthopaedic CLinic, PC**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached comments.

CMS-1385-P-12326-Attach-1.DOC

12326

UOC

University Orthopaedic Clinic & Spine Center

H. CHESTER BOSTON, JR., M.D. ★● Δ ❑
Spinal Disorders
Surgery of the Spine ▲

JOHN P. BUCKLEY, M.D. ★● ○ ❑
Arthroscopic &
Orthopaedic Surgery
Surgery of the Hand &
Upper Extremity ▲

STEPHEN T. IKARD, M.D. ● ❑
Arthroscopic &
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Total Joint Replacement ▲

DONALD S. SCOTT, M.D. ● ❑
Arthroscopic &
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Work Related Injuries

L. SCOTT ATKINS, JR., M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Knee & Shoulder Surgery

JAMES T. BARNETT, JR., M.D. ■
Physical Medicine &
Rehabilitation

WILLIAM C. STANDIFER, JR., M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Sports Medicine ▲

FREDERICK S. GRAHAM, M.D. ■
Physical Medicine &
Rehabilitation
Interventional Spine Procedures ▲

BRIAN S. CLAYTOR, M.D.
Spinal Disorders
Surgery of the Spine ▲

DONNA S. WOOD
Chief Executive Officer

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Tuscaloosa Fax: (205) 345-7341
Northport Fax: (205) 333-9935

www.univorthoclinic.com
Email: uoc@dbtech.net

OTHER LOCATIONS
Bibb Medical Associates
Centreville, Alabama

Fayette Medical Associates
Fayette, Alabama

August 29, 2007

Via Electronic Submittal to CMS
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

RE: CMS 1385-P
In Office Ancillary Services Exemption

Dear Sir or Madam:

Thank you for the opportunity to comment regarding whether changes are necessary pertaining to the PHYSICIAN SELF-REFERRAL PROVISIONS.

I am a licensed physical therapist in the state of Alabama who has chosen to work for an orthopaedic physician practice. Our physical therapy services are only offered to patients who are referred by the physicians in this practice. I find that this arrangement is highly beneficial to the patient because we are able to see patients the same day that physical therapy is prescribed, access the complete medical file and history of the patient and have greater interaction with the referring physician regarding the patient's care.

Once physical therapy is prescribed, the patient can choose where to receive their physical therapy services. Many patients prefer the convenience of having their physical therapy at the same location of their physician's office. This is not an arrangement that encourages abuse. Therapy services should continue to qualify for the in office ancillary services exception.

The views expressed by a national letter-writing campaign promoted by the American Physical Therapy Association are not representative of the opinions of the majority of physical therapists.

Sincerely,

Sandy E. Stanard

Sandy E. Stanard, PT

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See Attachment

CMS-1385-P-12327-Attach-1.DOC

#12327

August 28, 2007

To: Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

From: Ryan Smith, PT
CEO and Co-Owner
Sports Center Physical Therapy
1600 W. 38th St., Suite 201
Austin, TX 78731

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

Dear Mr. Weems,

My name is Ryan Smith and I am a physical therapist and private practice owner in Austin, TX. I have been practicing since 1998 in the state of Oklahoma and Texas. I received my Physical Therapy degree from the University of Oklahoma in 1998 and my Masters of Business Administration from Oklahoma City University in 2000. I currently co-own a private, outpatient, orthopedic physical therapy practice in Austin, TX called Sports Center Physical Therapy.

The purpose of my letter is to address **Physician Self-Referral to Physical Therapy**. I would like to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. My comments are intended to highlight the abusive nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

KEY POINT: The potential for fraud and abuse exists whenever physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to over-utilize those services for financial reasons. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, over-utilization of physical therapy services under the Medicare program, and enhance the quality of patient care.

Examples

- With the rise of physician-owned physical therapy practices in Austin over the past 5 years, we are now seeing a large portion of patients who are first being referred to their orthopedist's

inexperienced physical therapy group, exhausting their PT benefits and then arriving at our clinic without the resources to get the problem resolved. These are the same surgeons that we worked with for years in a professional manner to help heal our patients. Now they send all of their patients needing PT to their in-house PT group where the tools and staff are often inadequate to meet the patient's needs, particularly with joint disease, cartilage injuries, and tendon injuries. This occurs because the PT services are often an after-thought in terms of tools and investment because they are physicians first, not PTs. This only harms the beneficiaries.

- Patients are losing the right to choose where they receive their care. Many beneficiaries do exactly what their physicians tell them and they do not understand they have a choice in who they see. This gives physicians an unfair advantage since they are required to provide a prescription for PT services in Texas. As a result, Sports Center is the only major privately owned PT practice left in Austin, TX that we are aware of. All other PT practices are now either corporately owned through HealthSouth, USPT, or physicians. In the 16th largest market in the US, physical therapists should be able to succeed in the market, but they cannot because building a practice is so difficult due to physician self-referral.

- The "in-office ancillary services" exception is defined so broadly in the regulations that it facilitates the creation of abusive referral arrangements. With the physician's payments decreasing, the urge to self refer for PT is too strong and creates a significant other source of revenue. Our experience shows that the in-house PT services are often abused and inadequate to meet the patient's needs.

- The "in-office ancillary services" exception has created a loophole that has resulted in the expansion of physician-owned arrangements that provide physical therapy services. Because of Medicare referral requirements, physicians have a captive referral base of physical therapy patients in their offices.

- Due to the repetitive nature of physical therapy services, it is no more convenient for the patient to receive services in the physician's office than an independent physical therapy clinic such as ours that is located centrally in Austin, TX.

I strongly urge the CMS to remove physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws.

Thank you Mr. Weems for considering my comments.

Sincerely,

Ryan M. Smith, PT

Ryan Smith, PT
CEO and Co-Owner
Sports Center

Submitter : Dr. John Xerogeanes **Date:** 08/30/2007

Organization : Emory Sports Medicine Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Aug 30 2007

CMS-1385-P-12328-Attach-1.DOC

#12328

EMORY HEALTHCARE

EMORY SPORTS MEDICINE CENTER

59 Executive Park South, suite 1000
Atlanta, Georgia 30329
Phone 404.778.7176
Fax 404.778.7266

Dear Sir or Madam:

To Whom It May Concern; this is John W. Xerogeanes MD, Chief of Sports Medicine at Emory Orthopaedics and Spine Center, Emory Sports Medicine Center. Emory Sports Medicine Center is a sub-specialty sports medicine orthopaedic practice including 6 fellowship trained sports medicine physicians. We have employed certified athletic trainers in our practice for the past 10 years and feel these are key professionals and the most appropriate heath care providers in the orthopaedic 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.

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,

John W Xerogeanes MD
Chief of Sports Medicine, Emory Orthopaedics and Spine Center
Head Team Physician Georgia Tech Athletics, Emory University Athletics
Emory Sports Medicine Center
59 Executive Park South, suite 1000
Atlanta GA. 30329
ph: 404.778.7202
fx: 404.778.4324
John.xerogeanes@emoryhealthcare.org

Submitter : **Mrs. Susan Edkins** **Date: 08/30/2007**

Organization : **The University of North Carolina at Pembroke**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am the Director of the Athletic Training Education Program at The University of North Carolina at Pembroke. I was a practicing certified athletic trainer for 15 years, and now I am preparing young men and women to become certified athletic trainers. I have a masters degree in Human Movement Studies (Advanced Athletic Training) with a concentration in Clinical Anatomy from the University of Oregon.

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.

We recently completed the rigorous accreditation process through CAATE for the undergraduate Athletic Training Education Program I direct at UNCP. My university is in a rural area where lack of adequate health care is of major concern. The athletic training students we are educating are capable of and willing to perform services to a population of people who are currently very underserved, but this law will take job opportunties away from them.

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,

Susan Edkins, MS, ATC, LAT

Submitter : **Dr. David Willis** **Date: 08/30/2007**

Organization : **University of Utah**

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,

David M. Willis, M.D., Ph.D.

Submitter : SUsan Herrin **Date:** 08/30/2007

Organization : University Orthopaedic CLinic, PC

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached comments.

CMS-1385-P-12331-Attach-1.DOC

#12331

University Orthopaedic Clinic & Spine Center

H. CHESTER BOSTON, JR., M.D. ★● △ ❑
Spinal Disorders
Surgery of the Spine ▲

JOHN P. BUCKLEY, M.D. ★● ○ ❑
Arthroscopic &
Orthopaedic Surgery
Surgery of the Hand &
Upper Extremity ▲

STEPHEN T. BEARD, M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Total Joint Replacement ▲

DONALD S. SCOTT, M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Work Related Injuries

L. SCOTT ATKINS, JR., M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Knee & Shoulder Surgery

JAMES T. BARNETT, JR., M.D. ■
Physical Medicine &
Rehabilitation

WILLIAM C. STANDEFER, JR., M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Sports Medicine ▲

FREDERICK S. GRAHAM, M.D. ■
Physical Medicine &
Rehabilitation
Interventional Spine Procedures ▲

BRIAN S. CLAYTOR, M.D.
Spinal Disorders
Surgery of the Spine ▲

DONNA S. WOOD
Chief Executive Officer

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305 Bryant Drive, East
P.O. Box 2447
Tuscaloosa, AL 35403

400 Bryant Drive, East
Tuscaloosa, Alabama 35401

Northport Medical Plaza
2702 Hospital Dr., Suite 101
Northport, Alabama 35476

Phone: (205) 345-0192
(800) 218-4UOC (4862)
Tuscaloosa Fax: (205) 345-7341
Northport Fax: (205) 333-9935

www.univorthoclinic.com
Email: uoc@dbtech.net

OTHER LOCATIONS
Bibb Medical Associates
Centreville, Alabama

Fayette Medical Associates
Fayette, Alabama

August 29, 2007

Via Electronic Submittal to CMS
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

RE: CMS 1385-P
In Office Ancillary Services Exemption

Dear Sir or Madam:

Thank you for the opportunity to comment regarding whether changes are necessary pertaining to the PHYSICIAN SELF-REFERRAL PROVISIONS.

I am a licensed physical therapist in the state of Alabama who has chosen to work for an orthopaedic physician practice. Our physical therapy services are only offered to patients who are referred by the physicians in this practice. I find that this arrangement is highly beneficial to the patient because we are able to see patients the same day that physical therapy is prescribed, access the complete medical file and history of the patient and have greater interaction with the referring physician regarding the patient's care.

Once physical therapy is prescribed, the patient can choose where to receive their physical therapy services. Many patients prefer the convenience of having their physical therapy at the same location of their physician's office. This is not an arrangement that encourages abuse. Therapy services should continue to qualify for the in office ancillary services exception.

The views expressed by a national letter-writing campaign promoted by the American Physical Therapy Association are not representative of the opinions of the majority of physical therapists.

Sincerely,

Susan Herrin, PT

△ CERTIFIED AMERICAN BOARD OF SPINE SURGERY
❑ DIPLOMATE OF THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY (A.B.O.S.)
● FELLOW OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
▲ POST RESIDENCY FELLOWSHIP TRAINING
★ FELLOW OF THE AMERICAN COLLEGE OF SURGEONS
○ MEMBER AMERICAN SOCIETY FOR SURGERY OF THE HAND
■ DIPLOMATE OF THE AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION

Submitter : **Carrie Williams** **Date: 08/30/2007**

Organization : **University Orthopaedic Clinic, PC**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached comments.

CMS-1385-P-12337-Attach-1.DOC

#12337

UOC
University Orthopaedic Clinic & Spine Center

H. CHESTER BOSTON, JR., M.D. ★● △ ❑
Spinal Disorders
Surgery of the Spine ▲

JOHN P. BUCKLEY, M.D. ★● ○ ❑
Arthroscopic &
Orthopaedic Surgery
Surgery of the Hand &
Upper Extremity ▲

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Arthroscopic &
Orthopaedic Surgery
Total Joint Replacement ▲

DONALD S. SCOTT, M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Work Related Injuries

L. SCOTT ATKINS, JR., M.D. ● ❑
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Physical Medicine &
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Arthroscopic &
Orthopaedic Surgery
Sports Medicine ▲

FREDERICK S. GRAHAM, M.D. ■
Physical Medicine &
Rehabilitation
Interventional Spine Procedures ▲

BRIAN S. CLAYTOR, M.D.
Spinal Disorders
Surgery of the Spine ▲

DONNA S. WOOD
Chief Executive Officer

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Fayette, Alabama

August 29, 2007

Via Electronic Submittal to CMS
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

RE: CMS 1385-P
In Office Ancillary Services Exemption

Dear Sir or Madam:

Thank you for the opportunity to comment regarding whether changes are necessary pertaining to the PHYSICIAN SELF-REFERRAL PROVISIONS.

I am a licensed physical therapist assistant in the state of Alabama who has chosen to work for an orthopaedic physician practice. Our physical therapy services are only offered to patients who are referred by the physicians in this practice. I find that this arrangement is highly beneficial to the patient because we are able to see patients the same day that physical therapy is prescribed, access the complete medical file and history of the patient and have greater interaction with the referring physician regarding the patient's care.

Once physical therapy is prescribed, the patient can choose where to receive their physical therapy services. Many patients prefer the convenience of having their physical therapy at the same location of their physician's office. This is not an arrangement that encourages abuse. Therapy services should continue to qualify for the in office ancillary services exception.

The views expressed by a national letter-writing campaign promoted by the American Physical Therapy Association are not representative of the opinions of the majority of physical therapists or physical therapy assistants.

Sincerely,

Carrie Williams

Carrie Williams, PTA

Submitter : **Ms. Malina Maneevone** **Date: 08/30/2007**

Organization : **AANA**

Category : **Nurse**

Issue Areas/Comments

Background

Background

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 : **Dr. Tonya Parker** **Date: 08/30/2007**

Organization : **Grand Valley State University**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer and an educator in an athletic training education program.

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,
Tonya M. Parker, PhD, ATC
Grand Valley State University
Allendale, Michigan

Submitter : Mr. Clint Jones **Date:** 08/30/2007

Organization : Clemson University Sports Medicine

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Clint Jones. I am currently a Graduate Student at Clemson University in Clemson, South Carolina. I am working under an assistantship with Clemson Sports Medicine as a Graduate Athletic Trainer. I have also completed my Bachelor's of Science from Bowling Green State University in Bowling Green, Ohio. Where I obtained my Bachelor's degree from a four year Accredited Athletic Training Program.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Clint Jones

Submitter : Dr. Greg Sailer **Date:** 08/30/2007

Organization : Lincoln Anesthesiology Group, P.C.

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Thank you for your consideration on this very important issue. As an anesthesiologist working at a large community-based hospital, I find that an ever-increasing percentage of our surgical patients are medicare/medicaid recipients. Unfortunately, more and more of the privately insured patients are having their procedures performed at outpatient surgery centers. Therefore, an increase in CMS's anesthesia conversion factor would be a great benefit to those anesthesiologists who take care of a larger proportion of the medicare/medicaid population.

Submitter : **Ms. Markita Poellnitz** **Date: 08/30/2007**

Organization : **Alabama Orthopedic Clinic**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Thank you for the opportunity to comment on Physician Self-Referral Provisions.

I work for an orthopaedic physician practice which is benefical for our patients. This provision allow direct and effectient communication from their physician to their therapist, thorough and prompt response for patients medical history, and save patients time and money from their busy lifestyle. We should continue to give patients opportunity and resources to choose where they should recieve physical therapy. If the provision is not pass therefore you are taking away patients rights. Patients have the right to choose their physician as well as where they choose to recieve physicial therapy. We as skilled clinicians chose this profession to serve and to take care of patients with the best of our knowledge so patients can return to their functional lifestyle as soon as possible. Patients should not be limited nor prolong on their recovery because they have enough physical challenges in their life.

Sincerely,

Markita Poellnitz, LPTA

CMS-1385-P-12343

Submitter : Dr. Charles Laurito **Date:** 08/30/2007

Organization : University of Illinois at Chicago

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-12343-Attach-1.DOC

#12343

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 **August 30, 2007**

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.

Charles E. Laurito, MD

Professor of Anesthesiology and of

Anatomy & Cell Biology

University of Illinois at Chicago

Submitter : **Jill McCormick** **Date: 08/30/2007**

Organization : **Excel Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jill McCormick. I am a PT and an ATC. I own my own out patient clinic where we serve patients, young and old, athletic, geriatric, and in between. My clinic employs ATCs and we serve the local high schools, covering their athletic events to prevent and treat injuries "on the field".

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,

Jill McCormick, PT, ATC

Submitter : Dr. Lori Stricker **Date:** 08/30/2007

Organization : Children's Hospital of Michigan

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. John Meyer** **Date: 08/30/2007**

Organization : **Dr. John Meyer**

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

Dear Ms. Norwlk,

As a practicing Anesthesiologist in western North Carolina, your agencies reimbursement for anesthesia services directly affects me and my patients. At current reimbursement levels I lose money on every Medicare patient I take care of. With other costs in my practice continuing to rise, there is no longer any efficiencies to make up for this loss. I am going to be forced to cut back services to these patients, or not treat them at all. This is not what I want to do, but the economics leave little choice. The government does not expect defense contractors to produce our nations weapons systems at a loss; please don t expect us to take care of our nations citizens at below cost. I m not asking for a profit in taking care of these patients; I just don t think it is my professions responsibility to pay for their care out of our own pockets.

Please consider carefully CMS-1385-P and increasing the anesthesia payments under the 2009 Physician Fee Schedule. This is a serious matter that will affect seniors throughout the country.

Sincerely,

John A. Meyer, M.D.
Asheville Anesthesia Assoc., P.A.
Asheville, NC 28730

Submitter : **Dr. Ambrose Perduk Jr** **Date: 08/30/2007**

Organization : **Dr. Ambrose Perduk Jr**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

Re: TECHNICAL CORRECTIONS

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

By limiting a Doctor of Chiropractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,

Dr. Ambrose Perduk, Jr.

Submitter : **Dr. Daniel Maalouf** **Date: 08/30/2007**

Organization : **Hospital for Special Surgery**

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.

Daniel Maalouf, MD, MPH

Submitter : Dr. Kent Scriber **Date:** 08/30/2007

Organization : Ithaca College

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

August 30, 2007
Centers for Medicare and Medicaid Services
Re: Proposed rule changes regarding staffing of out-patient clinics and rehabilitation departments

Dear Sir or Madam:
My name is Kent Scriber and I have been practicing and teaching in the Athletic Training profession for the past 35 years. I am a certified athletic trainer credentialed in New York State, where I am also licensed as a Physical Therapist. I earned a doctorate in Education from Syracuse University and have been employed by Ithaca College, Ithaca, NY since 1972, essentially my entire professional career.
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,

Kent Scriber, EdD, ATC, PT
Professor/Clinical Coordinator
Ithaca College,
Ithaca, NY

Submitter : **Dr. Lauren Fisher** **Date: 08/30/2007**

Organization : **Hospital for Special Surgery**

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.

Lauren Fisher, DO

Submitter : **Mr. Jeff Flyer** **Date: 08/30/2007**

Organization : **Mr. Jeff Flyer**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Kerry N. Weems, Administrator-Designate,

I have been a liscensed physical therapist in New Jersey and an active member of the APTA for nearly 20 years. Currently, I am employed by Kessler Institute for Rehabilitation as a clinical specialist. I have endeavored throughout my career to avoid working in a referral-for-profit situation, lucrative as it may be for all involved, to avoid a potential conflict of interest where profit could be considered potentially ahead of the patient's best interests.

I am writing to express once again my strong opposition in principle to the ownership of physical therapy services by physicians or their proxies. Inherently, as the Stark laws correctly identified, there is the potential opportunity for abuse of Medicare patients (and non-Medicare patients)and overutilization of physical therapy services when the source of referral is able to directly or indirectly financially benefit from referral. This type of referral situation is really no different from that of a physician writing a prescription for a medication and receiving compensation from a pharmacy for the prescription.

With the abundant opportunity to refer patients to licensed, fully-trained independent physical therapists in varied non-physician owned settings throughout the country, today there appears to be no credible reason for a physician to own physical therapy services. Furthermore, having therapy services offered in a physician-owned PT office, potentially performed by a non-licensed individual under the "direct" supervision of a physician, makes little sense from a consumer perspective (it seems unlikely that a physician will have the time in his or her schedule to remain directly supervising throughout the administering of a physical therapy treatment, or have the specific training to oversee most appropriately a non-licensed individual delegated to perform "physical therapy").

For the good of Medicare and other healthcare consumers receiving physical therapy treatment, treatment should only be rendered by licensed physical therapists or licensed physical therapists assistants who are fully independent of a referral-for-profit arrangement. Thank you for your consideration of this important matter.

Sincerely yours,

Jeff Flyer, PT NJQA03922

Submitter : **Ms. Alicia Young** **Date: 08/30/2007**

Organization : **Citizens Memorial Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am a licensed athletic trainer and work for Citizens Memorial Hospital Outpatient Sports Medicine Center in Bolivar, Missouri. I provide physical medicine and rehabilitation services to injured athletes in the Southwest Missouri area. I have a college education, national certification, and state license that qualify me to provide athletic-specific care to these individuals. 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.
It personally offends me that the unique services which I provide may no longer be available to the patients who need them. It should also be troubling to the patients that will no doubt be forced to receive care from a professional who is not educated or trained to treat such injuries.
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,
Alicia Young, MSE, ATC, LAT

Submitter : **Sarah Piebes** **Date: 08/30/2007**

Organization : **Xavier College Preparatory**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Sarah Piebes. I am a certified athletic trainer and I licensed health care provider in the state of Arizona. I am a graduate of the athletic training program at Ithaca College in Ithaca, New York and I am currently working towards my Master s degree in athletic training from A.T. Still University Arizona School of Health Sciences in Mesa, Arizona. Additionally, I am the assistant athletic trainer at Xavier College Preparatory in Phoenix, Arizona.

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 medieal professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing thc day-to-day health care needs of their patients. I respectfully request that you withdraw thc proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility. Thank you very much for your time.

Sincerely,
Sarah K. Piebes, ATC, LAT

Submitter : **Mr. Todd Dean** **Date: 08/30/2007**

Organization : **Dept of Defense**

Category : **Physician Assistant**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 30, 2007

Dear Sir or Madam:

My name is Todd Dean and I am currently employed by the U.S. Army in Fort Leonard Wood, MO. I have been an Athletic Trainer for 12 years and I am also a Physician Assistant. I have worked both at the University level and professionally with the Navy SEALs for ten years. I spent four years in Orthopaedic Surgery working closely with Athletic Trainers and Physical Therapist.

I believe that my education in Healthcare Administration, Athletic Training, Physician Assistant and my work experience is well rounded in this request for 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,

Todd C. Dean MPAS, PA-C, A.T.,C.

Submitter : **Ms. Kimberly Holt** **Date: 08/30/2007**

Organization : **St. Mary's High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Kimberly Holt. Currently, I serve as the Head Athletic Trainer for St. Mary's High School in Annapolis MD. I am responsible for athletic injury prevention, evaluation, and rehabilitation for approximately 550 student-athletes at my school. I have been a Certified Athletic Trainer for the last five years. I received two Bachelors of Science degrees from Ohio University in Athletic Training and Exercise Physiology. Following my undergraduate work, I preformed a two year Athletic Training Fellowship with the Hughston Clinic while also receiving my Masters of Education from Auburn University. Through my formal education, and career experiences I have had the opprotunity to work in various settings outside of the traditional Athletic Training setting. These positions include physicians office, hospitals, and physical therapy clinics.

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,

Kimberly S.L Holt, ATC, MEd

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 30, 2007

Department of Health & Human Services
P.O. Box 8018
Baltimore, MD 21244-8018
ATTN: CMS-1385-P

RE: Physician Self-Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008".

To Whom It May Concern:

I appreciate this forum as opportunity to express my views referable to the provision of pathology services as impacted by the Physician Self Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008".

I am a board certified pathologist, member of the College of American Pathologists, as well as, a member of the New Jersey Society of Pathologists, and have been in practice within the City of Trenton, Mercer County, New Jersey since 1999. I am a member of a group practice comprised of three full-time and one part-time pathologists, primarily practicing in a hospital-based setting.

I commend CMS for taking steps to end abuses in regard to self-referral in the billing and payment for pathology services. I am aware of physician practice arrangements in my geographic area that enable medical groups to share in the revenues generated from pathology services, as ordered and performed for individual patients of these groups. I believe such arrangement to represent an abuse of the Stark law prohibition against physician self-referral. I support revisions in the interpretation of the Stark law. They close the loopholes that currently permit physicians to profit from pathology services. I believe that such revisions will keep good faith with the intent of the Stark law, and promote direct payment to physicians who actually perform professional services in the caring of patients.

I support the expansion of the anti-markup rule to purchase pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provisions of pathology services, unless the physician is capable of personally performing, or supervising the service.

Captive pathology arrangements of this type are primarily based on self-interest and do not enhance patient care. Furthermore, I believe that such practices corrupt and injure the practice of pathology as a profession in general. I believe that restriction on physician self-referral is an important safeguard to ensure that good medical practice and clinical decision-making is determined solely on the basis of the highest of professional standards and quality, in providing healthcare for the best interest of patients under the Medicare program. The proposed revisions to payment policies (CMS-1385-P) will not adversely impact the availability or delivery of pathology services, however, will help to eliminate sources of financial conflict of interest that would compromise the integrity of the Medicare program.

Sincerely,

Ellen H. Fox, M.D.

EHF:jab

Submitter : **Mrs. Theresa Vigiano** **Date: 08/30/2007**

Organization : **Center for Physical Medicine and Rehabilitation**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Theresa Vigiano and I am the practice manager for Center for Physical Medicine and Team Wellness in Warren, MI. I currently have an athletic trainer that is employed by Team Wellness, Dan Misiewicz.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,

Theresa Vigiano
Practice Manager

Submitter : **Dr. Edward Norfleet** **Date: 08/30/2007**

Organization : **Dept of Aneshesiology University of N.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Servicc s
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dcar Ms. Norwalk:
I am thc Chair of Anesthcsiology at the University of North Carolina which has aresidcncy training program. Over the past five years our Academic Department has cxpcrienccd scrious financial difficultics as a result of reimbursement issues. I am writing to exprcss my strongest support for the proposal to increase ancsthcsia paymcnts under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthcsia services, and that the Agcncy is taking stcps 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, Mcdicare 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 cnsurc 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,
Edward A. Norfleet MD
Professor and Chair
University of North Carolina at Chapel Hill
Dept. Of Anesthesiology

Submitter : Mr. Larry Starr **Date:** 08/30/2007

Organization : Nova Southeastern University

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Nova Southeastern University
Department of Athletics
August 30, 2007
Dear Sir or Madam:
My name is Larry Starr, the Assistant Athletic Director/Sports Medicine at Nova Southeastern University, Ft. Lauderdale, Florida. I have been a certified athletic trainer since 1968, hold licensure in both Ohio and Florida to practice as a healthcare provider. After spending 30 years in professional baseball as the Head Athletic Trainer for the Cincinnati Reds and Florida Marlins, I have returned to the academic world of college 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.
Finally, it is especially interesting to me that many times patients who have been treated at facilities that do not have athletic trainers have looked to athletic trainers for services. To deny them of those services would deny them of adequate care. Please seriously consider this request.
Sincerely,
Larry M. Starr, M.ED, ATC, CSCS, USPTA
3301 College Avenue, Fort Lauderdale, Florida 33314-7796 (954) 262-8260

Submitter : sean s **Date:** 08/30/2007

Organization : sean s

Category : Private Industry

Issue Areas/Comments

GENERAL

GENERAL

medicar should remburse doctors more than 16 dollars per unit as the industry mean is 50 dollars. especially on the older people who are more at risk.

CMS-1385-P-12362

Submitter : Michael sCHWARTZ **Date:** 08/30/2007

Organization : North Lake Tahoe Fire Protection district

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12362-Attach-1.DOC

#12362

NORTH LAKE TAHOE FIRE PROTECTION DISTRICT
866 Oriole Way – Incline Village, NV 89451-9439
(775) 831-0351 Fax (775) 831-2072 www.nltfpd.net
Michael D. Brown – Fire Chief

August 22, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008.

Dear Ms. Norwalk:

The North Lake Tahoe Fire Protection District provides emergency ambulance services to the communities of Incline Village and Crystal Bay, Nevada. The proposed rule would have a severely negative direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. In addition, we believe this proposed rule will inappropriately provide incentives to seek signatures from patients who are in need of medical care and under mental duress. Additionally, this proposed rule would have a negative impact on wait times in the emergency room impacting our operations and the operations of emergency rooms throughout the country. We therefore urgently submit comments on ills of the proposed rule.

In summary, here are the points we would like you to consider:

- Beneficiaries under duress should not be required to sign anything;
- Exceptions where beneficiary is unable to sign already exist and should not be made more stringent for EMS;
- Authorization process is no longer relevant (no more paper claims, assignment now mandatory, HIPAA authorizes disclosures);
- Signature authorizations requirement should be waived for emergency encounters.

We understand that the proposed rule was inspired by the intention to relieve the administrative burden for EMS providers. However, the "relief" being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and the hospitals and would result in shifting the payment burden to the patient if they fail to comply with the signature requirements at the time of incident. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for emergency ambulance services.

Current Requirement

When the beneficiary is physically or mentally incapable of signing, the industry has been following the requirements listed in the CMS Internet Only Manual, Pub. 100-02, Chapter 10, Section 20.1.2 and Pub. 100-04, Chapter 1, Section 50.1.6(A) (3) (c). These sections allow for a representative of the ambulance provider or hospital to sign on behalf of the beneficiary when the patient is unable to sign, document that the beneficiary was unable to sign, the reason and that no one could sign for the beneficiary.

The proposed rule directly conflicts with the existing rule. It requires that the provider representative sign **contemporaneously** with the transport and **seek an additional signature** from the hospital in the event a patient is unable to sign.

BENEFICIARY UNDER DURESS SHOULD NOT BE REQUIRED TO SIGN ANYTHING

Emergency ambulance providers have no admission department and no registration desk. The same individuals responsible to providing medical care and transportation to the hospital are also responsible for fulfilling the administrative functions. All EMS encounters are emergency in nature and medically necessary ambulance transports in particular are stressful events on patients.

CMS has recognized this modified its rules for obtaining Advance Beneficiary Notice and Acknowledgement of HIPAA Privacy Notices, creating exceptions that do not require ambulance crews to interrupt their care to seek a signature from a patient under their care.

In fact, CMS has deemed that all emergency encounters put the patient under great duress. Under such duress, patients would sign anything in order to get the care they require. Therefore, any signature obtained in an emergency situation cannot be relied upon.

Yet the proposed rule is so burdensome on ambulance crews that they will have every incentive to obtain a patients signature even though the patient is under mental duress. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

EXCEPTIONS WHERE BENEFICIARY IS UNABLE TO SIGN ALREADY EXIST AND SHOULD NOT BE MADE MORE STRINGENT FOR EMS

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. The proposed exception essentially mirrors the existing requirements that the beneficiary is unable to sign and that no authorized person was available or willing to sign on their behalf, while adding additional documentation requirements. Therefore, we believe that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed sub-division (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, we do not object to the requirement that an ambulance provider obtain documentation of the date, time and destination of the transport. Nor do we object to the requirement that this item be maintained for 4 years from the date of service. However, we do not see any reason to include these in the Regulation, as they are already required and standard practice.

The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. Our organization **strongly objects** to this new requirement as:

- Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.
- Hospital personnel will often refuse to sign any forms when receiving a patient.
- If the hospital refuses to sign the form, it will be the beneficiary that will be responsible for the claim.
- The ambulance provider or supplier would in every situation now have the additional burden in trying to communicate to the beneficiary or their family, at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.
- Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ER Admitting Record, etc.

We also strongly object to the requirement that ambulance providers or suppliers obtain this statement from a representative of the receiving facility *at the time of transport*. Since the proposed rule makes no allowances for the inevitable situations where the ambulance provider makes a good faith effort to comply, but is ultimately unable to obtain the statement, we believe this requirement imposes an excessive compliance burden on ambulance providers and on the receiving hospitals. Consider what this rule requires—the ambulance has just taken an emergency patient to the ER, often overcrowded with patients, and would have to ask the receiving hospital to take precious time away from patient care to sign or provide a form. Forms such as an admission record will become available at a later time, if CMS wants them for auditing purposes in addition to the trip transport that will already include date, time and receiving facility.

AUTHORIZATION PROCESS IS NO LONGER RELEVANT (NO MORE PAPER CLAIMS, ASSIGNMENT NOW MANDATORY, HIPAA AUTHORIZES DISCLOSURES)

Purpose of Beneficiary Signature

a. Assignment of Benefits –The first purpose of the beneficiary signature is to authorize the assignment of Medicare benefits to the health care provider or supplier. However, assignment of covered ambulance services has been mandatory since April 2002. Furthermore, 42 C.F.R. §424.55(c), adopted November 15, 2004 as part of the Final Rule on the Physician Fee Schedule (67 Fed. Reg. 6236), eliminated the requirement that beneficiaries assign claims to the health care provider or supplier in those situations where payment can only be made on an assignment-

related basis. Therefore, the beneficiary's signature is no longer required to effect an assignment of benefits to the ambulance provider or supplier.

CMS recognized this in the Internet Only Manual via Transmittal 643, by adding Section 30.3.2 to Pub. 100-04, Chapter 1. As a result, the beneficiary signature is no longer needed to assign benefits of covered ambulance services.

b. Authorization to Release Records – The second purpose of the beneficiary signature is to authorize the release of medical records to CMS and its contractors. However, the regulations implementing the HIPAA Privacy Rule, specifically 45 C.F.R. §164.506(c) (3), permit a covered entity (e.g. an ambulance provider or supplier) to use or disclose a patient's protected health information for the covered entity's payment purposes, without a patient's consent (i.e. his or her signature). Therefore, federal law already permits the disclosure of medical records to CMS or its contractors, regardless of whether or not the beneficiary's signature has been obtained.

Signatures Not Required for ABN's for Emergency Transports

The Third Clarification of Medicare Policy regarding the Implementation of the Ambulance Fee Schedule states that Advanced Beneficiary Notifications only be issued for non-emergency transports. The ABN's which require beneficiary signature "may not be used when a beneficiary is under great duress" which would include emergency transports. Would not the requesting of a Medicare Beneficiary's signature for any other reason during an emergency transport be less duress?

Signature Already on File

Almost every covered ambulance transport is to or from a facility, i.e. a hospital or a skilled nursing facility. In the case of emergency ambulance transports, the ultimate destination will always be a hospital. These facilities typically obtain the beneficiary's signature at the time of admission, authorizing the release of medical records for their services *or any related services*. The term "related services", when used by hospitals and SNFs, can mean more than only entities owned by or part of the facility. The term already includes physicians providing services at the facility. We believe that ambulance transport to a facility, for the purpose of receiving treatment or care at that facility, constitutes a "related service", since the ambulance transports the patient to or from that facility for treatment or admission. Therefore, we believe a valid signature will be on file with the facility. Additionally, for those transports provided to patients eligible for both Medicare and Medicaid, a valid signature is on file at the State Medicaid Office as a product of the beneficiary enrollment process.

Submitter : Dr. Gerard Rozea **Date:** 08/30/2007

Organization : East Stroudsburg University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1385-P-12365-Attach-1.DOC

#12365

August 30, 2007

Centers for Medicare and Medicaid Services (CMS)
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Sir or Madam:

My name is Dr. Gerard D. Rozea and I am currently employed as an assistant professor in the CAATE-accredited Athletic Training Education Program at East Stroudsburg University of Pennsylvania. In addition, I am also certified by the national Board of Certification® in athletic training and credentialed to practice as an athletic trainer in Pennsylvania through the State Board of Medicine. I have worked as an athletic trainer and rehabilitation specialist in secondary schools, colleges and universities, outpatient physical therapy settings and sports medicine centers.

While my primary role today is as a teacher-scholar and researcher, I continue to practice as an athletic trainer and share my expertise in rehabilitation, with colleagues and friends in medicine, physical therapy, clinical exercise physiology, physical education and other related professions. In addition, I continue to present at state and regional conferences. My eleven years in practice have further strengthened my belief that patients in need of physical medicine and rehabilitation services are best cared for when a team of qualified individuals work together to deliver evidence-based practices.

This is why I am writing you today to express my tremendous concern regarding the proposed changes in 1385-P. In recent years we have seen explosive growth in health care spending and substantial changes and shifts in health insurance. The major problem with affordable health insurance and access to affordable and competent health care is the continued increase of health care in the United States. With health care costs projected to rise over $4 trillion by 2015, it is perplexing that the Centers for Medicare and Medicaid Services would continue to make decisions that restrict qualified health care practitioners like athletic trainers, clinical exercise physiologists and others from assisting in a health care system that is clearly in crisis. It would be prudent at this time for CMS to take a step back and examine how they can appropriately engage other qualified health care providers in the fight to save our health care system.

In short, I am writing to **oppose** the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. Again, this decision is another uninformed action that will continue to drive the cost of

health care in America up while ignoring the education and qualifications of several health care providers that could undoubtedly help maintain the standard of care Americans desire and deserve. Additionally, I am concerned that the proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting. As a practitioner who has cared for a diverse population, I am confident that this decision will harm patients and further weaken our fragile health care system.

Athletic trainers and other health care providers restricted by the proposed changes in 1385-P have the education and training to perform physical medicine and rehabilitation services to a variety of patients. This is not the same as physical therapy which certainly holds a very important place in the health care; but not the only place. The education, clinical experience and national certification examination for athletic trainers ensures that patients will receive competent and quality care. State laws and an array of hospital medical professionals have recognized and sanctioned our qualifications to perform these services and these proposed regulations attempt to circumvent those standards. It is hard to see how CMS believes that this will best serve the patient-consumer.

CMS is certainly aware of the statistics shared earlier in this letter and the lack of access and workforce shortage in the physical medicine and rehabilitation industry. If CMS is truly concerned with delivering the highest standard in health care to the American public, they will withdraw these proposed changes and seek ways to improve upon the flexible standard of staffing in hospitals and other rehabilitation facilities. In today's health care environment, this is the only way we can ensure patient's the ability to receive the best treatment while containing health care costs.

My research suggests that CMS has come to these proposed changes without clinical or financial justification and therefore, I respectfully request that CMS delay making any decisions regarding 1385-P or physical medicine and rehabilitation until they have fully investigated how to integrated qualified health care providers more fully into the flexible guidelines that currently exist. On behalf of my faculty and the 200 future practitioners I am preparing for the health care industry, I 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. Gerard D. Rozea, ATC
Assistant Professor
Athletic Training Education Program
East Stroudsburg University of Pennsylvania
East Stroudsburg, PA 18301
(570) 422-3065

Submitter : **Dr. monty sigmon** **Date: 08/30/2007**

Organization : **asa**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. Adam Lake** **Date: 08/30/2007**

Organization : **Cleveland Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified and Licensed Athletic Trainer working for the Cleveland Clinic. I currently split my time between a local high school, providing athletic training services to athletes, and a physical therapy clinic treating a wide variety of patients. I hold a BS in Sports Medicine from Heidelberg College, as well as a MEd in Kinesiology with an emphasis in Athletic Training from Temple University. I am confident that my education and experience qualify me to provide the best possible health care every patient that I see.

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,

Adam W Lake, MEd, ATC, CSCS

Submitter : **Mrs. Lynn Reede** **Date: 08/30/2007**

Organization : **Aultman Hospital**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

August 30, 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,

Lynn Reede, CRNA, BA
2411 55th Street NE
Canton, Ohio 44721

Submitter : Dr. mark gilbert **Date:** 08/30/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

Background

Background

I am writing in support of CMS 1385-P, to update Medicare physician reimbursement for anesthesiology. The shortages of trained anesthesiology staff, who can provide the safest and most cost effective anesthesia to our aging population, will only begin to improve if Medicare makes the payment to physician providers equitable with all other areas of medical practice.

Submitter : Dr. STEPHEN HOANG **Date:** 08/30/2007

Organization : ANESTHESIOLOGISTS FOR CHILDREN

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Aeting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

Re: CMS-1385-P
Ancsthesia Coding (Part of 5-Year Review)

Dcar 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.

--STEPHEN HOANG, MD

Submitter : **Dr. Steve Emmons** **Date: 08/30/2007**

Organization : **OUHSC - Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor inerease as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Ms. Kathy Heptinstall** **Date: 08/30/2007**

Organization : **The Myelodysplastic Syndromes Foundation, Inc.**

Category : **Other Association**

Issue Areas/Comments

Drug Compendia

Drug Compendia

See Attachment

CMS-1385-P-12370-Attach-1.DOC

#12370

mds foundation
the myelodysplastic syndromes foundation, inc.

To: Centers for Medicare and Medicaid Services (CMS)

The Myelodysplastic Syndromes (MDS) Foundation, on behalf of our Board of Directors, and Medicare/Medicaid patients with MDS, would like to comment on the recently proposed process to authorize additional compendia for anti-cancer therapeutic regimens reimbursed under Medicare Part B. We are requesting that CMS establish a similar process for compendia used to authorize reimbursement under Medicare Part D.

Currently there are unnecessary delays in updating information in the currently authorized compendia for Medicare Part D. Many MDS patients, particularly Intermediate 2 and High Risk, require treatment immediately to prevent evolution to acute myeloid leukemia (AML).

We would like to suggest that CMS address the process of adding compendia under both Medicare Part B and Part D. This would assure that MDS patients have access to the most beneficial treatment for this neoplastic disease regardless of the site of service.

Thank you for your attention and consideration.

Sincerely,

Kathy Heptinstall

Kathy Heptinstall, BSN, RN
Operating Director
The MDS Foundation, Inc.

Cc: Board of Directors
The MDS Foundation, Inc.

36 Front Street ■ PO Box 353 ■ Crosswicks, NJ 08515 ■ Within the US: 1-800-MDS-0839 ■ Outside the US: 609-298-6746 ■ Fax: 609-298-0590

Submitter : **Dr. Charles Weiss** **Date: 08/30/2007**

Organization : **Dr. Charles Weiss**

Category : **Chiropractor**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

RE: Technical Corrections

Dear CMS:

X-rays are an important part of being able to treat a patient. Documenting subluxation is only one part of that equation. Ruling out pathology, determining a more accurate diagnosis and determining treatment options are also a part. Limiting a Doctor of Chiropractic from referring for an x-ray can actually increase the costs associated with treating a patient. It can cause delays in treatment, force CMS to pay for duplicative examinations and prevent early diagnosis of treatable conditions.

It with these thoughts in mind that I respectfully ask CMS to table this proposal. I believe if this proposal becomes a standing regulation patient care will ultimately suffer.

Thank you for your time.

Sincerely,

Charles G. Weiss, DC
Roswell, GA

Submitter : **Mr. Thomas Kramer** **Date: 08/30/2007**

Organization : **Mr. Thomas Kramer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.
Thomas Kramer

Submitter : Kelley Fako **Date:** 08/30/2007

Organization : NovaCare Rehabilitation

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an Athletic Trainer working for NovaCare Rehablitation an out-patient physical therapy clinic in Butler, PA. Butler High School has two contracts with NovaCare to provide Athletic Training services for the high school athletic program and I fill one of those contracts. I have a Bachelor Degree in Sports Medicine from Indiana University of Pennsylvania. I have been an Atheltic Trainer for four years and really enjoy the work at both the high school and the out-patient physical therapy clinic.
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,

Kelley Fako, ATC

Submitter : **Mr. Pete De Ruyter** **Date: 08/30/2007**

Organization : **Mr. Pete De Ruyter**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.
Pete De Ruyter

Submitter : Dr. Charles Weddle **Date:** 08/30/2007

Organization : Anesthesia Associates of Edmond

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern,

Anesthesiologists are in need of a significant increase in Medicare reimbursement in order to offset the rising costs of our business. The elderly are usually at higher risk and require more intensive care than the rest of the population. We are not reimbursed for any modifiers due to the patient's age or health risks. My specialty should be better compensated for these oftentimes high risk patients.

Sincerely

Charles C. Weddle, Jr., Ph.D., MD.

Submitter : Ms. **Date:** 08/30/2007

Organization : Ms.

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am the Assistant Athletic Trainer at the University of South Florida

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,

Donna Jordan, MA, MS, ATC/LAT

Submitter : **Mr. David Brown** **Date: 08/30/2007**

Organization : **GlaxoSmithKline**

Category : **Drug Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12377-Attach-1.PDF

price ("ASP"), a pricing point calculated by pharmaceutical manufacturers and reported to CMS. Given that provider payment rates depend largely on reported ASPs, GSK believes it is essential that the methodology used to determine ASP accurately incorporates the costs to a provider or supplier (hereafter "provider") for our products. Moreover, the ASP calculation and reporting requirements should be clearly articulated because manufacturers may be subject to significant penalties for the submission of incorrect ASP data.

GSK also urges the agency to increase access for Medicare beneficiaries to innovative cancer care by increasing the amount of recognized compendia. Further, we urge CMS to implement quality measurements that are physician led, empower the clinician and allow and support minority opinion in appropriate circumstances with justifying evidence. GSK believes that patient access to the best care should be enhanced by federal programs and submit these comments to further that goal.

ASP ISSUES

While GSK appreciates that CMS has proposed specific guidance regarding the treatment of bundled price concessions in an effort to ensure greater consistency in ASP reporting, we believe it is critical that CMS provide additional clarity to manufacturers on the scope of CMS's new definition of a "bundled arrangement." Such clarity is particularly important if CMS wants to promote consistency in the treatment of bundled price concessions for purposes of both ASP and average manufacturer price (AMP) reporting. We also urge CMS to consider the impact of its proposed definition and reallocation methodology on the estimation of lagged price concessions. Establishing an overly broad definition of a "bundled arrangement" may transform non-lagged discounts into lagged discounts and delay their impact on ASP reporting. We discuss these and other concerns in more detail below.

I. CMS Should Provide Additional Guidance On Its Definition of a "Bundled Arrangement" and the Application of the Reallocation Methodology.

CMS has proposed a new definition of a "bundled arrangement" and a reallocation methodology for purposes of reporting bundled price concessions in the ASP context. CMS makes clear in the preamble to the Proposed Rule that it is proposing "to establish a method for the treatment of bundled price concessions that is appropriately consistent with the proposed Medicaid policy for bundled sales . . . ."[2] GSK agrees that it is important to adopt "an overall consistent

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[2] *Id.* at 38,151.

methodology for addressing bundling in both contexts" in order to facilitate implementation by manufacturers, reduce the potential for error, and ultimately enhance the accuracy of ASP reporting. A consistent approach is also important because, as CMS notes in the preamble to the Proposed Rule, section 1847A(d) of the Social Security Act permits substitution of 103 percent of AMP for ASP-based payment in certain instances. We recognize that the Proposed Rule was published prior to finalization of CMS's Medicaid policy,[3] and that differences in the ASP and AMP calculations may require "minor differences" in the Medicare and Medicaid regulations.[4] Nonetheless, we believe it is critical that CMS provide specific guidance in the ASP Final Rule to address the differences between the definition of a "bundled sale" in the AMP context and a "bundled arrangement" in the ASP context and resolve the additional ambiguities raised by the preamble to the Medicaid Final Rule.

A. CMS Should Clarify That the Reallocation Methodology Applies Only Where there is a Price Concession Conditioned on Some Purchase or Performance Requirement.

GSK asks that CMS clarify in its Final Rule that a bundled arrangement exists only when the price concession is conditioned on some requirement, whether it is a purchase or some other performance requirement. CMS proposes to define a "bundled arrangement" as

> an arrangement . . .under which the rebate, discount or other price concession is conditioned upon the purchase of the same drug or biological or other drugs or biologicals or some other performance requirement . . . *or where the resulting discounts or other price concessions are greater than those that would have been available had the bundled drugs or biologicals been purchased separately or outside of the bundled arrangement.*[5]

GSK urges CMS to clarify the scope of this last clause. GSK believes that this language may be interpreted as applying only where the arrangement includes

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[3] 72 Fed. Reg. 39,142 (July 17, 2007).

[4] 72 Fed. Reg. at 38,151.

[5] 72 Fed. Reg. at 38,226 (proposed 42 C.F.R. § 414.802) (emphasis added).

includes a non-drug product. GSK believes that this is the clearest and most logical approach, and urges CMS to specify in the Final Rule that a "bundled arrangement" for purposes of ASP reporting may include both non-drug products and non-ASP eligible drugs and that manufacturers should reallocate across all drugs or products in the bundle. Importantly, although the regulation text in the Medicaid Final Rule was revised to specifically include "another product" in the definition of a bundled sale at section 447.502, the last sentence of that section directs that "where multiple *drugs* are discounted, the aggregate value of all the discounts in the bundled arrangement shall be proportionally allocated *across all the drugs* in the bundle."[16] If it is CMS's intent that manufacturers reallocate bundled discounts across covered outpatient drugs *and* across other products in the bundle, this language should be revised to state that where "multiple drugs *or products*" are discounted, all discounts must be proportionately allocated "across all drugs *or non-drug products*." GSK believes it is critical that CMS provide clarity on this issue for purposes of both ASP and AMP reporting.

E. CMS Should Clarify that the Proposed Definition and Reallocation Methodology Will Only Apply Prospectively and that Only Rebates Earned as of the First Quarter of 2008 Must Be Reallocated.

Finally, if CMS proceeds to finalize a new definition of a bundled arrangement, GSK urges CMS to specify in the Final Rule that this new definition will apply prospectively only. In its final rule on the physician fee schedule for calendar year 2007, CMS decided not to establish a specific methodology that manufacturers must use for the treatment of bundled price concessions for purposes of the ASP calculation.[17] CMS advised that "[i]n the absence of specific guidance, the manufacturer may make reasonable assumptions in its calculations of ASP, consistent with the general requirements and the intent of the [Social Security] Act, Federal regulations, and its customary business practices."[18] In the Proposed Rule, CMS reiterated that "[i]n the absence of specific guidance, we maintained existing guidance that manufacturers may make reasonable assumptions in [the] calculation of ASP."[19] Accordingly, it is our understanding that CMS's new definition of a bundled arrangement and the allocation methodology must be applied prospectively only. We ask CMS to make clear in the Final Rule that manufacturers may

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16 *Id.* (emphasis added).

17 71 Fed. Reg. 69,624, 69,675 (Dec. 1, 2006).

18 *Id.*

19 72 Fed. Reg. at 38,150.

continue to make reasonable assumptions in their treatment of bundled price concessions unless and until CMS implements its proposal.

GSK further requests that CMS specify that prospective application means that manufacturers may apply the reallocation methodology to contingent rebates that are *earned* as of the first quarter of 2008. The Proposed Rule states that manufacturers must allocate bundled discounts "beginning with the reporting period for the first calendar quarter of 2008."[20] GSK interprets this language to mean that the reallocation methodology will apply to bundled arrangements that occur, and discounts that are earned, as of the first quarter of 2008, because any other approach would require to manufacturers to apply the methodology to quarters before the effective date of the Final Rule.[21] We request that CMS confirm the reasonableness of this interpretation.

II. Compendia for Determination of Medically Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen - DRUG COMPENDIA.

GSK applauds CMS for addressing the need to develop a process to amend the list of Medicare-recognized compendia stated in §1861(t)(2) of the Social Security Act. Unfortunately, the current status of recognized compendia for Medicare coverage of medically accepted indications is insufficient causing considerable delays in patient access to certain drugs and biologicals used in anticancer chemotherapeutic regimens.

Although, we support the establishment of an annual process to update the Medicare-recognized compendia, we are deeply concerned that only one statutorily recognized compendium is currently available for Medicare coverage of medically accepted indications, which severely impedes beneficiary access to critical therapies for life-threatening diseases. Therefore, we urge CMS to address the impact of the proposed policy on those compendia that have already submitted applications and consider recognizing successor publications.

In addition, we ask CMS to re-evaluate the proposed compendia approval timeline and consider adopting a more expeditious schedule to review and approve additional Medicare-recognized compendia.

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[20] *Id.* at 38,151.

[21] If manufacturers are able to implement the reallocation methodology for rebates earned in prior quarters, we believe they should have the option of doing so.

Finally, expanding the number of Medicare-recognized compendia, and doing so in a more timely manner, will be an important step in ensuring medically appropriate beneficiary access to anticancer drugs, biologicals, and supportive care agents used to treat patients with these life-threatening illnesses.

III. TRHCA-Section 101 (b): PQRI.

GSK appreciates the opportunity to submit comments in support of CMS in its efforts to apply quality programs to improve the caliber and level of medical care, while reducing unnecessary medical costs. Quality measurements have great potential to help achieve a higher overall standard of care. We commend the PQRI program as a number of the proposed measures strengthen the 2007 program measures and encourage practice behaviors that seek to address public health priorities. The addition of universal screenings, vaccinations, smoking history, mammography and colon cancer screening are measures that demonstrate that CMS is committed to public health and disease awareness. We are also pleased to see the addition of measures that address the management of chronic conditions (diabetes, and measures associated with treatment plans (osteoporosis, prostate cancer, cardiac risk assessment and chronic kidney disease). GSK encourages CMS to continue this trend and further develop prevention and care management measures to target costly and disparate diseases. Specifically we encourage the agency to encompass earlier screening and treatment for conditions such as COPD, obesity, prostate hypertrophy, rheumatoid arthritis, and dementia.

As with any new program, we understand that CMS is mindful of the potential for unintended consequences and would be vigilant to such affects. One potential consequence of a quality measurement system is a fragmented system where the measure itself becomes the goal and clinicians "treats to the number" rather than the patient's condition. Consequently, care is taken out of context, is not enhanced and ultimately not applied efficiently. Therefore, it is imperative that whole systems of care and treatment are part of the measurement spectrum to enhance overall care, decrease unnecessary resource utilization and ultimately reduce healthcare expenditures.

We recognize that CMS includes measures set forth by one or more national consensus entities, however, there can be lengthy time lags between updates of such measures. These time lags can delay quality medical management and effective prevention screening. We recommend that CMS request that NQF and AQA require measure development entities to establish maintenance guidelines and provide timely updates to ensure the best in clinical standards and care.

While we agree with CMS' interpretation that each quality measure be endorsed or adopted by a consensus organization and that all measures be developed using a consensus-based approach, we encourage CMS to revisit the interpretation of several points that are either vague and/or weak in their description. These include:

A. Inclusion of measures submitted by a specialty society.

CMS defines consensus organization as "a consensus organization that must include in its consideration process at least some measures submitted by one physician or organization representing a particular specialty."[22] GSK believes this definition is ambiguous with regard to professional inclusiveness. For example, the AMA Physician Consortium Performance Improvement Committee in collaboration with NCQA has been the lead agency with the Secretary for Health and Human Services in the development of physician measures. There are over 80 collaborative agencies participating in the AMA PCPI and it is open to any group serving patient needs and interests. GSK recommends that the definition be carefully considered to preserve clinician leadership within the process, which is essential for program uptake and success.

B. Endorsement of measures for PQRI inclusion endorsed by NQF or AQA.

Currently the AQA does not meet the requirements of the NTTAA for a voluntary consensus standards body. However, we recognize the intent set forth in using AQA as a consensus organization as it provides practical measure review especially given the close working relationship with the AMA PCPI. We ask CMS to direct the AQA to adopt criteria that would meet voluntary consensus standards, specifically an appeals process. In addition, to meet the goal of an effective consensus body, GSK would ask CMS to require that the AQA be inclusive of its healthcare industry stakeholders who are equally vested in patient-centered value driven outcomes.

C. Consensus-based process for developing quality measures.

CMS' interpretation of meeting "consensus-based process for developing measures" as used in TRHCA does not provide sufficient specification to formal measure development organizations on the meaning of: a) consensus among stakeholders in the health care based system; b) level of openness; c) balance of

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[22] 72 Fed. Reg at 38,198.

interest; and, d) consensus reflected in the structures and processes of the NQF and AQA. GSK is supportive of utilizing multiple stakeholder groups in the development of quality measures, given the broad scope of professionals covered within the PQRI program. However, there should be a more defined level of process and conduct in order to be accepted for review by the NQF or AQA consensus bodies.

D. CMS Policies for Meeting TRHCA Requirements.

With regard to the eight policies CMS has established in identifying measures that meet TRHCA's requirements for having used a consensus-based process, GSK broadly agrees with the majority of the policies. There are several policies, however, that we believe require greater scrutiny with regard to language and possible misinterpretation.

1. "[T]he measure has achieved adoption or endorsement by a consensus organization having at least the basic characteristics of the AQA as a consensus organization as of December 2006."[23] We believe the statement "at least the basic characteristics" could be widely misinterpreted and request CMS to define a set of basic characteristics.

2. "[T]hose measures that meet the definition of 'voluntary consensus standards' are preferred to other measures not meeting the requirements of NTTAA."[24] The statement "are preferred" does not provide sufficient information to guide the Consensus Organizations as to how to prioritize the preference.

3. "[A] quality measure that has been adopted by the AQA (or another consensus organization with comparable consensus organization characteristics) will meet the requirements of MIEA-TRHCA."[25] Please refer to our comments on consensus organizations above.

4. The basic steps for developing the physician level measures may be carried out by a variety of different organizations. While we agree CMS should not restrict initial development to physician-controlled organizations, we do believe that physician led organizations such as the AMA PCPI have a significant role in the development of measures and for rapid program uptake and overall success.

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[23] 72 Fed. Reg. at 38,198.

[24] 72 Fed. Reg. at 38,199.

[25] Id.

Because the PQRI program and measure development and implementation process is in its early stage, it has considerable evolution and refinement opportunities. To assure patient centeredness and program success, provider acceptance and rapid uptake are essential. Toward this end, we believe five conditions must be assured:

- The PQRI measure development process should be physician led.
- The PQRI program should be an instrument to empower the clinician.
- The PQRI program should not be used coercively.
- The program should allow and support minority opinion in appropriate circumstances with justifying evidence.
- Patient access to best care should be enhanced by the program, not constrained.

GSK believes that these five conditions are fundamental to the creation of clinically appropriate and consensus based quality measures. We urge CMS to include these principles in the quality measurement development process in order to ensure that the process will remain objective and will achieve the intended goal of improving patient care.

E. Submission of Data via Medical Registry or Electronic Health Record.

GSK supports the use of medical registries as a means to capture and report data on the PQRI quality measures. In addition to the collection of PQRI measures, registries are valuable tools in collecting point-of-care information that often are not part of the claims dataset. Many of the PQRI measures are appropriately focused on clinical and communication issues where the traditional method of obtaining this information is chart review. This method of data capture is time consuming and expensive. Use of a registry is more cost efficient and can also be used as a tool to facilitate adherence to treatment guidelines by providing a checklist of things to do to ensure a patient is receiving high quality care. Registries are a very appropriate tool to collect quality information as compared to electronic medical records which were designed for visit documentation and billing purposes.

In reviewing the five registry options, GSK has concerns regarding some of the underlying assumptions as well as testing parameters. We have outlined areas of confusion both globally and within each of the proposed options below.

- It appears that all options assume registries can sort patient data by insurer to enable reporting of data from Medicare beneficiaries.
- It appears that responsibility for calculating rates differs by option; however, this is not always clear within the option description.
- Some of the options mention linkage to claims data and others do not. We do not know if this was intentional as a means to assess the use of registry data as the only source of performance reporting or an omission within the option reviews. Regardless, we ask the agency to clarify its intent.
- There are no references in the proposal to link Medicare Parts A & D claims data. However, some of the PQRI measures are within Part A and/or D claims data.

Regarding the specific options, GSK submits the following comments:

Option 1 – CMS gives examples of data elements needed from a registry that include data that identifies Medicare beneficiaries at the patient level. GSK is concerned that CMS does not specify how this data will comply with current privacy laws, especially the Health Insurance Portability and Accountability Act ("HIPAA"). Additionally, GSK asks for greater clarity regarding the process that CMS will use to link claims data to performance rates.

Option 2 – GSK understands that rate calculations are performed using registry data, however, we ask CMS to further clarify what they mean by "the registries would be required to add data elements to the database to allow collection of appropriate codes."[26] CMS also proposes to de-identify registry data with claims data. GSK urges the agency to clarify how they will achieve this and why this step is needed.

Option 3 – GSK appreciates the straightforward nature of this option. However, we ask that CMS consider implementing a process that annually validates the quality of medical registries.

Option 4 – GSK asks that CMS consider the administrative burden that this option could create. It appears the registry would include both claims data and payment information collected at various time points and therefore entered separately.

Option 5 – GSK's concerns mirror those from Option 1, as the physician is submitting beneficiary patient level data. This option mentions the submission of registry data for a specific service period of interest but does not provide clear information as to the intent of this item.

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[26] 72 Fed. Reg. at 38,203.

As CMS reviews the options to collect and report quality measures, we request that you keep an eye towards the future. The future of health care will hopefully be patient-centric care that captures the continuity of care between healthcare settings. This would be a great step in eliminating the fragmented healthcare provided to beneficiaries and increase the level of adherence to clinical standards, ultimately benefiting patient care and health outcomes.

GSK commends and supports CMS for the PQRI as part of CMS' mission to raise population health indices by setting best practices for the nation's health system.

* * *

GSK appreciates the opportunity to comment on these issues, and we look forward to working with CMS to ensure that the ASP reporting system is fair and accurate, and that it protects Medicare beneficiaries' access to critical drug therapies. Similarly, we urge CMS to add to the list of recognized compendia and implement quality measurements that are clinically based and rely upon a consensus based process. Please feel free to contact me at (919) 483-2353 if you have any questions regarding these comments. Thank you for your attention to this very important matter.

Respectfully submitted,

David Brown

David B. Brown
Vice President, Contract Management and Operations

Alex Hathaway

Alex Hathaway, MD, MPH, FACPM
Senior Medical Policy Advisor

Submitter : **Dr. Christopher Leichliter** **Date: 08/30/2007**

Organization : **Dr. Christopher Leichliter**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Lori Groover** **Date: 08/30/2007**

Organization : **Nicholls State University**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer, licensed athletic trainer, and a certified orthopaedic technologist. I have been a practicing athletic trainer for 15 years. Currently I work at a college as an assistant professor in the Allied Health Department and serve as a clinical instructor in our athletic training program. In the past, I have worked as an Orthopaedic Physician Extender, a High School athletic trainer, and as a staff athletic trainer employed at a hospital.

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,

Lori M. Groover ATC, LAT, OTC

Submitter : **Dr. Kelly Murie** **Date: 08/30/2007**

Organization : **Coral Canyon Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

Re: TECHNICAL CORRECTIONS

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

By limiting a Doctor of Chiropractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,

Kelly E. Muric, DC

Submitter : Ms. Carrie Harmon **Date:** 08/30/2007

Organization : Missouri Valley College

Category : Other Health Care Professional

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

August 29, 2007

Hello, my name is Carrie Harmon. I am an assistant athletic trainer & instructor at Missouri Valley College. I received my bachelor s degree from Missouri Valley College in 1999 & then proceeded to earn my Master s degree from Lindenwood University in 2002. I worked for two years as a clinic-outreach athletic trainer & the past four at the college level.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Carrie Harmon, ATC, MS
Assistant Athletic Trainer
Missouri Valley College
660-831-4695

Submitter : Mr. Donovan S Willis **Date:** 08/30/2007

Organization : DSW Anesthesia Services, LLC

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

CRNA

CMS-1385-P-12382-Attach-1.PDF

#12382

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.

- 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,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Mrs. Frances De Ruyter** **Date: 08/30/2007**

Organization : **Mrs. Frances De Ruyter**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.
Frances DeRuyer

Submitter : Mrs. JoAnne Jonathan **Date:** 08/30/2007

Organization : Advanced Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a licensed physical therapist. I have been working in a Private Practice Physical Therapy Clinic for over 20 years. It is also a certified rehab facility. Physician Owned Physical Therapy Clinics (POPTS) have significantly decreased the viability of our clinics. Referrals from these practices have dropped dramatically from the first day physicians opened their own P.T. Clinic. For instance, one orthopedic surgery group referred over 100 patients per month to a number of our clinics collectively. In September 2005 it dropped to less than 30 patients per day. This represents a loss of 8100 visits per year or net revenue of $790,900. Another orthopedic physician practice opened up a different POPTS in the Spring of 2006. Their new patient referrals went from 75 per month to less than 20 per month. This represents 6,100 visits/year and a loss of $590,000 in revenue. Together the loss to our company is $1,380,000 of net revenue per year. This loss caused staff lay off's and a higher fixed cost per patient. We need to downsize clinic space and in some cases move a clinic. I am aware that some patients had to travel nearly 15 miles to go to this POPTS three times a week for 4 weeks when they passed 8 other therapy clinics on the way. A few patients saw this distance as very costly due to gasoline prices and have come to our clinic anyway. Most of these patients have been previous patients at our clinics in the past and were aware of our quality of service and excellent outcomes. The patient's tell us that the referring physician insists on having the patient to their POPTS. These physicians say their therapists communicate with them daily and know their protocols the best. They have even gone as far as degrade our services yet they never have complained to us in the past. Is it not ironic that when I ask the orthopedic physicians about the quality of their therapists, after over one year at their PT office, the physicians don't even know the therapists names? Additionally, the protocals are written in black and white. We have done these protocols for years with no complaints and great outcomes. I heard another unsettling comment from a P.T. colleague in Northern Indiana. He said a specific orthopedic surgeon used to refer a lot of new patients to their practice. His orders always indicated only 1-3 visits for the total treatment sessions. Now that this physician owns his own POPTS, the referrals have changed to 3 times a week for 4 weeks. The therapist knows this because he has been referred a few of them over the last year. This sounds like effective cost containment. It is obvious why the duration of P.T. sessions have changed. Furthermore, sometimes these POPTS are so busy that patients wait hours for the session or one week before they can get their initial evaluation. Our company has always prided ourselves in getting patients seen initially within 1-2 days of the new referral. We still visit these physicians, viewing surgery or doing rounds to learn and get familiar with the specifics of these physicians orders. We remind the physicians of our convenient locations and staff specialties. Their answer frequently is 'We have a financial incentive to send to our own POPTS'; at least they do not hide their intentions.

Sincerely,

Physical Therapy in Indianapolis, Indiana 46260

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1385-P-12385-Attach-1.DOC

#12385

Dear Sir or Madam:

My name is James Hargenrader. I currently work in a secondary school but have connections to a clinic. I received a BS degree in Kinesiology from Charleston Southern University and a MS degree in Athletic Training from the University of South Carolina. I am NATA-BOC certified and have been for three years. Also I am licensed in the state of Virginia. At the school I work as the sole day to day therapy for injured athletes working in cooperation with my team physician.

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,

James Hargenrader, ATC, MS

Submitter : **Mr. Ramon Bieri** **Date: 08/30/2007**

Organization : **Agewell Health Services**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

To the Committee for review on Therapy Standards and Requirements.

I am a registered Kinesiotherapist, practicing in San Diego, California. I am objecting to the CMS committee revision to payment policies under the Physicain Fee schedule and other part B Payment policies. These new revisions in payment will negatively affect patients ability to access and receive skilled therapy services to those patients referrred by Physicians. A restriction on payment from therapy practictioner,(ie: Kinesiotherapist, Athletic Trainers, Lymphadema therapist) that Physicians deem qualified to provide quality rehabilitation services prevents both the patient and practictioners to assure cost effective treatment. It is the obligation of the government, that is funded by the taxes of US citizens, to allow those citizens open access to and to pay reasonable fees of Physicians and all skilled, medically qualified therapists that are referred to by those Physicians. Cost control is maximized when there is an larger suppy in the market place to services needed by the public. When monoply and constriction in services develop you creat a rise in costs and reduction is quality. The management for medical conditions and their cost will be better serve if you do not restrict payment to a limited number of practioners or the necessary access to medical referrals by Physicians.

Thank you,

RAmon W. Bieri, RKT

Submitter : **Dr. Jon Barrett** **Date: 08/30/2007**

Organization : **OUHSC Dept of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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,

J. Val Barrett D.O.
Resident Physician
OUHSC Department of Anesthesiology

#12388

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.

- 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,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : Mrs. Debbie Wasserman Schultz **Date:** 08/30/2007

Organization : Representative Debbie Wasserman Schultz

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12389-Attach-1.DOC

#12389

August 30, 2007

Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P -- Proposed Revisions to Medicare Payment Policies (CPT Codes 93325 & 17311-17315)

Dear Secretary Leavitt:

I write today to express my concerns over several Medicare payment policy revisions currently under consideration by your agency. It is critical that Medicare payment schemes are not only fair and appropriate, but based on the real world needs of patients seeking treatment. In particular, I am concerned about two proposals, one that I understand will negatively affect the prompt treatment of skin cancer, especially for the more elderly population, and one that negatively affects cardiology treatment for small children and infants. I hope you will consider these concerns and take appropriate corrective action before issuing your final rule.

CPT Code 93325 - Echocardiography services and pediatric cardiology concerns

This payment coding change deals with bundling Medicare payment for a particular service: Doppler Color Flow velocity mapping (CPT Code 93325), into all echocardiography services, thereby eliminating separate payment for these services effective January 1, 2008. I am concerned about the potentially negative impact such action would have upon a distinctly non-Medicare population – pediatric cardiology – and the potential impact on patient access to care in Florida and across the country.

I understand that this code is used, along with other imaging procedures, by pediatric cardiologists to look at structural abnormalities within the heart, in order to accurately diagnose a patient's medical condition. The Doppler Color Flow procedure is used by a physician to develop clinical decisions on treatment options. It is essential to help appropriately diagnose small children and infants.

I also am told that the CPT Editorial Panel has already approved a new code that will address the overwhelming majority of Medicare coding issues in this area for adults. Specifically, the CPT panel did not recommend bundling 93325 into any other services,

such as pediatric cardiology, yet CMS is now proposing to do so. I urge the Agency to reconsider this change and heed the advice of medical practitioners on this subject.

CPT Code 17311-17315 - Mohs Micrographic Surgery and skin cancer treatment

Section II.2 of the proposed rule recommends reducing reimbursements for "surgical procedures performed during the same operative session ... by 50 percent." Currently, the Mohs surgery codes are exempt from the multiple procedure payment reduction rules; however, the proposed change will remove that exemption. This proposal will have the consequence of placing skin cancer patients, especially the more elderly and less mobile patients, at greater risk due to delayed medical procedures.

As you know, over a million people are diagnosed with skin cancer each year and many of these individuals are diagnosed with multiple skin cancers at the same time. Therefore, my constituents, and many Florida residents, often face the need for multiple procedures to rid themselves of skin cancer. Currently, these multiple procedures can be accomplished in one visit to the doctor's office. Reducing the need for multiple office visits is not only efficient, but reduces the burden on patients. However, by reducing reimbursements for multiple procedures during the same doctor's visit by fifty percent by removing the Mohs micrographic surgery from its exempt status, many patients will have to wait, and return for a subsequent office visit to ensure the procedure in fully covered by Medicare.

Most obviously, it is of deep concern to me that this reimbursement change would delay needed medical care for a highly curable form of cancer. What may not be obvious to the agency is that this places an extra burden on the elderly population that is often less mobile and need more assistance in scheduling and getting to the doctor's office in the first place. Subsequent office visits may be greatly delayed, putting these patients at greater risk of having their cancers spread. We should be taking steps to make treatment for this segment of the population easier, not harder. I believe this reimbursement change would be a step backwards for treatment, not only of cancer, but for our elderly population that is at the most risk.

In sum, I urge the Agency to reconsider the proposed changes to the Medicare payment policies and weigh the practical effects these changes will have on important segments of our population - the young and the elderly. I would appreciate it if you kept my office apprised of your actions in these areas of interest not only to me, but my constituents.

Thank you,

Debbie Wasserman Schultz
Member of Congress

Submitter : **Date: 08/30/2007**

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Hayley Hahn and I am currently a masters student at the University of Toledo in the Kinesiology/Athletic Training program. I am also a graduate assistant at a local high school in Toledo.

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,

Hayley M. Hahn

Submitter : Dr. Barbara McAneny **Date:** 08/30/2007

Organization : New Mexico Oncology Hematology Consultants Ltd

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment/Users/bmcaneny/Desktop/Comments on Proposed Rule C 138

#1239

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Date: 08/30/2007**

Organization :

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a licensed athletic trainer. I understand that as athletic trainers working for a physcain owned physical therapy clinic, I have autonomy in treating patients. I also understand that athletic trainers are fighting for laws to be passed increasing this autonomy into privately owned therapy clinics- to be able to bill insurance companies for their services. I can appreciate the NATA wanting to keep physcian owned clinics around for the above reasons. The problem lies in the fact that physcians have created a monopoly within our health care system. They own the x-ray departments, the MRI centers, the surgical centers,and now the physical therapy clinics. The patient comes in, gets sent for x-rays($$ in physcian pockets), maybe an MRI(more $$ into physcian pockets), need outpatient surgery(more $$ in their pockets), and then sent to therapy(even more $$$ to themselves). They have created an environment where the patient never leaves their system and the physicians reap the benefits. I feel we should be more concerned about the quality of health care and the patient's rights than allowing physicians to control all aspects of the health care system. I feel a line needs to be drawn and eliminating physician owned PT clinincs is a good starting point.

Submitter : Mrs. Sheila Cathcart **Date:** 08/30/2007

Organization : Sports Plus+

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#12393

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Dr. John Schrader** **Date: 08/30/2007**

Organization : **Indiana Universtiy**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madame,
I have been a practicing athletic trainer, presently state licensed to legally treat paticnts in most venues for the past 37 years. In fact, I serve as a patient consultant for Rehabilitation Services Division of our local hospital.
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 ensures 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 and appropriate 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. John W. Schrader, LAT, ATC
Clinical Professor
Assoc. Chair for Academic Affairs
Dept. of Kinesiology
Indiana University
Bloomington, IN 47408

#12398

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : Mrs. Kathleen Cavanaugh **Date:** 08/30/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Kathleen G. Cavanaugh, CRNA
21034 SE 268th CT.
Covington, WA 9842

Submitter : Mrs. jennifer davis **Date:** 08/30/2007

Organization : association of nurse anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a certified registered nurse anesthetist (crna), I am writing to support the CMS proposal to boost the value of anesthesia services by 23%. Medicare currently under-reimburses for anesthesia services, paying 40% of private market value, vs. 80% for most other services. The availability of anesthesia services depends on fair and equal payment, and I strongly support this increase. Thank you,
Jennifer A Davis, CRNA
montgomery al

Submitter : Mr. Stephen Hornor **Date:** 08/30/2007

Organization : University of Central Arkansas

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-12401-Attach-1.DOC

#12401

August 28, 2007

Dear Sir or Madam:

My name is Steve Hornor. I am a Certified, Licensed Athletic Trainer and the Clinical Coordinator of the Athletic Training Education Program at the University of Central Arkansas. 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.

I am concerned that these proposed rules will create an additional lack of access to quality health care for patients, especially those in rural areas, such as you find in the great state of Arkansas.

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 board certification ensure that those I and graduates of the UCA program care for receive quality health care. State law and hospital medical professionals have deemed licensed athletic trainers qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of American citizens, to further restrict their access to physical medicine and rehabilitation 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 and care 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,

Steve Hornor, MA, ATC, LAT
Clinical Coordinator, Athletic Training Education Program
University of Central Arkansas
Prince Center, 133C
Conway, AR 72035-0001
(501) 450-5106
Fax (501) 450-5087

Submitter : **Ms. Stephanie Purget** **Date: 08/30/2007**

Organization : **Ms. Stephanie Purget**

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,

Stephanie Purget

Submitter : **Dr. Raymond Dufresne** **Date: 08/30/2007**

Organization : **University Dermatology, Inc.**

Category : **Physician**

Issue Areas/Comments

Coding--Multiple Procedure
Payment Reduction for Mohs
Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

The issue has been well described in the letter by Dr. David G. Brodland, President of the American College of Mohs Surgery. Obviously, I am in complete support of the position so well described. However, I want to add some personal thoughts.

When I came to Rhode Island in 1989, I was the first Mohs surgeon in the state and one of the few in New England. The local and regional polices on Mohs Surgery were severely aberrant. We entered into a period of negotiation with Blue Cross Blue Shield of RI, then the Medicare intermediary, and then appealed to Medicare. The local representatives literally saw the procedure personally or with a step-by-step slide presentation I made. All of this material was reviewed federally, resulting in the decision.

Nothing has changed in the codes to merit this change in the multiple procedure rules. I cannot believe the review recently by the RUC was anywhere as complete as it was in 1990-1991 that we did here in RI. I do not believe the decision was made with a proper understanding. Rather, because of the increased skin cancers, better education of physicians of the benefits of Mohs surgery, and more trained physicians, Mohs surgery became too successful in some eyes, i.e. rapidly increased utilization, was subjected to a whack it down mentality.

As one of the last regions to have a significant Mohs surgery presence and illogical policies, all the dire predications made in reference to these changes were real. People waited 4-6 months, only had one lesion attended to at a time, complex repairs were deferred overnight to the OR, or another reconstructive surgeon. It was needed for survival of the Mohs units. The overhead is huge for Mohs Surgery, and as an office procedure, is not billable.

Many of the busy units are academic affiliated. Academic Mohs surgeons make a commitment to the residents, fellows, and the community. We accept lower salaries and support the academic programs. In our system, it would have a chilling if not killing effect on the Dermatology program, immediately and in the future. I am also concerned that surgically oriented dermasurgeons will abandon Mohs surgery for cosmetic and more lucrative alternatives.

Thus, I am attesting these changes will reverse 20 years of progress on behalf of the patients in southern New England and the Brown Dermatology Program. Please reflect on these issues. I request the exemption be made permanent.

Sincerely,

Raymond G. Dufresne, Jr. M.D.

Professor, Department of Dermatology, Brown Medical School
Director, Dermatologic Surgery Division
Director, Fellowship Training Program, American College of Mohs Surgery

Submitter : **Mr. Clinton Hall** **Date: 08/30/2007**

Organization : **Levi Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am Clinton Hall, ATC/L presently employed by Levi Hospital. I work in the Outpatient Physical Therapy Department treating trating patients in the mornings and covering local schools sports and practices in the afternoon and evenings. I graduated from Henderson State University in 2003 with a BS in Sports Medicine. Received my NATA certifieation in 2006.

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 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 recieve those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-sffective 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,

Clinton E. Hall, ATC/L

Submitter : **Ms. Amelia Haggard** **Date: 08/30/2007**

Organization : **Ms. Amelia Haggard**

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,

Amelia Haggard

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing over concern that physical therapy services are not included in the in-office ancillary services exception to the Stark law for physicians. The OIG report revealed improper Medicare payments of over $136 million as a result of billing by physicians for physical therapy under this "loophole" in the Stark law. As a physical therapist, I have had numerous patients and family members impacted by this "loophole."

For example, I had been treating a patient with Medicare insurance for shoulder pain, referred for therapy by her family physician. The patient chose to attend physical therapy at our private practice office due to close proximity to her home and part time job. After approximately one month of treatment, her pain persisted and she visited an orthopedist who determined a rotator cuff repair was needed. This orthopedist's group has a physical therapy practice owned by the physicians in the same building as their office. When surgery was being scheduled for my patient with Medicare insurance, she was told she must attend physical therapy following surgery at the doctor's physical therapy practice, or he would not perform the surgery. Because she knew she needed the surgery, and she was told she had to go to the doctor owned PT practice, that is what my patient did. When she did not return to me following her surgery, I contacted her and she informed me of the one option her doctor had given her, so she did not come to see me for treatment, even though she would have preferred to because I was already familiar with her injury, was in closer proximity for her commuting time, and she was happy with the treatment she had previously received at our clinic. Typically, physical therapy following rotator cuff repair surgery may extend to 3 months+ depending on physician protocols. At 3x/wk, this could amount to 36+ physical therapy visits. After I explained to the patient that she has free choice where she wanted to go for her physical therapy, she was quite upset that she was not given that choice by her orthopedist.

I had a close family friend in another state have an elbow surgery, and was immediately referred for physical therapy at the doctor's practice "downstairs," 3x/wk for a month. This PT office was a 40min commute for my friend, and there were at least 2 physical therapy offices within a 10-15min drive from his home/work. After I had informed him that he could go where ever he wanted for PT, he spoke with the physician's office, and after some discouragement was finally given a new prescription to attend physical therapy at an office that was more convenient for my friend, not an office that was a financial interest of the physician.

Finally, I had also treated a patient with low back pain who had previously attended physical therapy at a physician owned practice. While doing exercises under my direct supervision, with techniques she had previously performed at the other practice, I/she discovered that she had been performing the exercises incorrectly. She complained the PT at the physician owned clinic was unable to supervise her directly, because she was usually treating 1-2 other patients at the same time. Persistent incorrect performance of the exercises were likely contributing to her LBP, and after I spent one on one time with the patient to teach her correctly, her LBP began to decline.

It is IMPERATIVE for CMS to include physical therapy services in the in-office ancillary services exception, so this type of abuse does not continue to occur at the expense of insurance dollars, but also at the expense of the patients' well being and recovery.

Submitter : Mr. **Date:** 08/30/2007

Organization : Mr.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a physical therapist I am quite concerned about the ability of a physician to refer for physical therapy to a clinic in which he/she has ownership. First of all, this presents a conflict of interest that is not in the best interest of the patient. Data has shown that referrals are significantly higher in self referral situations than with other referral situations. Secondly, self referral creates an unfair advantage to those of us in indcpendent practice. We cannot effectively compete against a self referral practice for those patients who can be a large component of our practice. For example, recently one of our Orthopedic Physician groups (representing 6 or the 7 surgcons in our community) proposed to have their own PT clinic in their new surgery center. They represent approximately 50% of the referrals to our clinic and a substantial amount to 2 other PT clinics. Had they decided to do so, they would havc greatly effected all of our practices. Thankfully, we were able to convince them not to persue it at this time.

I believc that paticnts should always havc the right to choose their health care provider. Referral for profit situations greatly limit choice and ultimately may lead to over utilization of serviccs. I urgc you to closc thc loopholc in the Stark physician self-referral law and protect physical therapy services.

Thank you for your consideration and for allowing me an opportunity to express my concerns.

Submitter : Mr. Thomas Sheridan **Date:** 08/30/2007

Organization : Tamarac Fire Rescue

Category : Local Government

Issue Areas/Comments

Beneficiary Signature

Beneficiary Signature

Our organization provides emergency ambulance services to the communities which we serve. The proposed rule would have a severely negative direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. In addition, we believe this proposed rule will inappropriately provide incentives to seek signatures from patients who are in need of medical care and under mental duress. Additionally, this proposed rule would have a negative impact on wait times in the emergency room impacting our operations and the operations of emergency rooms throughout the country. We therefore urgently submit comments on ills of the proposed rule.

In summary, here are the points we would like you to consider:

? Beneficiaries under duress should not be required to sign anything;

? Exceptions where beneficiary is unable to sign already exist and should not be made more stringent for EMS;

? Authorization process is no longer relevant (no more paper claims, assignment now mandatory, HIPAA authorizes disclosures);

? Signature authorizations requirement should be waived for emergency encounters.

We understand that the proposed rule was inspired by the intention to relieve the administrative burden for EMS providers. However, the relief being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and the hospitals and would result in shifting the payment burden to the patient if they fail to comply with the signature requirements at the time of incident. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for emergency ambulance services.

The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. Our organization strongly objects to this new requirement as:

"Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.

"Hospital personnel will often refuse to sign any forms when receiving a patient.

"If the hospital refuses to sign the form, it will be the beneficiary that will be responsible for the claim.

"The ambulance provider or supplier would in every situation now have the additional burden in trying to communicate to the beneficiary or their family, at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.

"Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ER Admitting Record, etc.

Based on the above comments, it is respectfully requested that CMS:

"Amend 42 C.F.R. ?424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported .

"Amend 42 C.F.R. ?424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.

"Amend 42 C.F.R. ?424.36(b) (5) to add or ambulance provider or supplier after provider .

Respectfuly submitted,

Thomas F. Sheridan

EMS Division Chief

City of Tamarac Fire Rescue

Submitter : Mrs. Jana Hamrell **Date:** 08/30/2007

Organization : University of Vermont - Sports Therapy

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jana Hamrell, ATC. I am a certified athletic trainer who works at the University of Vermont Sports Therapy department, providing rehabilitation for students who have sustained an injury.

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.

Thc 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 thc 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.

Sincc CMS seems to have come to thcse proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the rccommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw thc proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jana B. Hamrell, ATC

Submitter : Mr. Gregory Miller **Date:** 08/30/2007

Organization : Blue Ridge HealthCare

Category : Occupational Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

This is to express support for changes to the Medicare rules to prohibit making referrals to an entity for the furnishing of designated health services if the physician or immediate family member has a financial relationship with the entity. Allowing the rules to continue as presently structured in this area does two things: (1) it encourages physicians to create physical and occupational therapy practices when in many cases there are adequate services in a geographic locale, thus raising healthcare costs; and (2) enables physicians to order and subsequently perform ancillary services instead of making a referral to a specialist such as an occupational therapist. The very nature of "in office ancillary services" and inherent financial relationships with referring physicians encourages overuse, negates choice and competition, because patients being treated by physicians almost always seek ancillary services at the location recommended by the doctor. This in effect negates choice and in a "built-in" conflict of interest. I encouage CMS to consider eliminating physician owned practices for these reasons.

CMS-1385-P-12410-Attach-1.TXT

Submitter : **Mrs. Rosalie Gray** **Date: 08/30/2007**

Organization : **Mrs. Rosalie Gray**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

My husband and I are CRNAs and I am requesting that you consider this proposal for increase in reimbursement to anesthesia. We provide care that should be compensated appropriately for the quality of care that we give to extremely sick, old patients. We take a great deal of responsibilty putting patients to sleep and incur increasing rates of insurance to cover against lawsuits yet you continue to cut our reimbursement. I haven't had a raise in three years yet my bills continue to increase, but I still give quality care to patients regardless if I get paid or not.

I am asking for your help to make this reimbursement issue fair.

Rosalie & Carl Gray, CRNAs

Submitter : **Mrs. Darla Eddins** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Darla Eddins,CRNA,MA

16425 Ashbourne Drive
Dallas, Texas 75248

Submitter : Mrs. Debra Ford **Date:** 08/30/2007

Organization : Greensboro Orthopaedics

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

"See attachment"

CMS-1385-P-12413-Attach-1.DOC

CMS-1385-P-12413-Attach-2.DOC

#12413

Dear Sir or Madam:

I am a certified athletic trainer who works for Greensboro Orthopedics located in Greensboro, NC. I am employed to work in the clinic, as well as at a local high school providing sports medicine coverage. I have been certified and licensed as a certified athletic trainer for seven years. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Debra Ford, MS, LAT, ATC

Submitter : **Mr. Aaron Elmore** **Date: 08/30/2007**

Organization : **Middle Tennessee School of Anesthesia**

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:
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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,
_Aaron Elmore R.N, B.S.N., S.R.N.A._____
Name & Credential
4625 Big Springs Rd._____
Address
_Lebanon, TN. 37090_____
City, State ZIP

Submitter : Dr. Lawrence Geller **Date:** 08/30/2007

Organization : Physicians Urology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1385-P-12415-Attach-1.PDF

#12415

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 30, 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,
Samuel Smith, CRNA, MSNA
815 Jessamine St.
Richmond, Virginia, 23223

Submitter : **Dr. Keith Loud** **Date: 08/30/2007**

Organization : **Akron Children's Hospital**

Category : **Physician**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a pediatrician board-certified in Adolescent Medicine and Sports Medicine as well as a former certified athletic trainer. I practice adolescent sports health in the Midwest. I refer virtually every patient I see in my daily clinics with athletic injuries to local physical therapy groups, most of which, recognizing the quality care they provide, employ athletic trainers to assist with the rehabilitation of these injuries. Additionally, to best serve our patients, we augment our services with athletic trainers in our hospital Sports Medicine Center, and I supervise athletic trainers in our local high schools.

I am writing today to voice my strong opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am even more concerned that these proposed rules will create a lack of access to quality health care for my patients.

Athletic trainers are extremely well-qualified to perform physical medicine and rehabilitation services, which I appreciate are not the same as physical therapy. Athletic trainers' education, clinical experience, and national certification exam ensure that my patients receive quality health care from them. State law and hospital medical professionals have deemed them qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill physical medicine and rehabilitation positions is widely known throughout the industry. It is irresponsible for CMS to further restrict the ability of American citizens, especially those in rural areas, to receive those services. The current flexible standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatments available.

CMS seems to have come to these proposed changes without clinical or financial justification, perhaps as a result of lobbying from the American Physical Therapy Association (APTA). CMS has already hamstrung the abilities of medicine and therapy providers to employ athletic trainers through changes in incident-to billing rules and restriction of therapy codes. Although I am a friend of the APTA, having spoken at their national and regional conventions several times, I would strongly encourage the CMS to consider the ulterior motives of this organization and reject this, and other, initiatives that seek to remove my ability as a physician (and as a patient!) to utilize the services of athletic trainers as well as physical therapists. Instead, heed the recommendations of those professionals, like me, 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,

Keith J. Loud, MD, MSc, FAAP
Medical Director, Adolescent Health Services,
Akron Children's Hospital

Submitter : **Dr. Michael Duncan** **Date: 08/30/2007**

Organization : **Dr. Michael Duncan**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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,

Michael Duncan, M.D.

Submitter : Dr. Sameh Labib **Date:** 08/30/2007

Organization : Emory Orthopaedics and Spine Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

30 August, 2007

Submitter : Charles Hampsey **Date:** 08/30/2007

Organization : Hoffmann-La Roche Inc.

Category : Drug Industry

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1385-P-12420-Attach-1.PDF

#12420

Roche

August 30, 2007

VIA HAND DELIVERY AND EMAIL
www.cms.hhs.gov/regulations/eRulemaking

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: [CMS-1385-P] Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Acting Deputy Administrator Kuhn:

Hoffmann-La Roche Inc. ("Roche") appreciates this opportunity to submit comments regarding the proposed rule *Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for Calendar Year 2008.*[1] As a company dedicated to bringing innovative, effective, high quality therapies to patients, Roche supports updating payment policies under the Medicare Physician Fee Schedule (the "MPFS") to reimburse the provision of important services in a fair and equitable manner.

Roche understands the challenges the Centers for Medicare and Medicaid Services ("CMS") faces in advancing the healthcare system for the millions Medicare beneficiaries and thousands of its participating providers so that they receive and provide high-quality services at an appropriate cost. While we generally support most of the efforts proposed by CMS to promote fair prescription drug[2] reimbursement practices, we offer comments and recommendations regarding the following issues raised under the proposed MPFS rule. In brief:

[1] 72 Fed. Reg. 38122 (July 12, 2007).

[2] The term "drug" refers to both drugs and biologicals.

Hoffmann-La Roche Inc. 340 Kingsland Street Nutley, New Jersey 07110-1199 Public Policy Tel. 973-562-2010 Fax 973-562-2386

- Roche recommends that CMS adopt the Medicare Payment Advisory Commission's ("MedPAC") option for defining bundled price concessions under the average sales price ("ASP") methodology that would parallel bundling requirements under the Medicaid Drug Rebate Program.
- Roche supports the easing of the existing restriction on transporting Part B Competitive Acquisition Program ("CAP") drugs, where it is permitted by State law and other applicable laws and regulations.
- Roche applauds CMS's efforts to create a public process and standard criteria for adding and revising the list of approved compendia.
- Roche requests that CMS amend the proposed quality measure, number 73, to include planning for both oral and intravenous ("IV") chemotherapy.
- Roche recommends the addition of telehealth services to monitor and manage patients on oral chemotherapy.

ASP Issues

Under its current guidance, CMS permits pharmaceutical manufacturers to exercise discretion in allocating discounts across "bundled arrangements" in calculating average sales price ("ASP"). In its CY 2007 Physician Fee Schedule Rule, CMS states in part:

> "we believe it is important to be cautious in establishing a specific methodology that all manufacturers must follow for ASP purposes. Consequently, we are not establishing a specific methodology that manufacturers must use for the treatment of bundled price concessions for purposes of the ASP calculation at this time. In the absence of specific guidance, the manufacturer may make reasonable assumptions in its calculations of ASP, consistent with the general requirements and the intent of the Act, Federal regulations, and its customary business practices. Our intent in not being prescriptive in this area at this time is to allow manufacturers the flexibility to adopt a methodology with regard to the treatment of bundled price concessions in the ASP calculation that, based on their particular circumstances, will best ensure the accuracy of the ASP calculation and not create inappropriate financial incentives."[3]

For CY 2008, CMS now proposes a standard definition for "bundled arrangement," and to specify that, "all price concessions on drugs sold under a bundled arrangement must be allocated proportionately to the dollar value of the units of each drug sold under the bundled arrangement."[4] Although Roche continues to believe that the flexible approach that CMS adopted for CY 2007 was appropriate given the unique attributes of the ASP price reporting methodology (including use of a rolling average methodology

[3] 71 Fed. Reg. 69624, 69675 (Dec. 1, 2006).

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for lagged price concessions), Roche strongly agrees with CMS that, if a methodology is to be adopted, consistency where possible with the Medicaid Drug Rebate Program methodology for allocating bundled sales would be preferable to a methodology that is specific to ASP.

In the CY 2008 proposed rule, CMS offers two scenarios for consideration, both of which were first offered by Medicare Payment Advisory Commission ("MedPAC") in its January 2007, Report to Congress.[5] The first option would require manufacturers to allocate discounts for bundled arrangements in proportion to the sales of each drug sold under the bundled arrangement. This approach would parallel bundling requirements under the Medicaid program and therefore would be more convenient for manufacturers to administer. The second option would require manufacturers to allocate any increased discounts under a bundled arrangement to the sales of the drug that the higher discount was intended to increase (e.g. discount on drug A is offered if customer purchases drug B; then the discount on drug A is allocated to drug B for purposes of ASP).[6]

Roche strongly recommends that, if CMS determines that a standard allocation methodology should be developed for ASP calculations, CMS should adopt the first option outlined in the MedPAC January 2007 Report to Congress, requiring pharmaceutical manufacturers to allocate bundled discounts in proportion to the sales of each prescription drug sold. We believe that this option promotes CMS's goal for reporting consistency between ASP and AMP, thereby, allowing for more accurate reporting, which in turn stabilizes prescription drug prices. We also believe that this methodology would achieve the goal desired by MedPAC's recommendation to CMS, which was for ASP to reflect the average transaction price for each drug.

In addition to supporting implementing option one for reporting bundled price concessions, Roche seeks clarification regarding how the new guidance on bundled arrangements would interrelate with the rolling average methodology for estimating lagged price concessions. The adoption of any methodology for bundled arrangements can require adjustment to the rolling average methodology. Roche seeks clarification from CMS on this issue and urges CMS to allow manufacturers to use the same approach for ASP as for average manufacturer's price ("AMP"), which will also permit a rolling average methodology for lagged price concessions, effective October 1, 2007.

Competitive Acquisition Program ("CAP") Issues

Roche supports the easing of the existing restriction on transporting Part B Competitive Acquisition Program ("CAP") drugs, where it is permitted by State law and other applicable laws and regulations. We

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Footnote continued from previous page

[4] 72 Fed. Reg. 38122 (July 12, 2007).

[5] Report to Congress: "Impact of Changes in Medicare Payments for Part B Drugs," MedPAC, January 2007.

[6] Id. page 8-9.

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believe that physicians understand the need for drug stability and are capable of ensuring proper handling when transporting drugs. This action would enable physicians to administer treatments from their satellite offices or in patients' homes to better meet the scheduling needs of both patients and healthcare providers. This easement would allow flexibility in re-scheduling patient visits, leading to enhanced care and better compliance for Medicare beneficiaries.

Roche agrees that proper safeguards should be put into place so that no drug products are compromised during transport. We ask that the safeguards not be overly cumbersome nor impose additional costs or reporting burden for physicians, thereby nullifying the policy's intent. We strongly urge CMS to allow the public the opportunity to comment on any additions to the CAP requirements, such as adding safeguards, in a future rulemaking prior to implementation.

Drug Compendia

Roche applauds CMS's efforts to create a public process, with standard criteria, for adding or revising the list of approved compendia for determination of medically-accepted indications for off-label use of drugs in anti-cancer chemotherapeutic regimens. We agree that broad accessibility by the general public to the information contained in the compendia is beneficial to beneficiaries, their caregivers and providers -- many of whom rely on compendia as they research cancer therapy options.

Furthermore, Roche supports the Medicare Evidence Development and Coverage Advisory Committee's ("MedCAC") list of desirable characteristics for compendia. The need for a "(d)etailed description of the evidence reviewed for every individual listing" and "(u)se of pre-specified published criteria for weighing evidence" is clear based on the Agency for Healthcare Research and Quality ("AHRQ") assessment of leading compendia, which found the organizations' to be discordant in methodology and information.[7] Roche supports a transparent and evidence-based approach in putting forth specifications for desirable characteristics of recognized compendia.

We would like further clarification from CMS regarding "other reasonable means" by which CMS may notify the public regarding determinations involving requested changes to the list of compendia. Specifically, if CMS determines to utilize a means other than notification via the CMS website, what are the likely avenues of public notification regarding compendia changes? We believe that the process for requesting changes should be transparent and should not involve unexpected or unusual communication pathways as the sole notification of proposed changes. For example, CMS should dedicate a section on its website on Drug Compendia that includes a fact sheet, guidelines, and process for updating compendia.

[7] See "Compendia for Coverage of Off-Label Uses of Drugs and Biologics in an Anti-Cancer Chemotherapeutic Regimen" Final Report, Agency for Healthcare Research and Quality, May 2007.

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Lastly, Roche supports the inclusion of the National Comprehensive Cancer Network ("NCCN") as a recognized compendium under the Medicare program and we understand that NCCN, like any approved compendia, would need to meet all the desirable characteristics set by CMS.

TRHCA – Section 101(b): PQRI

Roche supports CMS efforts to encourage the improvement of quality health care for Medicare beneficiaries. The Physician Quality Reporting Initiative ("PQRI") is taking important steps to help ensure that physicians and other eligible professionals are armed with knowledge regarding the most appropriate care for beneficiaries depending upon their unique clinical care circumstances. Roche is pleased to comment on the "implications of including any given measure(s) proposed herein in the final 2008 PQRI quality measures."[8]

We believe, however, that PQRI measure #73 "Plan for Chemotherapy Documented Before Chemotherapy Administered" needs to be amended to explicitly include planning for *both* oral and IV chemotherapy. The denominator for this measure in its current form includes all cancer patients who were administered IV chemotherapy. Treating cancer patients has evolved from what was once largely exclusive to intravenous administration to a range of new chemotherapy products for oral administration. The omission of oral chemotherapy suggests that oral administration requires less planning or provides a lesser therapeutic option. Undoubtedly, when a patient undergoes any chemotherapy regimen, be it oral or IV, detailed and comprehensive planning is necessary to ensure that the patient experiences optimal health outcomes and the best possible quality of life. Therefore, we urge CMS to revise this measure to include both oral and IV chemotherapy in the denominator and to ensure that oral chemotherapy is represented in all corresponding denominator codes.

Medicare Telehealth Services

CMS maintains an established process for adding services to or deleting services from the list of Medicare telehealth services under the Social Security Act section 1834 (m)(4)(F). Services fall under two categories: Category #1 for "services that are similar to office and other outpatient visits, consultation, and office psychiatry services"; and Category #2 for "services that are not similar to the current list of telehealth services."

Roche is pleased to have the opportunity to submit a request to add telehealth services, such as telephone triage, delivered by physicians, nurses, nurse practitioners or physician assistants, to manage and monitor patients on oral chemotherapy. We believe that telecommunication systems used to manage patients on oral chemotherapy meet Category #1 requirements, as such services are similar to office and outpatient visits or consultations to monitor patients on IV chemotherapy. Roche feels strongly that patients

[8] 72 Fed. Reg. 38196 (July 12, 2007).

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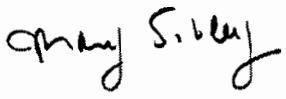
and providers should not be discouraged in the selection and delivery of oral versus IV chemotherapy treatment options. Providing access to equitable telehealth services for each type of chemotherapy treatment allows patients living in rural and other underserved geographic regions an important avenue to achieving better health outcomes and quality of life as a result of these vitally important consultations.

Conclusion

Roche appreciates the opportunity to provide our comments and recommendations. We hope that our suggestions will assist CMS in its mission to provide Medicare beneficiaries continued access to high quality therapies. Thank you for your attention to this matter. Please feel free to contact me at 973-562-2010 if you have any questions, or need additional information.

Respectfully submitted,



Mary Sibley
Executive Director, Public Policy
Hoffmann-La Roche Inc.

Hoffmann-La Roche Inc. 340 Kingsland Street Nutley, New Jersey 07110-1199 Public Policy Tel. 973-562-2010 Fax 973-562-2386

Submitter : **Mr. Kenneth Hart** **Date: 08/30/2007**

Organization : **EmpiCare**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Kenneth Hart. I am a Certified Athletic Trainer licensed in the state of Tennessee. I have performed physical medicine and rehabilitation services in athletic training facilities, outpatient settings, physician offices, and industry workplaces in the past. I feel that I have provided quality and effective health care for the 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. 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,
Kenneth D. Hart, Jr., MS, ATC

Submitter : **Dr. Sameh Labib** **Date: 08/30/2007**

Organization : **Emory Orthopaedics and Spince Center/ Sports Med**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

30 August, 2007

CMS-1385-P-12423-Attach-1.DOC

#12423

EMORY HEALTHCARE

EMORY SPORTS MEDICINE CENTER

59 Executive Park South, suite 1000
Atlanta, Georgia 30329
Phone 404.778.7176
Fax 404.778.7266

Dear Sir or Madam:

To Whom It May Concern; this is Sameh (Sam) A. Labib MD, FRCSC Assistant Professor of Orthopaedic Surgery at Emory University School of Medicine. I am one of the attending surgeons at Emory Sports Medicine Center in Atlanta GA. We are a sports medicine staff of six fellowship trained sports medicine physicians. We use certified athletic trainers extensively in our practice and feel they are the best fit professionals for the orthopaedic and hospital setting based on their specific training in musculo-skeletal injuries. The evaluation, patient education, and rehab skills ATC's possess are an imperative part on our clinic operations and patient satisfaction. We have employed certified athletic trainers in our practice for the past 10 years and feel these are key professionals and the most appropriate heath care providers in the orthopaedic 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.

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,

Sameh A. Labib, MD, FRCSC
Assistant Professor of Orthopaedic Surgery Emory University School of Medicine
Head Team Physician Oglethorpe University athletics, Georgia Perimeter College athletics
Emory Sports Medicine Center
59 Executive Park South, suite 1000
Atlanta GA. 30329
ph: 404.778.4398
fx: 404.778.4324
Sameh.labib@emoryhealthcare.org

Submitter : **Mrs. Kathleen Duncan** **Date: 08/30/2007**

Organization : **Mrs. Kathleen Duncan**

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,

Kathleen Duncan

Submitter : **Dr. Alison Snyder** **Date: 08/30/2007**

Organization : **A.T. Still University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

August 30, 2007

Dear Sir or Madam:

I am a certified and licensed athletic trainer working as an Assistant Professor in the Post-Professional Athletic Training Education program at A.T. Still University/Arizona School of Health Sciences.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Alison Snyder, PhD, ATC

Submitter : Dr. Elizabeth Callahan **Date:** 08/30/2007

Organization : SkinSmart Dermatology

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

As a physician, I am opposed to the proposed reduction and its possible affect on patient care. I am a dedicated professional and only treat patients requiring mohs surgery and the neccessary repair. You would be more successfuly in reducing unnecessary procedures if you restricted surgery to those with fellowships and carefully monitered surgey procedures. I am afraid your efforts will result in less patient care.

Submitter : **Dr. Ivan Ortiz** **Date: 08/30/2007**

Organization : **Dr. Ivan Ortiz**

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

Rc: CMS-1385-P

Anesthesia Coding (Part of 5-Ycar 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 recognizcd the gross undcrvaluation of anesthesia services, and that thc Agency is taking steps to address this complicated issue.

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To ensure that our paticnts havc acccss to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immcdiately implemcnting the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your considcration of this serious matter.

Ivan A. Ortiz, MD

Submitter : Mr. David Seigneur **Date:** 08/30/2007

Organization : Allegheny General Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

#12428

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Dr. Gabriel O'Sullivan **Date:** 08/30/2007

Organization : Dr. Gabriel O'Sullivan

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

As a Doctor of Chiropractic who takes care of several Medicare patients, I urge you to abolish the recommendation in CMS-1385-P b/c such a measure would disallow many Medicare patients to receive the proper Chiropractic care they need. Such a ruling would not be a detriment to the Chiropractic profession financially in any manner (i.e. We have nothing to gain monetarily), but would affect Medicare patients.

Submitter : **Mr. John Pare** **Date: 08/30/2007**

Organization : **Mr. John Pare**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

As a member of the American Association of Nurse Anesthetists, I am asking for support of the Centers for Medicare & Medicaid Services proposal to boost the value of anesthesia conversion factor by 32%.
If adopted, CMS' proposal would help to ensure that Certified Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

Sincerely:
John Pare
CRNA
11211 Bridgeport Dr
Temple, Texas 79502

Submitter : **Jason Nutter** **Date: 08/30/2007**

Organization : **MedCentral Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer employed at MedCentral Sports Medicine in Mansfield, Ohio and at Mansfield Senior High School. I have a Masters of Science Degree in Sport Science and recieved my Bachelor of Science Degree from Kent State University. I am certified as an athletic trainer by the National Athletic Training Association Board of Certification and licensed to practice in the state of Ohio by the Ohio Physical therapy, Occupational Therapy and Athletic Training Board.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

Jason D. Nutter, MS, ATC

Submitter : Mr. Mark Rutledge **Date:** 08/30/2007

Organization : Rehab Centers of Charleston

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

To whom it may concern
I am in opposition to another proposed reduction in re-imbursement for outpatient physical therapy procedures. I have been practicing physical therapy for 17 years in South Carolina. Our payment for services has been repetitively reduced over that time-frame to a level presently that if we undergo another reduction we will not be able to continue to provide services. Medicare has made claims they have raised re-imbursement percentages for outpatient therapy services where in reality they have reduced them. These claims are based off of raising re-imbursement on codes that are not traditionally utilized in outpatient therapy meanwhile reducing the re-imbursement on the codes that are utilized, therefore giving the appearance that re-imbursement has increased for these services when, in fact, they have been reduced. The economic impact with cost of living changes in this time-frame with the reality that our re-imbursement for services is effectively reduced over and over again has led to a state that I cannot envision outpatient rehab services being able to be continued with any further reductions. Interestingly physical therapy services continue to be recognized for their benefits in evidenced based research studies that demonstrate the cost-effectiveness of such services. Physical therapists education continues to be advanced with most physical therapy programs now at doctorate level and consisting of 3 years post-graduate work. It makes it difficult to understand the rationale of reducing re-imbursement for outpatient physical therapy services when considering the facts. I absolutely do not support a reduction in re-imbursement and believe that such a reduction will be the greatest disservice that could occur to those individuals who are under coverage by medicare.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 30, 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:

I am a member of the American Association of Nurse Anesthetists (AANA), and I am writing to support the Centers for Medicare & Medicaid Services (CMS) proposal intended to increase 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.

The Medicare payment increase is important for these reasons.
' 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.
' 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.
' 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,

Beverly J. Wynn, CRNA, BA
58720 Baugo Cove Drive
Elkhart, Indiana 46517-8684

Submitter : Dr. JERI KELLER **Date:** 08/30/2007

Organization : OZARK ANESTHESIA ASSOCIATES, INC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

To whom It May Concern:
I am overwhelmingly in favor of the four dollar per unit increase in medicare payment for anesthesiologists. I have served patients in this profession for a decade and recognize the gross underpayment for physician services as compared to other physician specialties. In order that we may continue to encourage talented men and women to choose anesthesiology and provide top-notch care to the growing number of people requiring our services. We are already experiencing a work load too great for our current level of available anesthesia providers. This is very likely to worsen given the relative appeal of other specialty choices based on both reimbusement and life-style differences to anesthesiology. The impact of the aging baby-boomer population will be more patients requiring a high level of professional education and ability found only within the training of physician anesthesia practitioners. To ensure a healty perioperative experience for our seniors one must support a correction of the gross undervaluation of anesthesia physician providers.
Warmly
Alex J. Keller, MD

Submitter : **Ms. Theresa Backous** **Date: 08/30/2007**

Organization : **Ms. Theresa Backous**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a nationally certified and SD state licensed athletic trainer working at Avera St. Luke's Hospital in Aberdeen, SD. I have been working in the clinical and outreach setting for nearly 16 years. I obtained both my Bachelor's and Master's degrees from Northern State University, also here in Aberdeen.

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,

Theresa Z. Backous, ATC

Submitter : **Mr. Brian Bradley** **Date: 08/30/2007**

Organization : **Butte Pain and Anesthesia**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
___Brian Bradley_____
Name & Credential
_____CRNA_____
Address
_____4190 Sourdough Road, Bozeman,Montana 59715_____
City, State ZIP

Submitter : Dr. mikhail abramov **Date:** 08/30/2007

Organization : Montefiore Medical Center

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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 : James Allivato **Date:** 08/30/2007

Organization : ATI Physical Therapy

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I have been a licensed athletic trainer for 16 years. I currently am the regional director of operations for an outpatient rehabilitation facility that employs athletic trainers, physical therapists and occupational therapists.

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,

James Allivato, LAT, ATC
ATI Physical Therapy
Chicago, IL

Submitter : **Brinn Spencer** **Date: 08/30/2007**

Organization : **SUNY Oneonta**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Brinn Spencer and I am a certified athletic trainer for the State University of New York at Oneonta. I have earned my bachelors degree from the State University of New York at Cortland and my masters degree from West Virginia University.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Brinn Spencer, MS, ATC

Submitter : Ms. Elizabeth Connell **Date:** 08/30/2007

Organization : Rowan County Emergency Services

Category : Local Government

Issue Areas/Comments

Ambulance Services

Ambulance Services

See attachment

CMS-1385-P-12440-Attach-1.DOC

#12440

August 22, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD, 21244-8018

Reference: Beneficiary Signature

Dear Sir or Madam:

In regards to the signed contemporaneous statement from the ambulance employee, this is an unnecessary duplication of effort. The ambulance call report required for NEMSIS (National EMS Information System) compliance requires a complete assessment of the patient which indicates both the physical and mental condition of the beneficiary at the time of the emergency transport. Our service requires signatures to be obtained whenever possible from the patient or next of kin. When signatures cannot be obtained a reason is recorded as part of the documentation.

Emergency patients are typically turned over to helicopter crews or emergency departments. Employees accepting these patients are assuming care of a patient with an urgent or serious medical need. Neither flight crews nor emergency departments have staff with the time to document the time and date that the beneficiary arrived at the receiving facility. Again this is a duplication of effort. The ambulance call report documents the time the patient arrived at the destination. This is a NIMS requirement.

Ambulance call reports are kept a minimum of seven years on Rowan County's retention schedule. Therefore, supporting documentation is available to the Medicare carrier whenever they wish to review it.

In Rowan County we have 7 ambulances on duty to manage the requests from a population of 135 thousand. We are understaffed, as the national industry standard

would require 13 ambulances to serve the needs of this population. This is not unique in North Carolina or other parts of the country.

Requiring contemporaneous statements from EMS employees and employees of the receiving facility are both burdensome and serve no purpose. Furthermore, the ambulance provider is left in the unenviable position of seeking compliance from hospital employees who are already busy with critical functions. Without their cooperation ambulance providers cannot collect the proposed required documentation for payment. There is no penalty or incentive for hospitals to assist us.

I recognize that CMS has a responsibility to prevent fraud and insure the best use of federal dollars. These signature requirements do not help you or the carriers accomplish these goals. If the carrier is coming back to the ambulance provider for supporting documentation to pay or review a claim without a beneficiary signature, the best information is in the ambulance call report.

Thank you for consideration of my points.

Sincerely,

Elizabeth A. Connell

Submitter : Dr. Lucille Mostello **Date:** 08/30/2007

Organization : Children's National Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. Adam Duncan** **Date: 08/30/2007**

Organization : **Mr. Adam Duncan**

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 Ageney 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,

Adam Duncan

Submitter : Mr. Paul Mavrakos **Date:** 08/30/2007

Organization : Alabama Orthopaedic Clinic, P.C.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
Thank you for the opportunity to comment regarding whether changes are necessary regarding Physician Self-Referral Provisions.
I am a registered physical therapist in Alabama. I have worked for a physician owned therapy practice for 10 years. Prior to this I worked in a hospital therapy department. I have 12 years of therapy practice and understand a lot about the stark laws and it's provisions. I am in opposition to the new provision to change the current Stark law. We have a very close working relationship with my patients and the referring physicians. I have access to information that assists me in a very high level of physical therapy care that other therapists do not have. I do not see overutilization in my current setting. We give all patients the opportunity to seek therapy services outside of our clinic if they so desire. Most patients prefer to stay in our clinic due the the proximity to their referring physician and our understanding of the referring physician's personal preferences for treatment. The government currently has appropriate guidelines in place to assure Medicare beneficiaries quality care provided by licensed staff. I can assure CMS that no new provisions are needed to inhibit patient choice for therapy services rendered. For this and many other reasons I am opposed to changing the current Stark provision allowing Physician Self-Referral for therapy services. I believe the current proposal is a self-seeking financial attack by private physical therapy practicioners and the American Physical Therapy Association. Thank you again for your time and understanding.

Submitter : **Dr. Merrill Morey** **Date: 08/30/2007**

Organization : **Anesthesiologist Group of Henry County, PC**

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.

This is especially important in practices like ours, in a small
rural community with a large proportion of retired people.

Thank you very much for your consideration in this important matter.

Sincerely,

Merrill Morey, MD

Submitter : Dr. Jon Starr **Date:** 08/30/2007

Organization : Self - sole proprietor

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

In 2006, CMS reviewed the American Medical Association s Current Procedural Terminology (CPT) codes 17304 17310 (Mohs micrographic surgery) and requested that new site-specific codes be developed similar to those used for other excisional surgery. The American Academy of Dermatology, the American Society for Dermatologic Surgery, and the American College of Mohs Micrographic Surgery and Cutaneous Oncology participated in last year s review of the Mohs CPT codes, and new codes were adopted (17311-17315) addressing CMS concerns without adversely affecting the delivery of these services to patients in need.

However, as of July 1st of this year, we were notified by CMS of a planned change in payment policy that in our opinion has the potential to negatively impact the care of our patients and could add significant cost to an already stressed healthcare budget. This planned change would remove Mohs surgery from a longstanding exemption from the multiple surgery reduction rule (MSRR, indicated by CPT modifier -51). This is a departure from a longstanding exemption agreed to by CMS and virtually all private insurance carriers since 1991. The change proposed would eliminate the exemption and decrease reimbursement by 50% for either the Mohs excision or for the associated repair, and for Mohs excision of any additional cancers treated on the same day; such a decrease in reimbursement would not cover the cost of providing the service.

If this proposed change is enacted, we will no longer be able to provide the same kind of high-quality, cost-effective services for our patients in need. We will be forced to change the way we deliver care in order to cover our costs of providing this service. The following paragraphs attempt to explain the rationale behind the need to exempt Mohs surgery from the multiple surgery reduction rule and the consequences of not doing so.

In its review of the Mohs codes in 1991, CMS agreed that Mohs excisions are separate staged procedures; they will be paid separately with no multiple surgery reductions. This rule was placed in the Federal Register at that time (Federal Register, November 25, 1991, volume 56, #227, pg 59602). In 2004, the Mohs codes were added to the CPT Appendix E list of codes exempt from the -51 modifier and the multiple surgery reduction rule, to eliminate the occasional carrier misunderstanding when the multiple surgery reduction was applied to these codes. The July 2004 CPT Assistant article reviewed the rationale: The rationale for this policy is that for many surgical procedures some of the work of a procedure is not repeated when two or more procedures are performed. For these procedures the intraservice work is only 50% of the total work, while the other 50% represents pre- and post-service work that overlaps when multiple procedures are performed on the same patient on the same date of service. For Mohs surgery, however, greater than 80% of the work is intraservice work that does not overlap when two or more procedures are performed. The pathology portion of Mohs surgery constitutes a large portion of this total and also is not reduced with multiple procedures. The pre-service and post-service work values are small because there is a zero-day global period. Together there is very little overlap or reduction in work when two or more tumors are treated on the same patient on the same day. Therefore, Mohs surgery codes are exempt from the use of modifier 51.

The consequence of applying the multiple surgery reduction rule to the Mohs codes would be a reimbursement reduction to a value less than the cost of providing the service. Therefore, I will be obligated, should I elect to continue to provide these services, to alter how I do this work. No doubt, it will be less convenient and more costly for our patients. I would prefer not to put them in that position and hope that you will agree.

Submitter : **Mr. Dale Kroll** **Date: 08/30/2007**

Organization : **Northwest Iowa Anesthesia Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Administrator,

Please support the proposed boost for anesthesia conversion factor.
I work in a rural hospital which does not qualify for pass-through reimbursement. It is very difficult to attract anesthesia providers to work in settings with inadequate reimbursement. It has become a burden to hospital budgets which require supplementing incomes.

Sincerely,

Dale Kroll

Submitter : Mr. Tim White, II **Date:** 08/30/2007

Organization : Mr. Tim White, II

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Tim White, II and I currently work at the University of North Carolina At Pembroke, where I serve as a Certified Athletic Trainer. In the past I have worked in physical therapy clinics and hospitals as well. I have an undergraduate and master's degree in athletic training. Also, I am nationally certified and 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,

Timothy E. White, II MS, ATC, LAT

Submitter : **Dr. Gunnar Klauss** **Date: 08/30/2007**

Organization : **Wake Forest University Baptist Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my 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.

Gunnar Klauss.

Submitter : Dr. Timothy Lair **Date:** 08/30/2007

Organization : American Society of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the significant 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.
Timothy Lair MD

Submitter : Dr. Elizabeth V. Saarel **Date:** 08/30/2007

Organization : Univ.of Utah, Primary Children's Medical Center

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Coding---Reduction In TC For Imaging Services

August 30, 2007

Dear CMS:

I am writing regarding the proposed change to eliminate CPT 93325 (Doppler Color Flow Mapping) and bundle this code into other echocardiography CPT codes. As a cardiac specialist caring for patients with congenital heart disease, this is of particular concern to me for a number of reasons.

I do not believe the appropriate process has been followed with respect to this proposed change. After significant interaction and research between the Relative Value Scale Update Committee (RUC) and the appropriate specialty societies (ACC and ASE), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that other echo codes be bundled as well with the 93325. Because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

Importantly, there is no proposed change to the RVUs of the codes with which 93325 will be bundled. The proposal would simply eliminate reimbursement for CPT 93325, yet the amount of work performed and time spent by the physician for this service will remain the same.

Color Doppler is typically performed in conjunction with 2D echo to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow velocities. The performance of echo in patients with congenital anomalies is unique in that it is frequently necessary to use color Doppler (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 code for the pediatric population stating that color Doppler is "& even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." There are many other complex anatomic and physiologic issues that we as cardiac specialists face on a daily basis when performing echos on patients with complex heart disease. Color Doppler imaging is a critically important part of many of these studies, requiring additional time and expertise from both the sonographer and the cardiologist interpreting the study. Bundling 93325 with other echo codes does not take into account this additional time, effort, and expertise. I am concerned that this change would adversely impact access to care for cardiology patients with congenital cardiac malformations. Programs caring for this select patient population do so not only for those with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for congenital cardiac services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to our patients will not be sufficient to continue to do so should the proposed bundling of 93325 with other echo codes be implemented.

I strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other cardiology echo codes until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Sincerely,
Elizabeth Saarel, M.D.
Assistant Professor

Submitter : **Dr. Mehmet Ozcan** **Date: 08/30/2007**

Organization : **OUHSC**

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 : Mr. David Florkowski **Date:** 08/30/2007

Organization : Physical & Athletic Rehabilitation Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

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,

David Florkowski
M.Ed., ATC, LAT, CEAS, CSCS

Submitter : **Ms. Caroline Duncan** **Date: 08/30/2007**

Organization : **Ms. Caroline Duncan**

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,

Caroline Duncan

Submitter : **Dr. Jeffrey Gaynor** **Date: 08/30/2007**

Organization : **Daly City Anesthesia Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. Ramon Soriano **Date:** 08/30/2007

Organization : Dr. Ramon Soriano

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12455-Attach-1.DOC

#12455

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. Ramon Bieri** **Date: 08/30/2007**

Organization : **AgeWell Health Inc.**

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 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 eduoation, clinical experience, and Registered status insure that my patients receive quality health care. Hospital and other facility medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards and accepted practices.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the health care industry. It is irresponsible for CMS to further restrict PMR services and specialized professionals.

It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to reconsider these proposed rules. Leave medical judgments and staffing decisions to the professionals. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Ramon Bieri, RKT

Submitter : **Ms. Felicia Dorsey** **Date: 08/30/2007**

Organization : **Athletic Training Student**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an Athletic Training Student from Sacred Heart University. In the fall I will hopefully become a Certified Athletic Trainer and be starting my professional career. I feel that it is important to participate in matters like this so that my voice can be heard and that the future of my profession is not compromised.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

When I become a full time athletic trainer, I will be qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam will ensure that my patients receive quality health care. State law and hospital medical professionals 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,

Felicia M. Dorsey, ATS

Submitter : **Jennifer Johannes** **Date: 08/30/2007**

Organization : **Jennifer Johannes**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer, formerly at University Orthopedics Center and Bellefonte High School (PA). I have cared for high school and middle school athletes who have sustained various injuries through competition or practices.

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,

Jennifer Johannes, AT,C

Submitter : **Louise Hershkowitz** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Administrator:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.
_ 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,

Louise E. Hershkowitz, CRNA, MSHA

2020 Turtle Pond Drive
Reston, VA 20191

CMS-1385-P-12459-Attach-1.DOC

CMS-1385-P-12459-Attach-2.DOC

Submitter : **Mr. Adam Hofflaines** **Date: 08/30/2007**

Organization : **Mr. Adam Hofflaines**

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,

Adam Hofflaines

Submitter : **Dr. Ronald Friedman** **Date: 08/30/2007**

Organization : **Daly City Anesthesia Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Christopher Doney** **Date: 08/30/2007**

Organization : **Paynesville Area Health Care System**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Chris Doney I am a Certified Athletic Trainer working for the Paynesville Area Health Care System (PAHCS). I earned my Bachelor of Science Degree in Athletic Training from Minnesota State University, Mankato (MSU). During my time there I was educated through classroom instruction and clinical experience on how to properly prevent, assess, treat and rehabilitate injuries to active individuals.

After spending four years studying Athletic Training as an undergraduate I attended graduate school at MSU for another three years where I studied Health Science and Exercise Physiology.

After finishing my coursework I began working with the PAHCS. Although most of my experience has come from working in competitive athletics, my skills transition well into working with everyday people with injuries. I was hired as the Athletic Trainer for the Lakes Sports Medicine division of the PAHCS becasue PAHCS recognezed my abilities reach far beyond the athletic arena.

I currently work under the direct supervision of Dr. George Morris, MD. Although I do outreach work to Rocori High School in Cold Spring, MN my primary job duty is to work as Dr. Morris' physician extender. In that role I work with many individuals that don't want formal physical therapy nor do they need to. With the help of my overseeing physician we decide whether formal physical therapy is best for the patient or whether they would benefit just as well from working with me. In my undergraduate education I was taught the limitations of my practice and understand I am not a Physieal Therapist and am not qualified to deal with all that a Physical Therapist handles. However, within the realm of musculoskeletal injuries there is a large area of overlap between Athletic Trainers and Physical Therapists. Please look into, and try to understand what Athletic Trainers are capable of. It will allow patients to recieve the best care available.

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,

Christopher P Doney, ATC, ATR

Submitter : **Dr. Cherian oommen** **Date: 08/30/2007**

Organization : **Milford anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Sincerely,

Cherian S. Oommen, MD

Submitter : **Dr. Vivian Kim** **Date: 08/30/2007**

Organization : **Daly City Anesthesia Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Ms. Heather Hoffhines** **Date: 08/30/2007**

Organization : **Ms. Heather Hoffhines**

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.

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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,

Heather Hoffhines

Submitter : Dr. Andrew Simon **Date:** 08/30/2007

Organization : Andrew L Simon, MD, FACS

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

#12466

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mrs. Mary Anderson **Date:** 08/30/2007

Organization : Rehabilitation Centers of Charleston

Category : Occupational Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Reduction in payments by 9.9% will greatly affect our practice. Every year payments seem to get cut yet all other expenses increase and cost of living increases. We strive to provide the best possible care and strive for the best outcomes and need to be paid fairly for these services.

Submitter : **Dr. Jan Ehrenwerth** **Date: 08/30/2007**

Organization : **Yale University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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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 fact, we can not even reach a break-even point at this level of reimbursement.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely yours,

Jan Ehrenwerth, M.D.

Professor of Anesthesiology

Yale University School of Medicine

Submitter : **Mrs. Linda Childers** **Date: 08/30/2007**

Organization : **Oregon Imaging Centers**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

The Direct Practice Expense RVU for 77080 (DXA)
lndirect Practice Expense for DXA and VFA
Deficit Reduction Act
Dear Mr. Weems:
I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.
As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:
a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;
b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:
? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;
? the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.
c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and
d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Submitter : **Mr. Eric Alkins** **Date: 08/30/2007**

Organization : **Mr. Eric Alkins**

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,

Eric Alkins

Submitter : Dr. Richard Flowerdew **Date:** 08/30/2007

Organization : Spectrum Medical Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-12471-Attach-1.DOC

#12471

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. Several studies have repeatedly demonstrated this inequity. Most recently, 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.

Anesthesia services have continued to function primarily through cost shifting i.e. the commercial insurance market covering the shortfall from Medicare. However this mechanism is exhausted as the Medicare population increases and .

In a rural state such as Maine, the payer mix is particularly adverse. We have a large Medicare population as the younger members of the community leave for better opportunities. We have one of the highest Medicaid populations (about 20%) and one of the lowest Medicaid reimbursement rates. If commercial payers tie their anesthesia reimbursement rate to the present Medicare rate, the outcome would be devastating on the access to anesthesia care. The academic centers, a major source of providers to the community, and tertiary care facilities in particular would be in an even worse position because of their patient profile and practice referral patterns.

I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Wayne Fuller** **Date: 08/30/2007**

Organization : **Anesthesia Associates of Muskegon**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq. 29 August, 2007
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 realize that you have received a form of this letter in many variations, however, this is so important and the basic premise is so concrete that this letter states all that needs to be presented.

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.

Wayne Fuller MD

Submitter : **Mrs. Crescentia Woods** **Date: 08/30/2007**

Organization : **OU Physicians Department of Anesthesiology**

Category : **Other Health Care Provider**

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.

Submitter : Joy Crouse **Date:** 08/30/2007

Organization : Alabama Orthopaedic Clinic, P.C.

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Certified Athletic Trainer, licensed in the state of Alabama who has chosen to work for an orthopaedic physician practice. Our physical therapy services are only offered to patients who are referred by the physicians in this practice. I find that this arrangement is highly beneficial to the patient because we are able to see patients the same day that physical therapy is prescibed, access the complete medical file and history of the patient and have greater interaction with the referring physician regarding the patient's care.

Once physical therapy is prescribed, the patient can choose where to recieve their physical therapy services. Many patients prefer the convenience of having their physical therapy at the same location of their doctor's office. This is not an arrangement that encourages abuse. Therapy services should continue to qualify for the in office ancillary services exception.

Sincerely,

Joy Crouse, ATC/L

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a Certified Athletic Trainer, licensed in the state of Alabama who has chosen to work for an orthopaedic physician practice.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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,

Joy Crouse, ATC/L

Submitter : **Mr. Andre Daniel** **Date: 08/30/2007**

Organization : **Milwaukee Bucks**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Andre Daniel. I am the Head Athletic Trainer and Travel Coordinator for the Milwaukee Bucks of the National Basketball Association. I received my Bachlors degree from Austin Peay State University. My certifications are the National Athletic Trainers Association, National Strength and Conditoning Association and National Academy of Sports Medicine. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Sincerely,

Andre Daniel, ATC/L, CSCS,PES,CES

Submitter : Hugh Harling **Date:** 08/30/2007

Organization : Hugh Harling

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Hugh W. Harling and I am a certified and state licensed athletic trainer. I hold a BS and MESS in Exercise Science and a Doctorate in Health Care Education. I have worked in intercollegiate athletics, high schools and rehabilitation centers during my 19 years as a certified athletic trainer. As an associate professor and Athletic Training Program Director at Methodist University in Fayetteville, NC I have concerns regarding accessibility to health care because of the Center for Medicare and Medicaid Services administrative policies.

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 rehabilitation specialist 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,

Hugh W. Harling EdD, LAT, ATC

Submitter : **Mr. John Ferrara** **Date: 08/30/2007**

Organization : **Case Western Reserve University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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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.

John Ferrara

Submitter : **Mr. Jason Forro** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Jason Forro CRNA, MSN
13481 Blaisdell Drive
Dewitt MI 48820

Submitter : **Mr. Eric Pfitzinger** **Date: 08/30/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 30, 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:
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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).
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Sincerely,

Eric Pfitzinger, CRNA, MS
Jefferson Memorial Hospital
P.O. Box 350
Crystal City, Missouri 63019-0350

Submitter : Mark Doughty **Date:** 08/30/2007

Organization : Newark High School

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Mark Doughty, and I am an Ohio Licensed and BOC Certified Athletic Trainer. I have a BS degree from West Virginia University and an MS degree from the University of Arizona. I have been a full time athletic trainer at Newark High School for the past 24 years.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As a past member and Chair of the Athletic Trainers Section of the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board, I am acutely aware of the stringent requirements for becoming a licensed professional in the health care arena.

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,
Mark P. Doughty, MS, ATC, LAT
Head Athletic Trainer
Newark High School
Newark, OH

Submitter : **Mrs. Debra McClure, BSN, CRNA,** **Date: 08/30/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Debra J. McClure, BSN, CRNA, APNP

6922 South 35th Street
Franklin, WI 53132

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Ms. Norwalk:
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Sincerely,
_____Cyd Kratzer SRNA_____
Name & Credential
_____Riverchase Blvd_____
Address
_____Madison, TN 37115_____
City, State ZIP

Submitter : **Mr. Rick Mckee** **Date: 08/30/2007**

Organization : **Mr. Rick Mckee**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. Chad Barker** **Date: 08/30/2007**

Organization : **Mr. Chad Barker**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer with a post graduate spinal specialty from the McKenzie Institute and a Post graduate Ergonomic Certification. I also have a MBA from Mississippi State university with 4 to 5 years expeirence as a Rehab Director at a joint commision accredited faciliity. I currently work in private practice in Tupelo Mississipi and have almost 12 years clincial expeirence.

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 amount of clinical expeirence and formal training I have, far exceed that of a 2 year associate degree and limiting patient access to my services is a providing a poor standard of care.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Chad Barker, ATC,Cert.MDT,CAE,MBA

Submitter : **Dr. Richard Flowerdew** **Date: 08/30/2007**

Organization : **Spectrum Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1385-P-12485-Attach-1.DOC

#12485

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. Several studies have repeatedly demonstrated this inequity. Most recently, 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.

Anesthesia services have continued to function primarily through cost shifting i.e. the commercial insurance market covering the shortfall from Medicare. However this mechanism is exhausted as the Medicare population increases and .

In a rural state such as Maine, the payer mix is particularly adverse. We have a large Medicare population as the younger members of the community leave for better opportunities. We have one of the highest Medicaid populations (about 20%) and one of the lowest Medicaid reimbursement rates. If commercial payers tie their anesthesia reimbursement rate to the present Medicare rate, the outcome would be devastating on the access to anesthesia care. The academic centers, a major source of providers to the community, and tertiary care facilities in particular would be in an even worse position because of their patient profile and practice referral patterns.

I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Vickie McKee** **Date: 08/30/2007**

Organization : **Mrs. Vickie McKee**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. Ira Weg **Date:** 08/30/2007

Organization : South Shore Internal Medicine

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

see attached comment

CMS-1385-P-12487-Attach-1.DOC

CMS-1385-P-12487-Attach-2.DOC

#12487

August 28, 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 month, 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.

Sincerely,

Ira L. Weg, MD, FACC

Submitter : **Dr. Cheryl Patterson** **Date: 08/30/2007**

Organization : **Affiliated Anesthesiologists PC**

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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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.

Cheryl Patterson MD
Northville, MI

Submitter : **Mrs. Dana Gunter** **Date: 08/30/2007**

Organization : **Mrs. Dana Gunter**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,

I am a certified Athletic Trainer in the state of Washington. I have been practicing for 22 years. My education includes a MS in Physiology as well as 22 years of CE credits. Currently, I am working in a Cardiac and Pulmonary Rehabilitation outpatient clinic in a Seattle Hospital.

I am writing today to voice my opposition to the therapy standards and requirements in regard 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.

Respectfully submitted by,

Dana Gunter, MS, ATC

Submitter : Allen Bryan **Date:** 08/30/2007

Organization : Enterprise Therapy Center

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I own an outpatient physical therapy clinic that is independently owned and operated. We are not affiliated with any hospitals or owned by any physicians. The current policies create a very biased playing field when the orthopedic surgeons offer physical therapy in their practice and is located under the same roof. It makes patient referrals very convenient to schedule for physical therapy. There have been many cases with patients where the patients are not aware that they have a choice on where they receive their physical therapy services. This also causes an issue for the patient if they are unhappy with their physical therapy. They either discontinue their visits to therapy or they stay unhappy throughout their treatments. This is a major problem. This again creates a very unlevel playing field and in my opinion discourages patient options for ancillary services. I have no problems with the physicians or their therapists and their performance. I do have a problem with them being partnered. I am certainly in favor of reviewing this policy to create a fair market for all patients. Thank you for your consideration.

Allen Bryan
Enterprise Therapy Center

Submitter : **Dr. Vatche Bezdikian** **Date: 08/30/2007**

Organization : **Dr. Vatche Bezdikian**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Jennifer Hansen** **Date: 08/30/2007**

Organization : **Cleveland Clinic Foundation**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Jennifer Hansen, MD
PGY-1 Anesthesiology Resident
Cleveland Clinic Foundation
9500 Euclid Ave.
Cleveland, Ohio 44195

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Jennifer K. Hansen, MD

Submitter : **Dr. David Raskin** **Date: 08/30/2007**

Organization : **Medical Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the revisions to the Medicare reimbursement schedule for anesthesiologists as proposed by docket CMS-1385 P. Thank you for recognizing the importance and value of our patient care. Sincerely,

David Raskin MD
Oakland, CA

Submitter : **Dr. Matthew Grabowski** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

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.

Submitter : **Mrs. maureen sizemore** **Date: 08/30/2007**

Organization : **university suburban sports medicine center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Maurcen Sizemorc and I have been practicing as a certified and licensed athletic trainer in the state of ohio for 15 years. I am employed by a sports medicine center and also work at a high school providing daily athletic training services. I havc a bachelor's degree in athletic training from BGSU and sat for an 8 hour national certification cxam with a 33% passing rate. I am also an EMT and maintain personal training certifications as well. I am directly responsible for 350 athletes that participate in 9 varsity sports every day. I also treat a variety of out patient orthopedic injuries in the sports medicine clinic. I am the sole carrier of health care for my family of 4 and would be gravely impacted by the decision before you. I am requesting you give this you full attention and respond according to the best interest of the athletes and active patients in this country.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilitics proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

Maurcen Sizemore ATC, EMT-B

Submitter : **Dr. Harold Jesser** **Date: 08/30/2007**

Organization : **Park Ridge Anesthesia Assoc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Sharon Cannon** **Date: 08/30/2007**

Organization : **Meritcare**

Category : **Other Practitioner**

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:
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Sincerely,
_____Sharon Cannon Certified Registered Nurse Anesthetist_____
Name & Credential
___1662 West Gateway Circle_____
Address
___Fargo North Dakota 58103_____
City, State ZIP

Submitter : Dr. matt supron **Date:** 08/30/2007

Organization : anesthesiology of marquette

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

It has taken ten years to service the debt that I accumulated through college and med -school and medicare is cutting my reimburement. It does not seem correct.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

12499

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Ms. Sunnie Atkins** **Date: 08/30/2007**

Organization : **Ms. Sunnie Atkins**

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,

Sunnie Atkins

Submitter : **Mrs. Toria Cornett** **Date: 08/30/2007**

Organization : **Essex High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Toria Cornett and I am a Certified Athletic Trainer. I am nationally certified and licensed by the state to practice athletic training. I currently hold a bachelor's degree and work with athletes at the high school 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,

Toria Cornett, ATC, LAT, CSCS

Submitter : **Dr. Alain Le** **Date: 08/30/2007**

Organization : **OUHSC**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

CMS-1385-P

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Alain Le, M.D.

Submitter : **Dr. lawrence deghetaldi** **Date: 08/30/2007**

Organization : **santa cruz medical clinic**

Category : **Physician**

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

see attachments

CMS-1385-P-12503-Attach-1.PDF

#12503

August 29, 2007

Herb Kuhn,
Department of Health and Human Services
Attention CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: Proposed reconfiguration of CA physician payment localities

Mr. Kuhn,

I appreciate the opportunity to comment on the proposed physician rule and applaud you for taking this step to improve the credibility of the physician payment process as it relates to the current payment localities. You and I have met on several occasions to discuss this issue – I appreciate your concern and sincere desire to improve payment accuracy to providers who care for Medicare beneficiaries.

The General Accountability Office in its June 2007 report calls on CMS to reform the physician payment localities. It offers to CMS several options to improve payment accuracy. The current physician payment locality configuration has seen an erosion in payment accuracy since they were last reconfigured in 1996. Many providers and legislators have lost confidence in the ability of CMS to fulfill its obligation to make appropriate geographic adjustments to providers caring for Medicare beneficiaries under Part B of Medicare. Hospitals and other providers receive much more accurate payments from CMS for several reasons not the least of which is the fact that Metropolitan Statistical Areas (numbering approximately five times more than the current 89 physician payment localities) are used to base geographic adjusters to those providers.

The GAO is aware of this and acknowledging that CMS has been reluctant to increase the number of physician payment localities in order to assist CMS in preserving administrative simplicity calls for long-needed reforms to the 1996 localities. I have been a practicing physician in Santa Cruz County since 1984 and have invested considerable time in helping CMS, the California Medical Association, and numerous legislators in correcting this problem.

I support an amended Option 3 in your proposed rule. I am concerned about the inconsistencies in the GAFs that you publish for several CA counties especially as those inconsistencies significantly affect the configuration of CA counties into the locality groupings that you propose. I am also concerned that a fundamental mathematical error misapplied the text that you (and the GAO) proposed for this mechanism of grouping like-counties by similar costs. This is the 95% problem which, I am sure that you are aware. It is outlined in the attached graph.

As you are aware, the Geographic Adjustment Factor (GAF) is used to compare global cost input differences between counties. It is not, however, used by CMS' intermediaries to pay providers. The actual GPCIs are used to do this. The GAF is a mathematical construct only. In order to properly calculate GAFs for individual counties or for an RVU-weighted assemblage of counties, you must use the actual GPCIs. This is the method that CMS has used since 1996. Bob Ulikowski, previous manager of the payment localities and GPCIs for CMS, has confirmed this to both me and other physicians in California who are well-versed with your methodology. It is essential that CMS

share the actual county GPCIs and county RVUs as you have done in the past for each of the years: 1999 – 2006. The sudden lack of transparency by CMS is very concerning.

Two CA counties deserve special comment:

1. Santa Clara County. The 9.2% proposed drop in the GAF for this county when its 50th percentile HUD rent data apparently drops at the same proportional rate as adjoining San Mateo County (whose GAF drops at half the rate of Santa Clara) is disturbing. CMS should present, in its final rule, the mathematical formula used in the application of the 50th HUD rent data and its affect on the various practice expense GPCIs for California's counties.
2. San Benito County. This county is part of the Santa Clara/San Jose two county MSA. I cannot understand how this county, and this county only, had county specific, rather than MSA specific, rent data applied to it in the calculation of its GPCIs and GAF. The GAO applied the same consistent approach that CMS has used throughout the rest of California in the calculation of the GAF for this county. CMS should be consistent and should apply the same HUD rent data for Santa Clara and San Benito in the calculation of those counties' cost input factors. This is the methodology used by CMS elsewhere in this state. I support the GAO's approach which is consistent and fair. If CMS chooses to not follow the recommendation of the GAO as it applies to this county, I request that CMS describe in the final rule why it chooses to not do so.

Lastly, CMS should not longer provide special privilege to state medical associations in the initiation of proposed locality reform. State medical societies should have the opportunity to comment on proposed reconfigurations but should not have special standing. Congress has not supported this policy. Previous administrations have held such actions as unconstitutional. Despite this, I am aware that current CMA policy supports locality revision even if it causes a decrease in reimbursement to some CA counties.

My organization includes optometrists, physical therapists, audiologists, speech pathologists, occupational therapists, physician assistants, podiatrists, and nurse practitioners. All of these providers bill CMS for services provided to Medicare beneficiaries. However, none of these providers are represented by the state medical society. Therefore, CMS, as it acknowledged in the 2005 final rule, bears the responsibility to update the physician payment localities.

Sincerely,

Lawrence deGhetaldi, MD

Cc. Secretary Michael Leavitt, Department of HHS
Sam Farr, Anna Eshoo - Members of Congress
Diane Feinstein, Barbara Boxer - US Senate

Proposed CMS Option 3	Corrected CMS Option 3 (Corrected Counties in Yellow)	Actual County GAF	CMS Threshold	
Locality 01	Locality 01	GAF		
San Mateo	San Mateo	1.204	Floor for this Locality is	
San Francisco	San Francisco	1.201	95% of San Mateo	
Marin	Marin		*95% of 1.204 =*	
	Santa Clara	1.148	*1.1438*	
Locality 02	Locality 02			
Santa Clara	Contra Costa	1.134		*The GAO used the correct method to calculate San Benito's GAF. They used its actual MSA HUD data for rent. The GAF shown is the GAO calculation for this county.*
Contra Costa	Alameda	1.129		
Alameda	Orange	1.128		
Orange	Ventura	1.128	Floor for this Locality is	
Ventura	Los Angeles	1.121	95% of Contra Costa	
Los Angeles	Santa Cruz		*95% of 1.134 =*	
	*San Benito	1.081	*1.0773*	
	Monterey			
Locality 03	Locality 03			
Santa Cruz	Sonoma			
Monterey	Napa			
San Diego	San Diego	1.053		
Sonoma	Santa Barbara	1.053	Floor for this Locality is	
Napa	Solano	1.051	95% of Sonoma	
Sonoma	Sacramento	1.047	*95% of 1.076 =*	
Solano	El Dorado	1.033	*1.0222*	
	San Bernardino	1.023		
Locality 04	Locality 04			
Sacramento	Placer	1.021		
El Dorado	Riverside	1.017		
San Bernardino	San Luis Obispo	1.015		
Placer	San Joaquin	1.006		
Riverside	Yolo	0.995		
San Luis Obispo	Stanislaus	0.979	Floor for this Locality is	
San Joaquin	Mono	0.977	95% of Placer	
	Nevada	0.975	95% of 1.021	
	Kern	0.973	0.96995	
	Locality 05			
	Sierra	0.967	All remaining CA	
	Amador	0.967	Counties move	
	Rest of CA	< 0.967	to Locality 05	

Counties in yellow were wrongly assigned to the proposed by CMS due to a mathematical error in the proposed rule.

The county in blue should be correctly assigned to the appropriate locality based on the application of the GAO's methodology in calculating its GAF.

Submitter : **Mr. Jay Brown** **Date: 08/30/2007**

Organization : **Mr. Jay Brown**

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,

Jay Brown

Submitter : **Mr. Lee Diederick** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,__Lee Diederick_____
Name & Credential
_4229 Timberline Drive_____
Address
__Fargo, North Dakota 58104_____
City, State ZIP

Submitter : **Dr. Barbara Ryan** **Date: 08/30/2007**

Organization : **Spectrum Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Ms. Dana Hale** **Date: 08/30/2007**

Organization : **Itawamba Community College**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Dana Hale and I have been a certified athletic trainer for the past 14 years. I received my athletic training degree from The University of Southern Mississippi. I am currently employed by Itawamba Community College as an instructor in the Health, Physical Education and Recreation Department. I have over the years worked in various clinical settings.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
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,
Dana Hale, ATC

Submitter : **Mr. Mike Hadden** **Date: 08/30/2007**

Organization : **Simpson College**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom it May Concern:

My name is Mike Hadden and I am Director of Athletic Training at Simpson College in Indianola, Iowa. I am a nationally certified and state-licensed athletic trainer. I am writing to voice my strong opposition to the therapy standards and requirements for staffing provisions for rehabilitation in hospitals and other facilities proposed in 1385-P.

The proposed changes will create a lack of access to certified athletic trainers, who are more than equipped to treat the physically active. An Athletic Trainer, or ATC, is fully qualified to perform physical medicine and rehabilitation services, which, is not of course, the same thing as physical therapy. An ATC's education includes didactic coursework and extensive clinical experiences ensures their patients receive quality health care. Outcome studies have proven this on numerous occasions. The American Medical Association, recognition by many state laws, and other qualified medical professionals have deemed us qualified to perform such services. The 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, to further restrict their ability to receive such services. The current flexible 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 ethics, and Medicare Part A or B hospital or rehabilitation facility.

Respectfully,

Mike Hadden MS LAT ATC CSCS
Director of Athletic Training
Simpson College
701 North C St.
Indianola, IA 50125

Submitter : Mrs. Leona Moat **Date:** 08/30/2007

Organization : Mrs. Leona Moat

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Leona Moat and I am a Certified Athletic Trainer. At the current time I am helping out with a rural High School athletic program for a very minimal amount of money. I have been an ATC since 2003.

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,

Leona Moat, ATC, MEd

Submitter : **Ms. Laura Brown** **Date: 08/30/2007**

Organization : **Ms. Laura Brown**

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
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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,

Laura Brown

Submitter : **Ms. Denise Harklau** **Date: 08/30/2007**

Organization : **Iowa State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am the Head Women's Athletic Trainer at Iowa State University. I have been working in this profession for over 20 years helping student-athletes and educating athletic training students. I have also been involved with the Board of Certification for Athletic Training for the past 20 years and realize the huge service that this organization performs. Their main purpose is to ensure the quality of certified athletic trainers to protect the health and welfare of the general population who need their services. Athletic Trainers possess unique skills which are beneficial to help prevent and treat injuries for the physically active person. I do not want to see a future where the the public will not have access to athletic training services. This would truly be an inservice to many patients.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
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Sincerely,

Denise Harklau, MS, ATC, LAT, NASM - PES

Submitter : **Mr. joseph kreklau** **Date: 08/30/2007**

Organization : **meritcare**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Baltimore, MD 21244 8018 ANESTHESIA SERVICES
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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,
_____Joseph Kreklau_____
Name & Credential
____608 192nd st. s _____
Address
__Hawley, MN 56549_____
City, State ZIP

Submitter : **Ms. Sandy Brown** **Date: 08/30/2007**

Organization : **Ms. Sandy Brown**

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,

Sandy Brown

Submitter : **Mrs. Christina Farley** **Date: 08/30/2007**

Organization : **Orange County Public Schools**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an Athletic Trainer that has been a resident of Orlando for 19 years. During those 19 years I have been employed by the Orange County School System as an Athletic Trainer in the High School Setting. It is with great distress that I am reviewing the new legislative changes that are being proposed.

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,

Christina Farley MSEd,ATC/L, NBCT
University High School
Orlando, Florida 32817

Submitter : **Mr. Jonathan Dunn** **Date: 08/30/2007**

Organization : **AANA**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Jonathan R.Dunn, CRNA

5030 Woodmont Ridge Ct.
Clemmons, NC 27012

Submitter : **Mr. Jeffrey Stone** **Date: 08/30/2007**

Organization : **Sufolk University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Impact

Impact

Dear Sir or Madam:

Thank you for allowing me to respond to CMS-1385-P. I am certified athletic trainer at Suffolk University in Boston, MA, and the District One Director of 2000 athletic trainers in New England. I have been a practicing athletic trainer for over 30 years, in the collegiate, interscholasdtic and clinical levels.

I am writing 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, state licensure 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.

Hospital-based sports medicine programs, which provide certified athletic trainers to satellite-based high school athletic programs, would be in jeopardy. The lack of quality-based sports health care at practices and games would drastically impact thousands of adolescent student-athletes on a daily basis.

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,

Jeffrey A. Stone
Head Athletic Trainer
Suffolk University- Boston, MA 02114

Submitter : Ms. Tonya Baker **Date:** 08/30/2007

Organization : Orthopaedic Assoicates of Dupage

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Tonya Baker, and I am a certified athletic trainer. I have been certified since 2004, and have since been working in the high school setting providing quality health care and rehabilitative services to athletes.
I am writing today to voice my opposition to the therapy standards and requirements in regard to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Tonya M. Baker, M.A, ATC

Submitter : **Mr. Boyd Cable** **Date: 08/30/2007**

Organization : **Mr. Boyd Cable**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Boyd Cable

Submitter : **Dr. David Schreibman** **Date: 08/30/2007**

Organization : **University of Maryland Department of Anesthesiolog**

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.

Resource-Based PE RVUs

Resource-Based PE RVUs

Submitter : **Pam Michael** **Date: 08/30/2007**

Organization : **American Dietetic Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12520-Attach-1.DOC

CMS-1385-P-12520-Attach-2.DOC

#12520

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Ms. Cheryl Cable** **Date: 08/30/2007**

Organization : **Ms. Cheryl Cable**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Cheryl Cable

Submitter : Mrs. Tracy Carter **Date:** 08/30/2007

Organization : Mrs. Tracy Carter

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

CMS is proposing to amend the regulations to change the plan of treatment re-certification schedule. Currently, the referring physician must certify the initial plan of care and re-certify every 30 days thereafter.

CMS proposes to change the re-certification period to 90 days.

I strongly support the proposal to extend the 30 day re-certification requirement to 90 days.

The 30 day re-certification is overly burdensome for physicians and physical therapists and is not an effective means of controlling utilization of therapy services.

CMS has adequate other requirements in place (referral, certification of the initial plan of care, specific medical necessity requirements, extensive documentation requirements, Local Coverage Determinations, Therapy Caps, CCI edits, etc.) and does not need the 30 day re-certification process in order to manage appropriateness of therapy care and utilization.

Submitter : **Ms. Brandy Cary** **Date: 08/30/2007**

Organization : **Ms. Brandy Cary**

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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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,

Brandy Cary

Submitter : Dr. n saidi **Date:** 08/30/2007

Organization : yale-anesthesia

Category : Physician

Issue Areas/Comments

Background

Background

MD

Submitter : Dr. Rod Walters **Date:** 08/30/2007

Organization : Walters Inc.

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer in Lexington, South Carolina. I have been working in the collegiate ranks for the past 28 years. Recently, I have ventured into the world of Consulting - providing services via education and outreach to physicians and athletic traienrs collectively.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilitics proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health 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,

D. Rod Walters, DA, ATC

Submitter : **Mr. Russell Farr** **Date: 08/30/2007**

Organization : **Caris Diagnostics**

Category : **Laboratory Industry**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see the attached electronic file. Thank you.

Russell O. Farr
SVP General Counsel
Caris Diagnostics

CMS-1385-P-12527-Attach-1.PDF

Submitter : Mrs. Kirsten La Mere **Date:** 08/30/2007

Organization : Gundersen Lutheran

Category : Other Health Care Professional

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Dear Sir or Madam:
My name is Kirsten La Mere and I am a Certified Athletic Trainer. I currently work in a clinical/outreach setting for a large medical center in Western Wisconsin.

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,
Kirsten L La Mere, MS, ATC, CSCS

Submitter : Mr. Marc Osborne **Date:** 08/30/2007

Organization : Medicomp Rehabilitation Network

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I am the Director of Sports Medicine for Medicomp Rehabilitation Network. My company has twelve Physical Therapy Clinics in Mississippi and Alabama, most in rural areas.

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,
Marc E. Osborne, ATC; LAT
Director of Sports Medicine
Medicomp Rehabilitation Network

Submitter : **Mr. Randy Cory** **Date: 08/30/2007**

Organization : **Mr. Randy Cory**

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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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,

Randy Cary

Submitter : **Date: 08/30/2007**

Organization : **OCPS**

Category : **Individual**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Eliminating the contracting of services of an athletic trainer through an outside rehabilitative agency would have an adverse affect on services provided to our student athletes. Our current athletic trainer is overwhelmed with her responsiblities and needs the help an outside part-time trainer. Please reconsider the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitative facility.

Submitter : **Ms. Laura Fafara** **Date: 08/30/2007**

Organization : **Duluth Clinic Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified Athletic Trainer. I work in a clinic outreach setting, where I spend mornings working closely with orthopedic physicians and physical therapists. In the afternoons I cover all the athletic practices and events at Hayward High School.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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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,

Laura Fafara, ATC

Submitter : **Mr. Meredon Cable** **Date: 08/30/2007**

Organization : **Mr. Meredon Cable**

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,

Meredon Cable

Submitter : **Dr. Daniel Higgins** **Date: 08/30/2007**

Organization : **Dr. Daniel Higgins**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Hello.
I am a Urologist in a medium sized city in WI and my practice services a number of small communities in our area. The physicians in our group travel to these communities, some 45 minutes away, to allow better access for these patients. I am concerned about issues that may affect my practice such as those related to Stark and especially the continued cuts in Medicare reimbursement. The cost of providing medical care continues to rise while payments decrease. As a urologist who is early in his career, I'm concerned that it will not be feasible to care for many of the patients I do now if cuts continue as they might. Even more worrisome to me is what the practice climate may be in five, ten or twenty years. I hope not to be a physician who has to leave the practice of medicine because of financial pressures.

I urge you to consider carefully these issues as they affect physicians. I feel as though I am taking on an inordinate amount of sacrifice as a urologist in the quest to provide health care to the patients of our country. Hospitals and health care companies, who obviously do not care for patients, are the entities that need to increase their 'contributions' to the costs of health care, not overburdened doctors.

Thank you for your consideration, and please feel free to contact me if so desired.

Daniel Higgins
Neenah WI
920-722-7747

Submitter : **Ms. Lauvern Cable** **Date: 08/30/2007**

Organization : **Ms. Lauvern Cable**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Sincerely,

Lauvern Cable

Submitter : **Ms. Sarah Eberhart** **Date: 08/30/2007**

Organization : **Concord Hospital**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

CMS is proposing to amend the regulations to change the plan of treatment re-certification schedule. Currently, the referring physician must certify the initial plan of care and re-certify every 30 days thereafter.

CMS proposes to change the re-certification period to 90 days.

I strongly support the proposal to extend the 30 day re-certification requirement to 90 days.

The 30 day re-certification is overly burdensome for physicians and physical therapists and is not an effective means of controlling utilization of therapy services.

CMS has adequate other requirements in place (referral, certification of the initial plan of care, specific medical necessity requirements, extensive documentation requirements, Local Coverage Determinations, Therapy Caps, CCI edits, etc.) and does not need the 30 day re-certification process in order to manage appropriateness of therapy care and utilization.

Submitter : Mr. Robert Tiffany **Date:** 08/30/2007

Organization : Tiffany Ford/ San Benito County Business Council

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

The county I live and work in, San Benito County in California, is significantly underpaid when it comes to Medicare reimbursements. The problem seems to be that this county has historically been an agricultural, "rural" area -- but in the last 15-20 years, things have dramatically changed. We are now a "bedroom community" for the Silicon Valley, and home prices and other costs have long ago gone through the roof. Our costs in San Benito County are now very much in line with other communities in southern Santa Clara County -- and yet we as a county are still treated reimbursement-wise like a rural area. The Medicare rates are badly out-of-date, and must be up-dated. It simply makes no sense that our rates would be significantly lower than Gilroy, CA, for example, which is just across the county border in Santa Clara County, about 12 miles away -- and yet the costs for the doctors and hospital/clinics here are precisely the same.

The situation is made that much worse because insurance companies like Blue Cross tie their reimbursements to the Medicare rates. So if the Medicare rates are out of line, the insurance reimbursements are equally out of line.

As a significant employer in San Benito County, this issue has the potential to greatly impact the health care that I provide to my employees. If the providers, especially the General Practitioners, do not get reimbursed enough by insurance companies like Blue Cross -- because of the Medicare issue -- and choose to walk away from using Blue Cross, my employees will be left with few options insurance-wise. We're a small county and simply have very few choices as it is.

Furthermore, with Medicare rates so low, it is darn near impossible for this community to attract good physicians to the county. 90% of the doctors recruited say 'no' once they look at the cost of living and running an office here as compared to the Medicare/insurance company reimbursement level. This dearth of talented doctors coming to San Benito County greatly impact the level of service that our hospital, clinics, and physicians can provide to my employees and other San Benito County residents. It's a huge problem for us.

Bottom-line, the rates must be updated. Option #3 of CMS' proposed rule would make the most sense for dealing with this issue in general. However, in order for our specific county to be brought up to a reasonable level, the individual numbers that CMS uses must be correctly calculated -- which is not the case right now. CMS needs to look at the June 2007 Report from the GAO to bring the county figures in line with reality.

Submitter : **Mr. Wayne Cable** **Date: 08/30/2007**

Organization : **Mr. Wayne Cable**

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 inerease as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Wayne Cable

Submitter : **Ms. Michele Talbot** **Date: 08/30/2007**

Organization : **Ms. Michele Talbot**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am Michele Talbot and am currently working on my Master's degree in Athletic Training at the University of Tennessee.

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,

Michele Lee Talbot

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I run an physician owned outpatient clinic. Our average number of visits per referral from our physicians is 8.5. This includes lumbar fusions, joint replacements and rotator cuff repairs. All of these are labor intense and require a long rehab.

We have direct access by computer to all of their dictation, the op notes, the x-rays, etc. If we have a problem with a patient, we can walk them next door and have them seen immediately. We work directly with them and know how they do their surgeries and what they want in the way of rehab.
Of our 7 PTs, 3 are McKenzie certified. There are 41 McKenzie certified therapists in the state. That gives us 7% of the certified therapists. One of the others has earned her OCS. This clinic not only paid for the education, travel, and exams for these therapists, it also encouraged them to do so.

We have 7 PTs, 4 PTAs, and 1 ATC. That s 12 licensed professionals. Our average number of patients per day is 95. That s about 8 patients per professional per day. We can spend the time that we need to with our patients. I understand that at Corporate owned PT services that each PT is encouraged to schedule a patient every 15 minutes. Potentially, that s 32 patients per professional.

I do understand that there are cases of abuse with some physician owned clinics. But abuse is not directly related only to physician clinic ownership. Any time there is money to be made from third party payers, there is great potential for abuse. I have heard of private practice PTs that have a tendency to over treat because they have bills to pay. I have worked in hospitals where administration encourages more billing to meet the budget. But there is, I think, much more abuse of the patient and the therapists in the corporate PT world. Three of our therapists have worked in corporate PT and they all tell me that they were encouraged and pressured to over treat and overcharge their patients. Ethics are a personal reflection of the owner of a practice and the administration of that practice. The type of practice is not necessarily an indication of the ethics of the facility.

Perhaps we should be policing for unethical business practices in general. Anyone who offers rehab services should undergo some sort of scrutiny, i.e., are PT s actually directing and planning the patient care? Who is in the clinic when PT services are being rendered? What is the case load as it relates to billable hours and do those hours exceed a typical 8 hour workday per therapist? What is the staff to patient ratio? How effective are the treatments? What is the number of visits per referral?

Although I have tried to see the issue from both sides, I do not understand the concept of the level playing field argument put forth by those who would want to limit PT s working for MD s. Should independent PT s who have friends who are doctors avoid taking their friends referrals because they have dinner together once a month? Should contracts be divided up so that rural rehab practices receive the same number of referrals as those with better proximity? Once we start trying to make it fair for all who want to own their own businesses, where does one draw the line? Should all PT practices be privately owned and run by the owner, thus cutting out corporations, hospitals, share holders and anyone else EXEPT the business owner him/herself as the one benefiting from profit? Don t we end up in the same place regarding ethics that it is the person not the situation that ultimately determines how the profits are received?

The physician owned PT practice issue is certainly heating up. The APTA has made the abolition of physician owned PT practices a top priority. Instead of looking at ownership, why don t APTA and CMS look at staff to patient ratios, number of visits per referral, costs per visit, qualifications of staff, or other indicators that more accurately reflect quality patient care?

Submitter : **Dr. Eleanor Romano** **Date: 08/30/2007**

Organization : **Stony Brook University Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our paticnts 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.

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Sincerely,

Eleanor Romano
Assistant Professor
of Clinical Anesthesiology
Stony Brook University
Medical Center
Stony Brook, N.Y. 11794

Submitter : Mrs. Sheryl Cheney **Date:** 08/30/2007

Organization : Concord Hospital

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

CMS is proposing to amend the regulations to change the plan of treatment re-certification schedule. Currently, the referring physician must certify the initial plan of care and re-certify every 30 days thereafter.

CMS proposes to change the re-certification period to 90 days.

I strongly support the proposal to extend the 30 day re-certification requirement to 90 days.

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Submitter : Dr. Anthony Fazzone **Date:** 08/30/2007

Organization : Springfield Hospital

Category : Physician

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Jered Mitchem** **Date: 08/30/2007**

Organization : **Mr. Jered Mitchem**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an athletic training student at Marietta College, in Marietta, Ohio. I am beginning my Junior year and plan to graduate with my degree in athletic training in May of 2009. At that time I will be searching for a position as an athletic trainer. I am writing you today in order to voice my opinion and opposition to the therapy standards and requirements of the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

I feel that following my education and receiving my certification in athletic training, I will be capable and willing to help fill the shortage in the therapy workforce. Through my education and national certification, I will be seen through the eyes of that State and medical professionals that I am qualified and capable to perform necessary treatment to my patients with the utmost care and concern. With these proposed regulations I will not be able to perform the skills that I have worked hard to learn and become professional at.

I feel that CMS has a responsibility to its patients to give them the care that they need, and with this shortage of therapy worker, it can be hard at time. By withdrawing the proposed regulations, certified athletic trainers would be able to help these patients that are having trouble getting the services that they need and deserve. I am now asking, respectfully, the withdrawal of the proposed regulations related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jered Mitchem, ATS

CMS-1385-P-12544-Attach-1.DOC

Submitter : **Mr. rawhi abu abdo** **Date: 08/30/2007**

Organization : **usc school of medicine and phr**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Rawhi Abu Abdo_____
Name & Credential
Rawhi Abu Abdo SRNA_____
Address
columbia, sc 29229_____
City, State ZIP

Submitter : **Ms. Phyllis Cable** **Date: 08/30/2007**

Organization : **Ms. Phyllis Cable**

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,

Phyllis Cable

Submitter : Mr. Kevin Lyons **Date:** 08/30/2007

Organization : Lyons Ambulance Service LLC

Category : Other Health Care Provider

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

As a provider of both emergency and non-emergency ambulance transportation the update of thc Geographic Practice Cost Indices will further impair our ability to provide quality services to our CMS customers. The recent GAO cost study indicates that we are currently reimbursed below our costs and the updating of the GPCI with further reduce already substandard reimburesment levels

Submitter : **Dr. Gino Ang** **Date: 08/30/2007**

Organization : **Yale University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1385-P-12548-Attach-1.DOC

#12548

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Sincerely,

Gino Ang, M.D.

Submitter : **Dr. James Gagnon** **Date: 08/30/2007**

Organization : **Dr. James Gagnon**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Submitter : Mr. G Garth Grant **Date:** 08/30/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

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.
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.

Submitter : **Mr. Glenn Downs** **Date: 08/30/2007**

Organization : **Mr. Glenn Downs**

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,

Glenn Downs

Submitter : Jack Brady **Date:** 08/30/2007

Organization : City of North Lauderdale, FL

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P
Proposed revisions to the Payment Policies of Ambulance Services under the Ambulance Fee Schedule.
SEE ATTACHMENT

CMS-1385-P-12552-Attach-1.PDF

#12552

701 Southwest 71st Avenue, North Lauderdale, Florida 33068-2395
954-722-0900 Fax 954-720-2151 www.nlauderdale.org

August 30, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008.

Dear Ms. Norwalk:

The City of North Lauderdale provides emergency ambulance services to our residents. The proposed rule would have a severely negative direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. In addition, we believe this proposed rule will inappropriately provide incentives to seek signatures from patients who are in need of medical care and under mental duress. Additionally, this proposed rule would have a negative impact on wait times in the emergency room impacting our operations and the operations of emergency rooms throughout the country. We therefore urgently submit comments on ills of the proposed rule.

In summary, here are the points we would like you to consider:

- Beneficiaries under duress should not be required to sign anything;
- Exceptions where beneficiary is unable to sign already exist and should not be made more stringent for EMS;
- Authorization process is no longer relevant (no more paper claims, assignment now mandatory, HIPAA authorizes disclosures);
- Signature authorizations requirement should be waived for emergency encounters.

We understand that the proposed rule was inspired by the intention to relieve the administrative burden for EMS providers. However, the "relief" being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and the hospitals and would result in shifting the payment burden to the patient if they fail to comply with the signature requirements at the time of incident. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for emergency ambulance services.

Thank you for your consideration of these comments.

Sincerely,

Mayor Jack Brady
City of North Lauderdale

Cc: Richard D. Sala, City Manager
Sam Goren, City Attorney
Lou Cavallo, Public Safety Director
Kevin Bowen, Fire Chief

#12557

Dear Sir or Madam:

Hello, my name is Carrie McCloskey. I am an athletic trainer that works at Kentucky State University for the University of Kentucky Sports Medicine department. I have been a certified athletic trainer for thirteen years. I have a bachelors' and masters degree. I have worked in the college and clinical setting along side many other medical professionals.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Carrie McCloskey, MA, ATC

Submitter : **Dr. Phillip Gribble** **Date: 08/30/2007**

Organization : **University of Toledo**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an Assistant Professor in Athletic Training at the University of Toledo. I am also a Certified Athletic Trainer. I am the director of a graduate program in Athletic Training in which students pursuing a master's degree may work as a graduate assistant Athletic Trainer in settings including Division I college sports and with local high schools. In both settings, these 12 students enrolled annually provide Athletic Training services as certified Athletic Trainers licensed in the state of Ohio, including rehabilitation of injuries and pathologies in this group of physically active individuals.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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Sincerely,

Phillip Gribble, PhD, ATC

Submitter : **Dr. Daniel Landry** **Date: 08/30/2007**

Organization : **Spectrum Medical group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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.

Daniel P. Landry, M.D.

Submitter : **Dr. derek mitzel** **Date: 08/30/2007**

Organization : **arizona anesthesia consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. Nathan Tellers** **Date: 08/30/2007**

Organization : **Ridgeview Medical Center**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Nathan Tellers, I am an athletic trainer in a small community about 1 hour southwest of Minneapolis, MN. I have been working as an athletic trainer performing rehabilitative medicine with and under the direct supervision of physical therapist for the past four years. I graduated from one of the premier athletic training progams in the country, Minnesota State University, Mankato and completed a three part certification process in order to become a certified athletic trainer registered in the state of Minnesota.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare part A or B rehab facility.

Sincerely,

Nathan M. Tellers ATC,CSCS

Submitter : **Ms. Shelley Downs** **Date: 08/30/2007**

Organization : **Ms. Shelley Downs**

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,

Shelley Downs

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a duly certified (nationally and State) athletic trainer working in an academic setting. I work under the direction of licensed physicians as I provide athletic training health care to my patients. I've had excellent outcomes over the past 29 years in practice.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Keith Webster MA, ATC

Submitter : **Ms. Sonya Easley** **Date: 08/30/2007**

Organization : **Ms. Sonya Easley**

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,

Sonya Easley

Submitter : **Mr. Troy Hershman** **Date: 08/30/2007**

Organization : **Ball State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Troy Hershman and I am an assistant athletic trainer at Ball State University in Muncie, IN. I have been a Certified Athletic Trainer for 15 years and licensed to practice Athletic Training in Indiana for the past ten years. Prior to working at Ball State I spent four years as a ATC/clinical assistant in an orthopedic clinic working side by side physicians to provide care to the public.
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,
Troy C. Hershman, MS, LAT, ATC

Submitter : Wanda Wilson **Date:** 08/30/2007

Organization : American Assoc. of Nurse Anesthetists

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1385-P-12562-Attach-1.PDF

#12562

August 31, 2007

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Bldg
200 Independence Ave., SW
Washington, DC 20201

ATTN: CMS-1385-P

Re: Comments on Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008 and Other Part B Policies for 2008 (72 Fed. Reg. 38122, July 12, 2007).

I. BACKGROUND & IMPACT
II. TRHCA-SECTION 101(b): PQRI

Dear Sir/Madam:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the proposed rule for the Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008 and Other Part B Policies for 2008. *(72 Fed. Reg. 38122, July 12, 2007)* The AANA is submitting comments for the Background, Impact and TRHCA-Section 101(b): PQRI sections. We would particularly like to extend our appreciation to you for your proposal to correct the value of anesthesia services which have long slipped behind inflationary adjustments and to request that CMS finalize this proposal. Also, we would like to comment on the Physician Quality Reporting Initiative (PQRI), the AANA's involvement in development of PQRI measures, and the process by which measures are endorsed or adopted.

The AANA is the professional association for more than 36,000 Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice nurses who administer about 27 million anesthetics given to patients each year in the United States, according to the 2005 AANA

American Association of Nurse Anesthetists Office of Federal Government Affairs
412 First St., SE, Suite 12, Washington DC 20003 // 202-484-8400 // fax 202-484-8408 // www.aana.com

Member Survey. Nurse anesthetists have provided anesthesia in the U.S. for over 125 years, and high quality, cost effective CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1986, have billed Medicare directly for 100 percent of the physician fee schedule amount for their services.

CRNA services include administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide assessment and evaluation for acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and are the sole anesthesia providers in almost two-thirds of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization, and pain management capabilities. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Forces. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management units and the offices of dentists, podiatrists, and all varieties of specialty surgeons.

I. BACKGROUND & IMPACT

A. Request that CMS Finalize Increase in Value of Anesthesia Services

As Medicare Part B anesthesia providers we appreciate your efforts in collaboration with the American Medical Association (AMA) Relative Value Update Committee (RUC) to increase the value of anesthesia services by 32 percent, and to increase the anesthesia conversion factor by up to 25 percent. We request that these increases be finalized in the Final Rule.

In comments we have made previously to CMS, while other specialties have received updates to the value of their services, anesthesia services have been undervalued and have long slipped behind inflationary adjustments. The 2007 physician fee schedule update reduced anesthesia payment by approximately 8 percent even though Congress had acted in December 2006 to reverse the 2007 payment cuts on all physician services attributable to the flawed "sustainable growth rate" (SGR) formula, as part of making increases to other services' relative values budget-neutral within Medicare Part B. Without the increases proposed by CMS in July, CRNAs would provide anesthesia services in 2009 for Medicare reimbursements nearly a third below 1992 levels, with prospects of further Part B payment cuts attributable to the SGR formula of 35 – 40 percent by 2012, to the detriment of the nurse anesthesia profession and our patients. The

proposed increase in the value of our services and the anesthesia conversion factor would help to ensure that Medicare beneficiaries throughout the country continue to have access to quality CRNA-provided anesthesia services.

Additionally, with the Institute of Medicine finding in its 2000 report *To Err is Human* that anesthesia is 50 times safer than 20 years previous,[1] these increases to anesthesia payment recognize CRNAs long-standing initiative in improving quality and patient safety in the field of anesthesia.

B. AMA-RUC Process Should Be Transparent, Represent All Specialties

While we appreciate the work of the AMA-RUC and CMS in appropriately increasing the value of our anesthesia services, each year we find that CRNAs still have no real voice in determining the value of the services we provide and are left in the dark about the process of setting values for these services. We have previously commented to CMS on this transparency and representation issue. Much of the transparency problem for CRNAs in the area of Medicare payment stems from the fact that the vast majority of the payment changes CMS makes are based on recommendations from the AMA-RUC – a committee in which CRNAs are excluded from directly participating. AMA-RUC is charged by CMS with representing all healthcare specialties in making recommendations to CMS on Relative Value Units (RVUs) for new and revised CPT codes. While CRNAs continue to be directly involved in providing some 27 million anesthesia services in the United States annually and can bill Medicare directly for 100 percent of the value of their services, CRNAs are excluded from directly participating in AMA-RUC activities and initiatives based on the fact that CRNAs are not physicians. Changes to codes and their values directly impact CRNA practice and payment. Without fair representation by all specialties that bill Part B directly, CMS' reliance on the AMA-RUC as representing the professional views and knowledge of all healthcare specialties is deeply flawed. The AMA-RUC and CMS are missing out on the long-standing knowledge and experience in anesthesia and in related healthcare services that CRNAs could bring to the AMA-RUC table. For CMS to conclude that CRNA viewpoints are fairly represented by coming under the "umbrella" of representation of the American Society of Anesthesiologists (ASA) or the American Nurses

[1] Kohn L, Corrigan J, Donaldson M, ed. To Err is Human. Institute of Medicine, *National Academy Press*, Washington DC, 2000.

Association (ANA) is inadequate. The AMA-RUC is not representative of all specialties because its system of governance excludes providers such as CRNAs who have an equal stake in the success of the healthcare system.

In its March 2006 Report to Congress and its August 17, 2006, comment letter to CMS, the Medicare Payment Advisory Commission (MedPAC) raised similar concerns about CMS' relatively unchecked reliance on the AMA-RUC. In its comment letter, MedPAC stated, "We recommended that CMS reduce its reliance on physician specialty societies by establishing a standing panel that would provide expertise in addition to that provided by the RUC."

Should CMS decided to establish a standing panel as recommended by MedPAC we request that CRNAs have an opportunity to be active participants and members of this standing panel. In addition, we also request that CMS encourage and persuade the AMA-RUC to provide CRNAs with an opportunity to have meaningful and direct representation on the AMA-RUC and related committees such as the Health Care Professionals Advisory Committee (HCPAC) and on the Practice Expense Review Committee (PERC).

C. Need to Reform Current SGR Formula

We echo the comments we have made previously to CMS and those comments by medical and other professional societies in regards to establishing a better methodology for calculating the SGR. We understand that the intent of the Balanced Budget Act (BBA) in replacing the Medicare Volume Performance Standard (MVPS) calculation with the SGR methodology was to curb Medicare expenditures. We also understand that Section 1848(f)(2) of the Act specifies the formula for establishing yearly SGR targets for physicians' services under Medicare and that it is up to Congress whether to change the SGR formula.

CMS has noted that two of the most volatile factors used to calculate the SGR are the number of fee-for-service enrollments and gross domestic product (GDP). Linking Medicare expenditures to GDP growth burdens both the healthcare community and Medicare patients for any economic slowdown. Further, the SGR as it is calculated does not use the most current figures related to the rising costs of drugs and new technology, the increases in malpractice premiums, and the growth in Medicare utilization over projected amounts. Therefore, the SGR calculated minus 10

percent estimate for the 2008 physician fee schedule update does not accurately account for these actual increases in health care provider costs for quality services.

II. TRHCA-SECTION 101(b): PQRI

A. CRNAs' Continued Contribution to PQRI & Pay for Performance Initiatives

We appreciate Congress' and CMS' efforts to seek the expertise of all professional provider associations in developing quality measures for each specialty. In particular, we appreciate CMS' use of the term "eligible professional" when referring to both physician and non-physician providers as healthcare professionals who can participate in the PQRI program. In our experience, exclusive use of the term "physician" when referring to both physicians and Medicare Part B providers who are not physicians, such as CRNAs, causes confusion among our members, other healthcare providers, healthcare facilities, and billing entities. This confusion can result in a delay in payment for CRNAs services and a bar to CRNAs participating in important CMS initiatives such as the PQRI. With CRNAs providing 27 million anesthetics annually, we want to ensure that CMS receives CRNAs' reporting data, data that is vital to accurately measuring quality and accountability in anesthesia, and that our members are appropriately rewarded for their participation in the PQRI and future quality initiatives. CMS's continued use of the term "eligible professional" will assist in this effort.

To date, our work Pay for Performance initiatives has been multifaceted. In the policy arena, we have worked with members and committees of Congress to review and promote Pay for Performance provisions that place CRNAs and other healthcare providers who are not physicians on an equal footing with one another, and communicated our work and interest in the subject with senior CMS staff. In 2006, we hosted CMS' Dr. Thomas Valuck at a major AANA federal policy conference in Washington, DC, to discuss pay-for-performance systems.

In related clinical and policy development venues, the AANA has played a partnership role with the Centers for Disease Control & Prevention's (CDC's) Surgical Care Improvement Project (SCIP) in the development and vetting of performance measures. AANA continues to play an active role in the National Quality Forum (NQF), as the first major national anesthesia professional organization to serve as a member.

At the suggestion of CMS staff, the AANA has been an active participant in the deliberations and decisions made by the AMA Physician Consortium on Performance Improvement (AMA-PCPI) Perioperative Work Group and more recently with its Anesthesiology Work Group. With the PCPI Perioperative Work Group we contributed to the development of the five 2007 PQRI Perioperative measures listed in Table 16 of this proposed rule related to the administration of an antibiotic prophylaxis.[2] As members of the PCPI Anesthesiology Work Group we have contributed to the development of the AMA/PCPI measures listed in Table 17 which include (1) Stress Ulcer Disease (SUD) Prophylaxis in Ventilated patients, (2) Prevention of Catheter-Related Bloodstream Infections (CRBSI) in Ventilated patients – Catheter Insertion Protocol, and (3) Perioperative Temperature Management for Surgical Procedures Under General Anesthesia.[3]

The AANA has also responded to requests from CMS contractor Quality Insights of Pennsylvania (QIP) to develop and vet quality measures appropriate for healthcare providers who are not physicians to use in ambulatory care settings. Through this year, AANA has provided CRNAs as expert review panelists in the development of measures relating to universal documentation of medications, universal influenza vaccine screening and counseling, universal weight screening, and universal weight screening follow-up. The AANA also provided comments to QIP on its measures, and provided a list of CRNAs for QIP to use in vetting the measures in the clinical setting.

Thus, CRNAs and the nurse anesthesia profession continue to play a leadership role in shaping legislation and in developing performance measures specific to anesthesia services. The 36,000 members of the AANA look forward to continued opportunities to extend to CMS our profession's longstanding commitment to improving anesthesia patient safety.

B. Consensus Organizations Developing PQRI Measures Should Represent All Specialties

We appreciate CMS' detailing of the requirements for a body to be considered by CMS as "voluntary consensus standards body" as under the National Technology Transfer and

[2] 72 Fed.Reg. 38122, July 12, 2007. p. 38200.
[3] id. p. 38201.

Advancement Act of 1995 (Pub. L. 104-113) (NTTA) and as implemented by the OMB Circular No. A-119 (OMB A-119). Such transparency is helpful in understanding the PQRI measurement development process and the role CRNAs can play in this process.

We are encouraged to see the inclusionary nature of these consensus organization requirements and CMS' emphasis on voting participation by a breadth of stakeholders.
We understand that under OMB A-119, a voluntary consensus standards body must maintain the following attributes: "(1) Openness; (2) Balance of Interest; (3) Due Process, (4) An appeals process; (5) Consensus; which is defined as general agreement, but not necessarily unanimity, and also includes a process for attempting to resolve objections by interested parties."[4] CMS further qualifies the requirements for an organization to be considered a consensus organization by stating in this proposed rule, "...we believe Congress intended that consensus organizations should, in the context of section 1848(k)(2)(B) of the Act, have a breadth of stakeholder involvement and voting participation substantially comparable to that of the NQF or AQA."[5] Additionally, the proposed rule states that at the measure development level though organizations may utilize "consensus as a mechanism of achieved agreement among the developer's participants or within the developer's organizational structure" this does not constitute meeting voluntary consensus standards" and that the measures therefore must also be approved by organization like the NQF and AQA which meet the NTTA requirements.[6]

Our participation on the multi-specialty AMA-PCPI Perioperative and Anesthesiology Work Groups has been a rewarding and positive experience and one we would like to continue. The work groups generally use consensus from work group members to achieve agreement on measures. However, once the work group finalizes its analysis on a measure the work group then sends those measures to the full AMA-PCPI for approval. The AMA-PCPI then votes on whether the measures should be accepted as written or by consensus. The accepted measures are then sent to NQF when NQF issues a call for the measures. The AMA as a physician focused organization, allows only physicians to sit on the PCPI and to vote on these measures, whereas, practitioners who are not physicians, such as CRNAs, who may be members of the work group, do not have a vote on the AMA-PCPI. Because the AMA-PCPI does not allow full voting

[4] id. p. 38197.
[5] id. p. 38198.
[6] id.

participation from the "breadth of stakeholders" we would caution CMS to consider the AMA-PCPI as a voluntary consensus standards body as under NTTA. The fact that there is not full voting participation means there is a break in the chain of CRNAs' ability to contribute our expertise in evaluating and assessing quality measures.

We recognize and appreciate the efforts of CMS, the AMA-PCPI, its work group leaders and members, and AMA staff in meeting aggressive statutory deadlines to have the PQRI up and running. As the PQRI continues to develop we encourage CMS to address the broader question at issue -- how can all Medicare Part B providers participate fully in each link of the measure development process. In our meetings with CMS staff, CMS staff has mentioned that CMS might develop a measure development process outside of the AMA to address inequities in participation by healthcare practitioners who are not physicians. We would welcome CMS' comments on the status of this proposed process and are prepared to assist and share our insights with CMS on this topic.

We thank you for the opportunity to comment on the proposed rule. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400.

Sincerely,

Wanda Wilson, CRNA, PhD, MSN
AANA President

cc: Jeffery M. Beutler, CRNA, MS, AANA Executive Director
Frank Purcell, AANA Senior Director of Federal Government Affairs
Pamela Kirby, JD - AANA Associate Director, Federal Regulatory & Payment Policy

Submitter : **Mrs. Terrie Kerr** **Date: 08/30/2007**

Organization : **Mrs. Terrie Kerr**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Daneshvari Solanki** **Date: 08/30/2007**

Organization : **Academic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Mary Rock **Date: 08/30/2007**

Organization : University of Nevada, Las Vegas

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer working at the University of Nevada, Las Vegas. I have received my master's degree in advanced athletic training, as well as, national certification from the NATA Board of Certification and licensure from the state of Nevada. I have been working as a certified athletic trainer for the past 10 years. I work with injured athletes on a daily basis and am personally responsible for his and her treatment protocols including rehabilitative services.

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,

Mary Rock, M.S, ATC, LAT
Assistant Athletic Trainer
University of Nevada, Las Vegas

Submitter : Mr. Gregory Sills **Date:** 08/30/2007

Organization : RCC

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,
I am currently a liscened PTA in Charleston and am writing to oppose the cut in the Medicare Fee Schedule. Medicare patients will continue to make up a huge part of physical therapy and are some of the most beneficial recepients of our services. To cut the re-imbursement will only hurt the future healthcare of Medicare paitents as facilities may deem them as a loss because of re-imbursement. Would you like a family memeber of yours to not have PT because they have Medicare, even though they would require it?

Submitter : **Ms. Kathryn Kropski** **Date: 08/30/2007**

Organization : **Barrington Orhopedic Specialists**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Kathryn Kropski, and I am an athletic trainer. I have been certified and licensed for 5 years. Before I could sit for the national certification exam and then to apply for licensure by the state of Illinois, I first had to obtain a bachleor's of science degree. Because of the degree I earned, I currently work for a physician owned practice in there rehabilitation department. I work with patients of all ages to rehabilitate their orthopedic injuries.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kathryn A. Kropski, MS, ATC

Submitter : **Mr. Marcel Lak** **Date: 08/30/2007**

Organization : **Axis Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 30th, 2008

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule
Physician Self-Referral Issues

Dear Mr. Weems,

We are writing this letter since we are quite concerned about the July 12, 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception. We are physical therapists who have been in independent private practice for 10 years on the Monterey Peninsula and have been licensed physical therapists for respectively 18 and 20 years. On the Monterey Peninsula we have build a strong following through the deliverance of quality physical therapy. Both physicians and patients are quite familiar with the type of care that we provide which in turn has provided us with a steady flow of satisfied patients. Over the years we have seen a steady increase in private practices in our area which all have been started by local physical therapists. This has created a healthy competitive element in our community and only has resulted in improved care through a greater drive for continuing education and level of care.

However, recently we were invited by a local group of orthopedists who corner a large percentage of the market for orthopedic care in our area. They were in the process of interviewing local physical therapists to become part of their new orthopedic office which would provide physical therapy services. Their idea was for us to give up our practice and become an employee of the new orthopedic office. They would take over the billing and they informed us that they could bill Medicare since there was a loop-hole that made this possible for them. Should we decide against this proposal, the implication was that we would not see any patients from them in the future since they would all be (self)- referred to the new entity. They basically just needed us since we had a physical therapy license and a Medicare provider number. We had expected a conversation that would discuss improved patient care, stream-lining the referral process and quality of care issues but we stood corrected. We returned from this meeting with the strong feeling that this was all about increasing their income and not about improving patient care. This group already has branched out and owns, as well self refers to, a MRI facility. We strongly feel that referring their patients to their own physical therapy practice is a highly unethical practice that will only affect patient care in a negative way. This should result in higher cost for Medicare and less overall results in treatment outcomes. We strongly urge you to do something about these unethical practices and close the loophole that exists today.

We appreciate your time in this matter.

Sincerely,

Mario Teering, PT and Marcel Lak, PT

Submitter : Mr. William Hammond **Date:** 08/30/2007

Organization : Mr. William Hammond

Category : Attorney/Law Firm

Issue Areas/Comments

IDTF Issues

IDTF Issues

IDTF ISSUES

Set forth below are our comments/questions with respect to certain provisions contained in the Medicare Physician Fee Schedule CY 2008 Proposed Rule published in the Federal Register on July 12, 2007 (72 Fed. Reg. #133, pp. 38122-38395). We appreciate the opportunity to provide comments and questions on behalf of an independent diagnostic testing facility (IDTF) client, and CMS consideration of same.

1. Insurance Requirements. Please explain the need for IDTFs to include the applicable CMS Medicare contractor as a policyholder on its liability insurance policy. This may result in additional insurance costs for IDTFs. Does CMS have a similar requirement for other Medicare providers and suppliers? What makes IDTFs unique such that they should be subjected to this additional burden?

Additionally, please clarify the meaning of an insurance policy carried by a non-relative owned company. In particular, how, if at all, is this intended to impact investments in large, publicly-traded insurers whose stock is traded on a national stock exchange?

2. Prohibition Against Shared Space. In 42 CFR 410.33(g)(15), CMS proposes to prohibit the IDTF from subleasing its operations to another person. Please clarify what is meant by operations. For example, may an IDTF lease one of its technologists on a part-time basis to another person, such as another IDTF, a hospital or a physician practice which owns equipment and performs diagnostic tests?

In addition, CMS has requested comments with respect to the applicability to mobile IDTFs of regulations prohibiting the sharing of space, equipment and staff with another person and the sublease of an IDTF s operations to another person. Please clarify that this is intended only to prohibit an IDTF from leasing its space, equipment and/or staff to another person, such as a physician or physician practice, for use by that person. Please also clarify that it is not intended to prohibit an IDTF from leasing space, equipment and staff from another person. Mobile IDTFs and IDTFs with portable equipment make services convenient and accessible for patients and their physicians by bringing services directly to the patient, often by providing services at the practice location of the patient s treating physician. This benefits elderly Medicare and indigent Medicaid patients in particular who are less mobile and/or frequently must rely on relatives, friends or public transportation to take them to and from medical appointments. Prohibiting a mobile IDTF, or an IDTF with portable equipment, from leasing space, equipment and personnel located at a physician s practice will effectively eliminate this convenience since these IDTFs typically use the practice s exam room(s) or other facilities, and share reception areas, equipment such as telephones, faxes and copiers, and staff such as reception personnel. It would be impossible for these IDTFs to continue to provide services at such locations if they were prohibited from leasing/sharing any space, equipment and/or staff.

We note that CMS indicates in the proposed rule that the prohibition against sharing space, equipment and staff is designed to help CMS ensure that each IDTF establishes and maintains Medicare billing privileges and meets all required performance standards. 72 Fed Reg. #133, p. 38171. Where an IDTF with portable equipment or operating on a mobile basis leases/shares space, equipment and/or staff from/with a host location, this concern should be alleviated in circumstances where the IDTF is enrolled in Medicare with Medicare billing privileges and bills for the services rendered at the host location. Accordingly, at least under those circumstances, the prohibition against sharing/leasing space, equipment and staff should not apply.

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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1. Anti-markup Provision. Please clarify that the anti-markup provision with respect to the professional component of diagnostic laboratory tests does not apply to an IDTF that purchases the professional component from the interpreting physician, particularly in states where the corporate practice of medicine prohibit the IDTF from hiring the physician as an employee.

Again, we thank you for your consideration of our comments/questions.

Submitter : **Mr. Richard Mello** **Date: 08/30/2007**

Organization : **Blue Ridge Healthcare**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

POPS clinics pose a problem for the community for two main reasons. one is patients should always have a choice of where they would like to go for services. Also many physicians, who own there own therapy clinics, give patients false information about local clinicians and facilities to assist the patient into choosing the physician's facility.

Submitter : **Dr. William Jones** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

William P. Jones M.D.

Submitter : **Dr. Asle Aarsland** **Date: 08/30/2007**

Organization : **Univ. of Texas Medical Branch, Galveston**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.
Asle Aarsland MD

Submitter : **Dr. Rhonda Cross Beemer** **Date: 08/30/2007**

Organization : **Simpson College**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

First of all, I would like to thank you for taking the time to read my letter. Currently I am a certified athletic trainer with my PhD working at a College in Iowa. I am the athletic trainer for 6 sports at this college, where I am well qualified to perform physical medicine and rehabilitation services. Imagine your child being in a game and suffering a compound fracture of the tib/fib complex. The time leading up to the EMS getting there is very critical in the return of that child to physical activity. If he/she is treated in an incorrect manner, then he/she may never have the same quality of life. The certified athletic trainer is educated in taking care of these acute injuries, then after the injury we are educationally qualified to take care of that athlete in a rehabilitative setting as well as recondition the athlete after rehab to prevent injuries. We are the only health care provider that is trained in doing so. How would that make you feel to have someone every step of the way treating your child? Now, imagine how it would make you feel not to have that person there at all. Athletics are not the only patients that certified athletic trainers have. We work with all physically active individuals, aiding them in the prevention of injury, care and rehabilitation of the injuries, and reconditioning of those injuries.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

Rhonda S. C. Beemer, PhD, ATC, LAT

Submitter : **Dr. Gregory Eskew** **Date: 08/30/2007**

Organization : **Dr. Gregory Eskew**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter

Sincerely,

Gregory S. Eskew, MD

Submitter : **Dr. Richard Iannacone** **Date: 08/30/2007**

Organization : **Dr. Richard Iannacone**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Richard Iannacone, DO

Submitter : **Mr. David Kainrad** **Date: 08/30/2007**

Organization : **Lee County Emergency Medical Service**

Category : **Local Government**

Issue Areas/Comments

Ambulance Services

Ambulance Services

Medicare has recently proposed additional patient signature requirements prior to submission of claims for payment that will add significant burden to Lee County Emergency Medical field and administrative staff.

Currently, if a Medicare patient is physically or mentally incapable of signing and no family member or friend is available to sign, Lee County EMS Paramedics or EMT s document on an ambulance run report the patient s inability to sign and the reason for it. Also, EMS medics obtain a hospital staff signature on the ambulance run report when a patient is left a medical facility. The proposed Medicare revision would require Lee County EMS field staff to obtain and maintain for four years, the signature of a hospital staff member or other facility documenting the patient s name, date and time of transport and name and location of receiving facility. By having an additional form to be completed by EMS staff and signed by staff from a medical facility, places an unnecessary and undue burden on Lee County EMS.

Lee County EMS feels strongly, as does the American Ambulance Association that this requirement is without merit since all proposed information is already available on Lee County EMS ambulance run reports, emergency dispatch communication records as well as hospital records for any auditing purposes. Therefore, Lee County Emergency Medical Service respectfully requests CMS to reconsider the need for having an extra form to track Medicare clients arrival by ambulance to a medical facility.
Respectfully Submitted

David Kainrad
Manager

Lee County EMS Administrative & Finance

Submitter : **Mrs. Diane Olimpio** **Date: 08/30/2007**

Organization : **Concord Hospital**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

CMS is proposing to amend the regulations to change the plan of treatment re-certification schedule. Currently, the referring physician must certify the initial plan of care and re-certify every 30 days thereafter.

CMS proposes to change the re-certification period to 90 days.

I strongly support the proposal to extend the 30 day re-certification requirement to 90 days.

The 30 day re-certification is overly burdensome for physicians and physical therapists and is not an effective means of controlling utilization of therapy services.

CMS has other adequate requirements in place (referral, certification of the initial plan of care, specific medical necessity requirements, extensive documentation requirements, Local Coverage Determinations, Therapy Caps, CCI edits, etc.) and does not need the 30 day re-certification process in order to manage appropriateness of therapy care and utilization.

Submitter : **Dr. Haleh Saadat** **Date: 08/30/2007**

Organization : **Yale**

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.

Haleh Saadat, MD

Submitter : **Date: 08/30/2007**

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)

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Ronald E. Stevens, M.D.

Submitter : **Mrs. Bobbie Kerr** **Date: 08/30/2007**

Organization : **Mrs. Bobbie Kerr**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Ms. Jacquie Flesher** **Date: 08/30/2007**

Organization : **Ms. Jacquie Flesher**

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,

Jacquie Flesher

Submitter : **Robert Kerr** **Date: 08/30/2007**

Organization : **Robert Kerr**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **W Richard Dunseth** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

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.

? 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,
W Richard Dunseth, CRNA

Name & Credential
2374 Mound Rd
Address
Jacksonville, IL 62650
City, State ZIP

Submitter : **Mr. Robert Sheppard** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

August 30, 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
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Sincerely,
Robert M. Sheppard, BA, CRNA
2320 Forest Ave
Great Bend, KS 67530

Submitter : **Mr. Larry Flesher** **Date: 08/30/2007**

Organization : **Mr. Larry Flesher**

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.

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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,

Larry Flesher

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist practicing for approx. 8 years. I recommend closing the loophole in the Stark physician self-referral law in order to protect physical therapy services as Congress originally intended. One of my concerns with physician self-referrals is that physical therapy services should be limited only to those who have had formal training in an accredited physical therapy institution. Physicians should not have the right to supervise or oversee services provided by physical therapists. Physicians do not have adequate training in physical therapy and as such should not have a part in its services. Continuation of this pattern will only demote the professional of Physical Therapy, damage the autonomy of the physical therapy profession and reduce physical therapists to mere technicians. Physicians need to focus only on their specific training and leave physical therapy and it's services to Physical Therapists. How many other areas will physicians attempt to get their hands into? Personal training services? Obesity management with physical training? Chiropractic services? Orthotics and prosthetics? My point is that there are many areas physicians can claim a role in as a related services. The truth is that they are insufficiently trained in these areas and should not be allowed to participate in its services or reap any financial benefits. Physical therapy and all that is associated with it needs to be limited to those who have had adequate training through an accredited physical therapy institution. Thank you for attending to this matter and I urge you to act in such a way as to maintain the integrity of the physical therapy profession and not to allow it to become just another "source of revenue" for physicians.

Submitter : **Mr. Donald Heimbach** **Date: 08/30/2007**

Organization : **Mr. Donald Heimbach**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Samuel Chen** **Date: 08/30/2007**

Organization : **Case Western Reserve University School of Medicine**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Robert Huggins** **Date: 08/30/2007**

Organization : **University of Virginia**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Robert Huggins and I am an Athletic Trainer at the University of Virginia. I am a graduate student at the university and I work as a graduate assistant for the field hockey team. I received my bachelors of science from the University of Connecticut in Athletic Training and I am a Certified Athletic Trainer. Currently I am licensed in the state of Virginia.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for 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 Huggins, BS ATC

Submitter : **Mr. Gerald Stevens** **Date: 08/30/2007**

Organization : **FirstChoice Physical Therapy and Sports Rehab**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

August 30, 2007
Dear Sir or Madam:
My name is Gerald Stevens. I am president and owner of a physical therapy and sports rehabilitation company in Jacksonville, FL.

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 would create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans; especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
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Sincerely,
Gerald A. Stevens, ATC, LAT, President
FirstChoice Physical Therapy and Sports Rehabilitation, Inc.

Submitter : Mr. Christopher Queram **Date:** 08/30/2007

Organization : Wisconsin Collaborative for Healthcare Quality

Category : Other Health Care Professional

Issue Areas/Comments

TRHCS--Section 101(b): PQRI

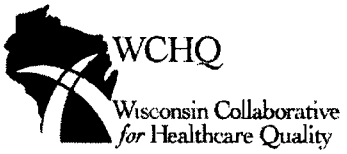
TRHCS--Section 101(b): PQRI

Please see the attached Word files containing comments on TRCHA--Section 101(b): PQRI

CMS-1385-P-12592-Attach-1.DOC

CMS-1385-P-12592-Attach-2.DOC

#125 92



Thursday, September 13, 2007

Herb Kuhn
Acting Administrator
Center for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

RE: "TRHCA - - Section 101(b): PQRI"

Dear Mr. Kuhn,

As one of the six (6) regional quality coalitions serving as pilot sites for the "Better Quality Information for Medicare Beneficiaries" (BQI) program sponsored by the Center for Medicare and Medicaid Services (CMS), the Wisconsin Collaborative for Healthcare Quality (WCHQ) is a stalwart supporter of the Department's various initiatives designed to improve the quality and cost-effectiveness of healthcare services for all Americans. A key component of this multi-pronged effort is the "Physician Quality Reporting Initiative" (PQRI) which was officially implemented in July of this year. While WCHQ is broadly supportive of the goals of the PQRI, we believe there are numerous opportunities to enhance the design of the program and ensure a greater alignment with other CMS initiatives, notably the BQI. In that spirit, we offer the following comments on the "Proposed Revisions to Payment Policies under the Physician Fee Schedule, and other Part B Payment Policies for CY 2008" as published in the Federal Register on July 12.

1. Strengthen the link between the BQI and PQRI by functionally integrating the two initiatives. As noted above, WCHQ is serving as one of six (6) pilot sites for the BQI initiative. This program - - initially conceived by the AQA in late 2005 and officially launched by CMS in January of 2007 - - is designed to test methods of increasing the availability of comparative performance information on servicesphysicians for the benefit of Medicare beneficiaries. Despite the fact that the BQI is striving toward exactly the same goals as the PQRI, there appears to be little operational coordination between the two initiatives. While this is understandable when considering that the genesis of the two programs is different, the perpetuation of programmatic "silos" represents a lost opportunity for strategic and operational synergies that would enhance both programs. To correct this, there are two concrete actions we would recommend to achieve this goal:
   a. Ensure complete alignment between the performance measures reported under each initiative.

P.O. Box 258100 • Madison, WI 53725-8100 • Phone: (608) 250-1223 Fax: (608) 294-3903 • www.wchq.org

b. Allow medical groups and practitioners that report performance information through the BQI pilot sites to receive their full or substantial "pay for reporting" incentive under the PQRI through participation in the BQI.

2. Allow the WCHQ to serve as a demonstration site for a data submission model under "Option 3" in 2008. In today's environment, healthcare organizations are presented with requests or demands to participate in a number of measurement and reporting initiatives, each of which represent legitimate and important opportunities to improve the quality and cost-effectiveness of healthcare services. While virtually all are well intentioned, these initiatives are frequently uncoordinated and thus introduce complexity and competition for the proportion of organizational resources that can be devoted to measurement, reporting, and improvement. We view the PQRI as an important opportunity for organizations to assess the quality of care on an individual physician level of their Medicare beneficiaries. The WCHQ proposes to demonstrate that the methods we have developed for our membership can offer a streamlined approach that integrates the work that our member medical groups are doing for WCHQ with the efforts for PQRI, thus giving greater recognition and value to both measurement and reporting initiatives.

   In order to demonstrate how this would work, the following paragraphs describe our measurement model in more detail.

   The WCHQ's current method of reporting involves submission of a numerator and denominator for each corresponding measure to the data tool found on our website. Members use their own programmers internally to write the code to apply the measurement specification, collect the data and prepare for data submission. The data is made available for preview for one week prior to being posted live at www.wchq.org in order to allow member organizations to check their work and confirm that all of the data is accurate before it is made public. Of the options listed in the proposed rule, Option 3 most closely matches the process currently in use by WCHQ members.

   Our vision is that members of WCHQ will submit their data, stratified by payer to allow for identification of the Medicare population. Once this population has been isolated, numerators and denominators will be factored through the data tool for individual physicians and then submitted to CMS via a web upload. The data would be identifiable to individual physicians according to their National Provider Identifier (NPI). No beneficiary level information would be made available publicly so as to avoid compromising HIPAA laws.

   Our member organizations would submit data based on WCHQ's distinctive, "all patient, all payer" measurement methodology. Our measures have been designed using HEDIS as a template and applying a three-question algorithm that is integral to determining which patients actually belong to the medical group and in the measurement denominator. This method has numerous advantages, with one of the

most important being the fact that the emphasis on construction of an accurate denominator results in the generation of a ready-made patient registry for the condition being measured. The accuracy and utility of the patient lists that are downloaded from these measurement specifications have created a significant degree of support and engagement from both clinical leaders and practitioners. We believe that piloting this methodology in the PQRI will give CMS a representative view of the performance of any given physician submitted under WCHQ's process while providing CMS with a richer data set (both administrative and clinical data) on the measures we currently report.

The benefits of this approach are significant. First, physicians will be more supportive of this data than of other measures that might be reported, especially at the individual physician level. Second, the process of complying with PQRI would be less cumbersome as the organizations will fulfill the obligations for preparing data to be submitted for WCHQ.

These are a number of important questions yet to be resolved in the design and implementation of this model. These include HIPAA regulations on storage of confidential patient information, understanding of the CPT-II modifier codes and how they will be implemented into our current measurement process, and development of a data tool to be used for a web upload. Overall, however, this process is one that will allow the members of WCHQ - - representing approximately 50% of the state's primary care physicians - - to submit data for PQRI giving the Centers for Medicare and Medicaid Services a broader picture of the care that is being given to their beneficiaries.

3. Include WCHQ's performance measures, and the detailed specifications, on the list of approved measures for 2008. The WCHQ fully supports the need for the adoption and use of a consistent set of performance measures as a critical component of a national quality strategy. At the same time, it is important to recognize that the United States has relatively little experience with the development and deployment of measures that accurately portray the performance of medical groups in managing a population ("all patient, all payer") of patients. The WCHQ stands alone in achieving a level of sophistication in ambulatory performance measurement that has generated a high degree of physician engagement. The WCHQ uses performance measures - - listed in the attachment - - that are either AQA or NQF endorsed and has developed, tested, deployed, and gained acceptance of detailed measure specification that marry administrative and clinical data at a population level. While these measure specifications vary from those developed by the AQA and NQF, WCHQ formulated the numerator according to current HEDIS specifications. Our algorithm for calculating the denominator has been endorsed by our physician leadership and members as a significant enhancement to HEDIS due to the fact that our model generates highly accurate, population-based measure results. Our confidence in the reliability and accuracy of our specifications has led us to initiate discussions with NCQA regarding the potential relationship to their "Physician HEDIS" measures; we plan similar discussions with NQF regarding our denominator algorithm. The

WCHQ would like the opportunity to demonstrate the potential for our community level measures to serve as a model for broader adoption in the United States. In view of these considerations, we believe that our proposal to use these measures in conjunction with the PQRI in 2008 will present CMS with a valuable demonstration of the utility of this measurement methodology and specifications, and is consistent with the latitude CMS has for "selecting measures for PQRI based on a lesser degree of consensus where necessary to meet CMS' programs needs . . .".

We appreciate the opportunity to comment on the proposed rules and look forward to joining with CMS to demonstrate our commitment to furthering the goals of PQRI in 2008.

Sincerely,

President/CEO

CQ/trc

Submitter : Dr. Ralph Armstrong, DO **Date:** 08/30/2007

Organization : San Benito County Medical Society

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

See Attachment

CMS-1385-P-12593-Attach-1.PDF

#12593

San Benito County Medical Society

911 Sunset Drive
Hollister, CA 95023

August 30, 2007

Dear Ms. Norwalk,

I am writing to you as the President of the San Benito County Medical Society concerning the proposed CMS Rule for the 2008 Physician Fee Schedule. Specifically, it is aimed at changing the locality designations in California to better reflect the costs of running a medical practice. The physicians in San Benito County which number around 105 with approximately 50 physicians residing in the county would like to see Option 3, the county-based geographic adjustment factor, accepted. If properly calculated, San Benito County would be taken out of locality 99 and placed into a designation similar to our neighboring counties, Monterey and Santa Cruz.

Changing our locality designation to match our surrounding counties would ease the disparity we already have with Santa Clara County, which borders us to the north. For example, Gilroy which is 15 miles away from Hollister has a 20% higher reimbursement rate. The cost of running a practice in Gilroy is not that much higher than Hollister.

The problem we have for this difference is it is difficult to recruit and maintain physicians who want to live in this area of California. We have been unable to recruit a much needed Pulmonologist for this exact reason. If we could level the playing field, if you will, physicians could come to San Benito county more comfortably and its citizens could be better served by not having to leave the county for specialized care. Also, even more concerning, if Medicare reimbursements go down instead of remaining steady or increasing, more and more San Benito County physicians may stop taking Medicare which would further limit patient's access to healthcare in this county.

It has been brought to our attention that CMS miscalculated the designation of the new payment localities according to the June 2007 Government Accountability Office (GAO) report, *MEDICARE - Geographic Areas Used to Adjust Physician Payments for Variation in Practice Costs Should Be Revised*. According to this GAO report, San Benito County should be included in the locality change.

The legislation discussed above is already in place as prepared by Representative Sam Farr in Section 308 of HR 3162. This bill supports Option 3 discussed above but leaves a provision to allow correction based on the June 2007 GAO report which would effectively include San Benito County in the same locality as Santa Cruz and Monterey counties. This section also includes a "hold harmless" provision that would prevent locality 99 counties seeing decreases in reimbursement rates for the upcoming year.

Please accept Option 3, correctly calculated, so we, as a medical community, may provide better access to care for our patients.

Sincerely,

Ralph Armstrong, DO
President, San Benito County Medical Society
Obstetrics & Gynecology
931 Sunset Dr.
Hollister, CA 95023
(831) 635-0604 ofc
ralpharmstrong@mac.com

Submitter : **Miss. Alecia Puls** **Date: 08/30/2007**

Organization : **Mercy Hospital/Washington High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:
My name is Alecia Puls and I work in Cedar Rapids, IA and am the head Certified Athletic Trainer at Cedar Rapids Washington High School. My educational background includes at BA from the University of Northern Iowa in Cedar Falls, IA and a MS degree from the University of Toledo in Toledo, OH.
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,
Alecia S. Puls MS, ATC

Submitter : **Mr. Dan Weaver** **Date: 08/30/2007**

Organization : **Northern Star Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Weems,

I am a physical therapist practicing in Saint Cloud, MN. I am a partner in a physical therapist owned practice that sees 3000-4000 new patient evaluations each year. We employ approximately 28 individuals. Our patient population is primarily out patient orthopedic. Our business has been operating for the past 14 years. The original 4 partners established our practice out of frustration of practicing in a physician owned physical therapy practice. I am writing to you to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception.

Physician owned practices (POPTs) have an inherent financial incentive to refer patients into their practice. They use the guise that they want direct supervision or they have the best physical therapists. This is a common practice for one of the major (POPTs) in Saint Cloud. I have had numerous patients report to me that they were brow-beaten when they requested to receive physical therapy at our practice after a consult or surgical procedure at an orthopedic clinic in town. Only the very assertive patients have stood their ground and demanded to receive PT at our clinic. On one occasion, the decision to receive therapy at our clinic created a poor relationship between the patient and the doctor.

Physician direct supervision is not needed to administer PT services. Physical therapists contact physicians if and when needed to provide the best and most efficient quality of care. Therefore, physical therapy services provided away for the physician s office are equally as proficient as those provided in the POPT.

The in-office ancillary services exception is defined so broadly in the regulations that it facilitates the creation of abusive referral arrangements. For example, our practice used to receive 50-100 referrals per year from a physician in town until approximately 1.5 years ago. The physician hired his own physical therapist approximately 1.5 years past and now we receive less than 10 referrals per year from his practice.

As a physical therapist, business owner and a taxpayer, I strongly urge the CMS to remove physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws. The current law has the potential for fraud and abuse due to the inherent financial incentive for physicians to refer patients into their own physical therapy clinics. Also, the current law allows for an environment that negatively impacts a patient s choice due to the pressures incurred when they are instructed to receive physical therapy in a POPT.

Thank you for the consideration of my comments. Please contact me with any questions.

Sincerely,

Dan Weaver, PT
Northern Star Therapy
Saint Cloud, MN
320-240-6955

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Local orthopedic surgeons have created their own physical/occupational therapy services. This has created a huge upswing of therapy referrals to themselves versus the period of time when therapy had to be sent to private or hospital based therapy programs. The care is substandard but because the physician sells the patient on "being there" while they have therapy many patients, especially Medicare aged patients do not want to go against their physician's wishes.
It's a very unjust process where the referral source that has a financial interest in where the patients are sent has all the power. Yes, patients have a choice but like stated above many will not go against their physician's directions.
I hope that you can level the playing field again and limit the referral options of a physician similar to the original Stark Law of years past.
Thanks for your consideration of this request
Eldon Jones
Canton, OH

Submitter : **Dr. Robert Petras, et al** **Date: 08/30/2007**

Organization : **AmeriPath**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Mr. Kuhn:

We appreciate the opportunity to comment on the proposed rule CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. We are group of gastrointestinal pathologists employed by AmeriPath. AmeriPath and its parent company, Quest Diagnostics, is the single largest provider of anatomic pathology services in the nation. This letter provides comments on the physician self-referral provisions contained in the CMS-1385-P.

The Stark Law prohibits physician self-referral and it is our opinion that the Stark Law is currently not adequately enforced. The current proliferation of surgical pathology laboratories within gastroenterologists and other clinicians (e.g., urologists) offices abuses the in office ancillary services exception to the Stark law and must be stopped. This proliferation of high complexity laboratories adds tremendous cost to the system in terms of unneeded duplication of equipment and services. The only goal for this is increased revenue to the gastroenterologists and other clinician practioners (e.g., urologists). Moreover, quality in these in office laboratories decreases because they largely operate outside the usual laboratory inspection system, frequently have unqualified laboratory directors or directors in abstentia, and often have inadequate supervision especially supervision of gross dissection and description. We have noted in our referral practice poor quality of histological slide preparation and tissue specimen mix-ups. Pathologists have been forced to use less than optimal staining techniques only to reduce cost and to increase the profitability of these ancillary laboratories.

The potential for abuse by self-referral in these arrangements is alarming. The rapid increase in the number of in-office laboratories will drive quality laboratory providers out of the market and in the end will reduce access to quality gastrointestinal diagnostics. One of our practices in Ohio provides training in gastrointestinal pathology. The reduction in patient volume jeopardizes our fellowship programs because of insufficient material for teaching. We are aware of major pathology residency training programs in which the pathologists in training have little or no experience with gastrointestinal or prostate biopsy specimens because these specimens are going to the gastroenterologists or urologist in house laboratories.

We believe that CMS should enforce a return to the original intent of the in office ancillary services exception. This exception should be limited to simple chemistries (e.g., dip-stick for urine, spun hematocrit, etc.) or microscopy done by the clinician themselves (e.g., Gram stain, urine analysis, vaginal smear for Trichomonas, India ink preparation, etc). These tests are done in an urgent fashion to facilitate a diagnosis and plan for the patient that day. The in house ancillary services exception should never allow for the development of full surgical pathology laboratory and high complexity laboratory procedures in which interpretation cannot be done while the patient is still in the office. This proliferation of surgical pathology laboratories within non-pathologist physician offices is designed solely for enhancement of revenue to the gastroenterologist and urologist practice.

We are pleased to have the opportunity to comment on these regulations and we appreciate your consideration of these comments.

Sincerely,

Robert E. Petras, M.D.
Cecelia Fenoglio-Preiser, M.D.
Janet Stephens, M.D., Ph.D.
Daniel M. Jondle, M.D.
Michael R. Robles, D.O.
Edward Uhlemann, M.D.
Scott Sittler, M.D.

CMS-1385-P-12597-Attach-1.DOC

Submitter : **Ms. Crystal Cochran** **Date: 08/30/2007**

Organization : **Florida Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Crystal Cochran. I am a nationally certified athletic trainer and also a certified strength and conditioning specialist. Having graduated from a four-year university with a dual major in athletic training and exercise physiology, I am trained to work under physician and physical therapist supervision. I am currently employed by a hospital performing athletic training duties on an outreach contract with the Walt Disney World Resort, as well as assisting as needed in our physical therapy clinics.

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,

Crystal Cochran, ATC, CSCS

Submitter : Mr. Tristan North **Date:** 08/30/2007

Organization : American Ambulance Association

Category : Association

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

Please see attached letter.

CMS-1385-P-12599-Attach-1.DOC

#12599

American Ambulance Association
8201 Greensboro Drive, Suite 300
McLean, Virginia 22102
Phone: (703) 610-9018
Fax: (703) 610-9005
Website: www.the-aaa.org

"The American Ambulance Association promotes health care policies that ensure excellence in the ambulance service industry and provides research, education, and communications programs to enable members to effectively address the needs of the communities they serve."

August 29, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, Maryland 21244-8018

Re: CMS-1385-P: "Geographical Price Cost Indices"

Dear Mr. Kuhn:

On August 13, the American Ambulance Association (AAA) submitted to the Centers for Medicare and Medicaid Services (CMS) our comments on the "Ambulance Services" section of the Proposed Rule entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions" ("Proposed Rule"), 72 Fed. Reg. 38122 (July 12, 2007). This letter serves as our comments on the "Geographical Price Cost Indices" section of the Proposed Rule. We again thank you for the opportunity to submit comments on the Proposed Rule.

While the AAA recognizes the statutory requirement for CMS to update the geographical price cost index (GPCI), we strongly oppose any reduction in Medicare reimbursement for ambulance service providers which could have an adverse impact on patient access to vital emergency and non-emergency ambulance care. The reductions in reimbursement resulting from the proposed changes in the GPCI is in direct contradiction to the findings of the May 2007 Government Accountability Office (GAO) report entitled "Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly" (GAO-07-383) which determined that Medicare reimburses ambulance service providers on average 6% below their costs of providing services and 17% for providers in super rural areas. For those ambulance service providers who would receive lower reimbursement as a result of the changes to the GPCI, the Proposed Rule will further exacerbate the problems already caused by below-cost Medicare reimbursement.

The GAO recommended that CMS monitor the utilization of ambulance transports to ensure that negative Medicare reimbursement does not impact beneficiary access to ambulance services particularly in super rural areas. We believe that the Proposed Rule would have a considerable impact on beneficiary access in all areas adversely affected by the changes in the GPCI. We implore CMS to take this into consideration as it finalizes the Proposed Rule and alleviate any harmful impact these changes in the GPCI will have on providers while ensuring that those providers who would benefit from the changes receive the proposed increases which are desperately needed.

Thank you for your consideration of these comments. If you or your staff should have any questions regarding our comments, please contact myself or Tristan North, AAA Senior Vice President of Government Affairs, at 703-610-9018.

Sincerely,

Jim McPartlon
President

Submitter : **Dr. Clifford Hallam** **Date: 08/30/2007**

Organization : **The Care Group LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter with comments on multiple sections.

CMS-1385-P-12600-Attach-1.DOC

#12600

THE CARE GROUP LLC

THE CARE GROUP, LLC
Cardiology

Indianapolis

- **The Care Group at St.Vincent**
  8333 Naab Road, Suite 400
  317-338-6666; 800-732-1484
- **The Care Group at The Heart Center**
  10590 North Meridian Street
  317-338-6666; 800-732-1484
- **The Care Group at Methodist Hospital**
  1801 North Senate Boulevard, MPC 2, Suite 300
  317-924-5444; 800-365-9170
- **The Care Group at Clarian North**
  11725 Illinois Street, Suite 565
  317-338-6666; 800-732-1484
- **The Care Group at Clarian West**
  1115 N. Ronald Reagan Pkwy, Suite 329
  317-217-2300
- **The Care Group at Eagle Highlands**
  6920 Parkdale Place, Suite #107
  317-329-7000; 800-365-9170
- **Children's Heart Center at St.Vincent**
  8333 Naab Road, Suite 320
  317-338-3000; 877-207-3917

Other Locations:
Anderson
Crawfordsville
Danville
Greenfield
Kokomo
Lafayette
Lebanon
Marion
Seymour

Primary Care

Carmel
Diagnostic Medicine of Carmel

Fishers
Fishers Internal Medicine

Indianapolis
Comprehensive Adult Medicine

Diagnostic Medicine of Indiana Family Practice

HMS Medical Consultants

Meridian Adult Medicine

Meridian Family Practice

Moore Family Care

Northside Internal Medicine

Lafayette
Horizon Oncology Center

Richmond
James R. Lewis, MD Internal Medicine

Zionsville
Northwest Internal Medicine

August 29, 2007

Herb Kuhn, Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018, Baltimore, MD 21244-8108
By electronic submission

Re: Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Mr. Kuhn:

Thank you for the opportunity to comment on the proposed rule regarding revisions to the payment policies under the Physician Fee Schedule, and other Part B Payment Policies for CY 2008, document, CMS-1385-P. The Care Group is a practice that sees approximately 350,000 patients each year in the greater Indianapolis area, our 131 physicians and 733 employees appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the Proposed Notice.

Coding – Additional Codes From 5-Year Review

We strongly urge CMS to wait for and fully consider the RUC's decision about the work and practice expense for CPT 93325 before taking any action on the proposal to bundle this code into others.

This is a concern to our cardiologists and represents a substantial and unwarranted cut for cardiology services payments, as well as a deviation from the foundation of the RVU process.

The AMGA reports that our speciality society, the American College of Cardiology (ACC) have been working with CMS to resolve concerns about 93325 for nearly two years.

In March, 2007 ACC and ASE submitted a proposal to the CPT Editorial Panel for a new code combining 93307, 93325 and 93320 (spectral Doppler). AMGA reports that the CPT Panel approved the new code in

June for implementation in January 2009. This new code is fully expected to address any outstanding issues relative to Medicare utilization of 93307 and will have been analyzed in depth by appropriate national medical societies, the CPT editorial panel, and the RUC.

Color flow Doppler is not intrinsic to all echocardiography procedures. Use of the color flow add-on varies significantly across the different echo services. There is considerable diagnostic value in use of the technology and there is distinct physician work and practice expense associated with 93325 that is not accounted for in the relative value units for the other echo codes. Bundling, as proposed, without additional payment is inappropriate and unfair.

We strongly urge CMS to wait for and fully consider the RUC's decision about the work and practice expense for the new code before taking any action on CPT code 93325.

Resource-Based PE RVU's

We are extremely concerned with the 2008-2010 PE RVU's established for non-facility outpatient cardiac catheterization procedure codes and the significant negative impact that could result for our practice and our patients if these values are finalized for the 2008 Physicians Fee Schedule.

TCG has operated our own cath lab for 15 years. We now operate four labs performing 5000 cases per year. We have been actively involved in the PERC process submitting direct and indirect cost data to the ACC and COCA in conjunction with the AMA process. One of our interventional cardiologists, Dr. Edward Fry, actually presented the data in conjunction with the ACC and SCAI to the PERC committee earlier this year.

The current limitations of the process restrict the data to be considered and this flawed process has resulted in PE RVU recommendations that severely undervalue the direct and indirect costs associated with providing cardiac catheterization to our patients.

The PE-RVU values set out in July 2 Proposed Rule would result in a devastating cut in reimbursement for cardiac catheterizations performed in practice or IDTF locations. For example, if the 2007 conversation factor is applied to the technical component of the primary three CPT codes for a Left Heart Cath (93510TC, 93555TC, and 93556TC) the reimbursement in 2008 would be cut by **32%** and when fully implemented the total reimbursement would be reduced by **49%**.

These reductions would very likely result in the closing of the majority of non-facility outpatient cardiac catheterization labs in the country forcing all patients who now benefit from improved access, outcomes,

patient satisfaction and lower costs into more acute hospital settings. Many hospitals simply do not have the capacity to deal with an increase in volume and could result in wait times that may very well endanger Medicare beneficiaries who need these cardiac services. This would also result in a presumed unintended consequence of forcing patients back into the hospital setting and this would result in an increased cost to the Medicare program as a whole.

Over utilization does not appear to be an issue for outpatient cardiac caths as national cath volumes have been flat and actually declining as a percentage of patient visits for several years – this is supported by Medaxiom data.

The inappropriateness of the current rate setting process becomes self-evident when the proposed negative changes for outpatient diagnostic cardiac catheterization codes listed in the 2008 Physician Fee Schedule are compared with the proposed 2008 APC rate increase of 11.18% for APC 0080 "Diagnostic Cardiac Catheterization" published in the August 2, 2007 Federal Register (CMS-1392-P). It is clear that the RUC recommendations concerning the cost of performing these procedures are dramatically at odds with those that CMS determined for the same procedures performed in facility-based outpatient cardiac catheterization centers. This comparison is set out in the following chart:

Comparison of Payment Rates by Site of Service for Family of Diagnostic Catheterization Codes (PFS 93510 TC, 93555 TC, 93556 TC and APC 0080)

	Actual	Proposed	Proposed		2008 PFS as	2010 PFS as
	2007	2008	2010	% Change	% of 2008 APC	% of 2008 APC
APC Rate	$2,283.55	$2,539.00		11.19%		
PFS Rate	$2,138.56	$1,450.34		-32.18%	57.12%	
PFS Rate	$2,138.56		$1,090.69	-49.00%		42.96%

We believe that you have no interest in supporting a flawed process that would drive non-facility cardiac catheterization centers out of business. There is a statement made by CMS in the July 2 Proposed Rule when expressing concern with service furnished under arrangement with a hospital because it *"not only costs the Medicare program more, but also*

costs Medicare beneficiaries more in the form of higher deductibles and coinsurance" (CMS-1385-P, pages 349-50). This concern about increased Medicare program and beneficiary costs must also apply to other services...which is exactly the point cath lab owners have been expressing since the proposed reimbursement cuts in 2006.

We would strongly encourage CMS to continue to evaluate the consequences of the "bottom-up" methodology and it's impact on services such as the technical components of a cardiac cath, and continue to seek input on the actual direct and indirect costs of providing such services before adopting a fee that may well close these centers.

We believe a better solution for addressing the flawed system as pertains to cath lab services might be to tie the non-hospital outpatient cath lab reimbursement to a reasonable percentage of the hospital APC rates for these exact same procedures.

Proposed Conversion Factor Reductions

Due to the Sustainable Growth Rate, physicians now face drastic Medicare payment cuts totaling almost 40% over the next eight years. Yet, during this same time period, the Medicare Economic Index (MEI) which measures increases in medical practice costs, is expected to increase by about 20%. Physicians cannot absorb these drastic cuts. Payments to physicians today in 2007 are essentially the same as they were six years ago in 2001.

Only physicians and other health professionals face steep cuts under this flawed formula. Other providers, such as hospitals and nursing homes have payment updates that reflect the cost of inflation.

Physician practices are also businesses and must have stable, and reasonable reimbursement patterns that keep pace with the increased cost of providing care. Reimbursement cuts such as those faced by cardiologists will force us to consider taking measures that seem in conflict with the ever increasing focus on improving quality of care, and sustaining Medicare beneficiary access.

The AMA reports that "Compared to the rest of the country, Indiana at 14 percent, has an above average proportion of Medicare patients and, at 16 practicing physicians per 1,000 beneficiaries, has a below-average ratio of physicians to Medicare beneficiaries, even before the cuts take place." The AMA also reports that "40 percent of Indiana's practicing physicians are over 50, an age at which surveys have shown many physicians consider reducing their patient care activities."

It seems unrealistic to expect practices to absorb these significant reimbursement cuts, with current rates already at about the same rate as they were in 2001, while our expenses continue to grow, yet also be able

to make the needed investments in staff and health information technology in order to support continued quality measurements and continue to accept more and more Medicare patients.

Recalls and Replacement Devices

We are concerned about the correlation CMS seems to be drawing between recalled and replacement devices (pacemakers and ICD's), and physician monitoring services provided for patients affected by a recall action. We understand the concern for potential additional costs to the program, however we would encourage CMS to hold off on any policy changes until an appropriate advisory panel of experts can complete work on developing recommendations for appropriate follow-up care. This approach would help to ensure the objectives of the agency are met and protect the best interest of Medicare beneficiaries, as well as maintain the role of the physician.

One solution might be the development of a modifier and or specific diagnosis code to help with the identification of this patient population and any associated expenses. This approach may actually benefit payors in the commercial segment as well, since we are currently receiving numerous forms and questionnaires from commercial payors who are also trying to identify these patients and their associated costs.

Cardiac Rehabilitation

The potential development of a unique Medicare code with wording to define a "session" of cardiac rehab as an hour seems to be an issue where additional options should be explored prior to the development and implementation of a new Medicare specific code. Even with the existing code's wording, an hour is a standard session and one would expect that those who may submit the code for less than an hour session would be very minimal. If survey data from providers of cardiac rehab services confirming the length of their "sessions" has not been performed this seems to be a reasonable step prior to creating the additional burden of a Medicare specific code.

A recommendation to either change the existing CPT code wording to per hour, or ask providers who are billing for a session that is less than one hour to temporarily add a modifier to indicate a reduced service – such as modifier 52, would seem to be an easy to implement temporary solution.

The creation of a Medicare specific rehab code would create additional difficulties for claims resolution with Medicare secondary payors as this would not be a valid CPT code for them. This would place undue burden on both providers and beneficiaries as they would need to educate payors and convert the Medicare specific code back to the current CPT code in order for correct claims processing.

PQRI

We would encourage CMS to continue the voluntary nature of participation in the PQRI program with the practice able to identify and choose the measures most relevant to their patient population.

We would also support that new measures be endorsed by organizations such as NQF with input from our specialty societies.

We also agree that additional options such as electronic reporting or registry reporting should be explored further as another potential option.

Many practices with electronic health records have the capability for example to run a report of all Medicare patients with congestive heart failure and identify all those who are on a Beta Blocker or ACE/ARB, and communicate that information in a single report transmission.

The implementation of PQRI reporting processes has been a difficult undertaking, but one we have embraced in our organization. Providers do need adequate time to learn how to best capture this data and be given the benefit of feedback prior to the program evolving from voluntary participation.

In summary we would encourage CMS to continue to work with providers and their specialty societies in the spirit of partnership, in order to identify the best possible solutions to strengthen the Medicare program with fair and rationale solutions.

We appreciate the opportunity to provide comments and feedback on the proposed rule.

Sincerely,

Clifford C. Hallam, M.D.
Managing Partner and CEO

The Care Group, LLC
8333 Naab Road, Suite 400
Indianapolis, IN 46260

Submitter : **Dr. Jared Mitchell** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

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.

Jared Mitchell, MD
5763 Scarborough Dr
Oakland, CA 94611

Submitter : **Dr. Tejbir Sidhu** **Date: 08/30/2007**

Organization : **MetroHealth medical Center, Cleveland**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Tejbir Sidhu,MD

Submitter : **Date: 08/30/2007**

Organization :

Category : **Occupational Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I strongly suppport the proposal to extend the 30 day re-certification requirement to 90 days. The current 30 day requirement places unnecessary burdens on physicians and therapists. It is not an adequate means of controlling utilization of therapy services.
Other requirements include certification of the inital plan of care,LCDs, CCI edits, specific medical necessity requirments which assist in monitoring appropriateness of therapy.
Physicians are over burdened with new requirements for every insurance and rarely have the time to review the plans adequately to influence the therapy.

Submitter : Mr. Joseph Zahn **Date:** 08/30/2007

Organization : Concord Hospital

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I agree and support the recommendations for lengthening the CMS re-certification date from 30 to 90 days. It is time consuming and often very confusing for both referring physicians/PCP's and those providing rehabilitative to provide documetation every 30 days to show progress; bill approriately and abide by CMS rules/regulations when a 60 to 90 re-certification period would show the extent to which both physician and rehabilitative care is beneficial to CMS, physicians, therapists and patient's

A 90 day re-cert would allow sufficient time and care to be offered to patients and show that care was utilized in a more economical way than getting a re-cert every 30 days that may not show sufficient improvement from the previous evaluation.

Submitter : Mr. Keith Rupp **Date:** 08/30/2007

Organization : Rivier College

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I have been an athletic trainer for the past 10 years at both the clinic and college level. I currently work for a small college in New Hampshire as the head athletic trainer. I received an undergraduate degree in Biology with a minor in athletic training. I am nationally certified and licensed in the states of New Hampshire and Florida.

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,

Keith Rupp, ATC

Submitter : **Robert Klein** **Date: 08/30/2007**

Organization : **Robert Klein**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Frank Parker** **Date: 08/30/2007**

Organization : **Frank Parker**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. Donald Irish** **Date: 08/30/2007**

Organization : **Baystate Health Ambulance**

Category : **Other Health Care Provider**

Issue Areas/Comments

Ambulance Services

Ambulance Services

August 30, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, Maryland 21244-8018

Re: CMS-1385-P: Geographical Price Cost Indices

Dear Mr. Kuhn:

This letter serves as our comments on the Geographical Price Cost Indices section of the Proposed Rule (CMS-1385-P). Our organization strongly opposes any reductions in Medicare reimbursement for ambulance service providers which would have an adverse impact on patient access to vital emergency and non-emergency ambulance care. The Proposed Rule would unfortunately cause that exact effect in areas where providers would receive lower reimbursement as a result of the updated Geographical Price Cost Index (GPC) figures.

While we recognize the statutory requirement for CMS to update the GPCI, any reductions in reimbursement would be in direct contradiction to the findings of the May 2007 Government Accountability Office (GAO) report entitled Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly (GAO-07-383) which determined that Medicare reimburses ambulance service providers on average 6% below their costs of providing services and 17% for providers in super rural areas. For those ambulance service providers who would receive lower reimbursement as a result of the changes to the GPCI, the Proposed Rule will further exacerbate the problems already caused by below-cost Medicare reimbursement.

The GAO recommended that CMS monitor the utilization of ambulance transports to ensure that negative Medicare reimbursement does not impact beneficiary access to ambulance services particularly in super rural areas. We believe that the Proposed Rule would have a considerable impact on beneficiary access in all areas adversely affected by the changes in the GPCI. We implore CMS to take this into consideration as it finalizes the Proposed Rule and alleviate any harmful impact these changes in the GPCI will have on providers while ensuring that those providers who would benefit from the changes receive the proposed increases which are desperately needed.

Thank you for your consideration of these comments

Sincerely,

Donald L Irish, Jr.
General Manager
Baystate health Ambulance
338 High St.
Greenfield, MA 01301

Submitter : Dr. Douglas Miller **Date:** 08/30/2007

Organization : Rehabilitation Centers of Charleton

Category : Physical Therapist

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

To whom it concerns,
Reducing Medicare reimburscment for out patient physical therapy services by 9.9% would be a severe detriment to the well being of our physical therapy practice. We are regularly seeing greater restrictions on services covered by Medicare and not only do we as a business suffer, the well being of our patients suffer as they often cannot receive the care they truly require. In our practice we take pride in performing only those services required to achieve desired improvement in our patients' condition.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

As a Nurse Anesthetist and member of the American Association of Nurse Anesthetists (AANA), I urge you to follow through with the proposal to raise anesthesia reimbursement for Medicare patients. Many providers are dropping care of Medicare patients. This proposal would bring reimbursements to a more fair level. Thank you for your consideration.

Submitter : **Hank Dunlap** **Date: 08/30/2007**

Organization : **Benchmark Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I work part time at a local high school as their Head Athletic Trainer. I have been working as an athletic trainer now for thirteen years, both in the clinical setting, and at secondary schools. I became certified as an athletic trainer in 1994 and have been licensed to practice athletic training in Georgia and Florida since 2001.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restriet their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Hank Dunlap, MS, ATC

Submitter : **Dr. Aaron Sandler** **Date: 08/30/2007**

Organization : **Duke University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Yours,
Aaron Sandler, MD, PhD

Submitter : Mr. Vincent Faraci, MS, ATC **Date:** 08/30/2007

Organization : Copley Hospital/ Copley Rehab

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

As a Certified Athletic Trainer I urge you to include athletic trainers and other qualified healthcare providers in the list of approved CMS providers. By excluding these groups you are limiting a physician's choice for the care of their patients and jeopardizing the employment of thousands of highly qualified professional healthcare providers. This reaches well beyond the clinic setting. This could impact all settings in which certified athletic trainers practice and are vital to the care of patients of all ages. Thank you for your attention to this important matter.

Vincent Faraci, ATC

Submitter : **Mr. Todd Bartley** **Date: 08/30/2007**

Organization : **Ursinus College**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Todd Bartley and I am a certified athletic trainer at Ursinus College in Collegeville, PA. I have been a certified athletic trainer for over sixteen years providing quality healthcare to many people. I have both a Bachelor s degree in Athletic Training and a Masters degree in Exercise and Sports 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.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Todd Bartley, MS, ATC

Submitter : **Dr. Diane Biery** **Date: 08/30/2007**

Organization : **Dr. Diane Biery**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Normand Townley** **Date: 08/30/2007**

Organization : **American Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern:
I am an anesthesiologist near retirement, however I am concerned more for my own anesthesia care as I am for those providing it. I encourage you in the strongest terms to pass this.
Normand T. Townley, M.D. (Will attempt to add attachment.)

Submitter : Mr. Stephen Correia **Date:** 08/30/2007

Organization : RCC

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern,

My name is Stephen Correia and I am a practicing Physical Therapist in Charleston, South Carolina. I am in my 15th year of practicing and have seen the profession of Physical Therapy grow into one of the more important specialized areas of health care. Over these same 15 years, I have seen the Medicare population grow significantly in the percentage of patients I see on a daily basis. This population is living longer, and being more active later in life. It is not uncommon now to see 75-85 year old men and women having very high qualities of life, and thus having a greater need for our services. Unfortunatly this population of patients are also the most needy as far as time and effort to treat. Most require constant supervision and instruction for balance deficits, strength/endurance training, and basic functional needs such as sit to stand transfers etc. They are a very rewarding population to treat because they appreciate the individual attention. The proposed reduction in reimbursement will futher the deficit clincians are faced with concerning spending the quality time with medicare patients and treating other paying insurance patients. Continued reduction in fees will cause the clinicians to reevaluate medicare patients care secondary to the lack of funding they recieve per visit. The paperwork required to treat medicare recipients is already more than any other insurance based patient. Continued reduction will cause therapists to reevaluate if it is financially feasable for us to continue to treat medicare patients or drop this population all together.

I would like all of you to think of your parents and grandparents and what would happen if they broke there hip, sustained a stroke, or any other abnormality which required physical therapy services.

Thank you for you attention,

Stephen Correia PT, MHS, OCS, MTC

Submitter : **Mr. greg isch** **Date: 08/30/2007**

Organization : **Mr. greg isch**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,
Greg Isch

Submitter : **Dr. Kasinathan Shanmugam** **Date: 08/30/2007**

Organization : **Tidewater Anesthesia P.A**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V.Norwalk,ESq.
Acting Administrator,
Centers for Medicare & 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 hereby submit my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I appreciate the recognition by CMS about the gross undervaluation of anesthesia services and its steps to address this issue.
Under the RBRVS , anesthesia services have been under valued and under paid. Today, more than a decade since RBRVS took effect medicare payment is just $16.19/unit. This system creates imbalance for the anesthesia services in the hospitals serving a larger proportion of senior citizens.
RUC's recommendation, that CMS increase the anesthesia conversion factor to offset a calculated 32% work under evaluation will be 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.
Thanking you for your consideration of this serious matter.

Kasinathan Shanmugam, MD

Submitter : **Mr. Ted Helgerson** **Date: 08/30/2007**

Organization : **Northern Star Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Mr. Weems;

My name is Ted Helgerson. I graduated form Mayo Clinic School of Physical Therapy in 1975. For the past 14 years. I have been a founding partner of a thriving PT/OT private practice. We have worked closely with the patient community and physicians in providing a high level of medical services to the city and surrounding area of St. Cloud. In 1978 another physical therapist and I established a Physical Therapy department in a large Orthopedic Physician owned clinic. I worked for the clinic for sixteen years, several as director of P.T. I worked closely with the physicians during this period and as a group they were very ethical. However, with changes in medical economics during the early 90 s the ethical patient care issues were turned over to administration (accounting). In the setting the doctor s were insulated. Physical Therapy then became an assembly line money making endeavor. Having worked for & directed their P.T. services, I feel my professional standards are of the highest quality.

Patient that have followed me for care at my present business have shared with me the following statements from my previous employer. 1) Per doctor you need to be seen in my office so I can monitor your case progress more closely. 2) My therapists are better trained. 3) I can not guarantee the quality of your Rx if you don t go with us. These statements seem to me that referral patterns are driven by monetary gains.

Our success as an independent Physical therapy practice in the open market place has come form a mission statement that places patient care 1st and monetary consideration secondary.

We have not become rich doing business this way. However, I have received a fair compensation for my professional expertise.

Therefore, I feel you should remove Physical therapy as a designated health services, permissible under the in-office ancillary exception of the federal physician self referral laws. It offers a setting where there is a greater opportunity for fraud and over use.

Sincerely,

Ted Helgerson, PT #1398 State of MN

Submitter : **Mr. joe green** **Date: 08/30/2007**

Organization : **Mr. joe green**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Joe Green

Submitter : **Mr. Dean Wennerberg** **Date: 08/30/2007**

Organization : **Bethesda Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an Registered Athletic Trainer in the State of Minnesota currently practicing. I work with NovaCare Rehabilitation as an Atheltic Trainer and with HealthEast Bethesda Hospital as a Community Liaison.

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,

Dean Wennerberg MS,ATC CSCS

Submitter : Dr. Jeffrey Gunderson **Date:** 08/30/2007

Organization : Ozark Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

To Whom it may concern, I am a practicing physician in the specialty of anesthesiology and have strong feelings on the issue of medicare reimbursement for anesthesia services. The proposed increase is a step in the right direction to redress the consistent decreases in reimbursement that the specialty has endured. The specialty at this point is in danger of dying a death by a 'thousand cuts'. This is translating into real difficulty in retention and recruitment to the specialty. The practice of anesthesiology has seen incredible advances in expertise over the past twenty years that I have been practicing and hence the patient safety and scope of treatments has been nothing short of phenomenal. I would like to see this continue as I would hope to receive the same excellent care that I and my fellow practioners have been providing should I so be in need of such. The 'graying' of America is a serious issue as the complexity of treatment and comorbidities in the elderly are quite taxing to all who provide health care services. Anesthesiology is a critical specialty that is now having real difficulty in recruiting and retaining qualified professionals. I would hope that it is not the intention of medicare to do away with anesthesiology as a medical profession as the demands of the specialty are greatly increasing. Please feel free to contact me at jgundersonmd @oaaweb.com. Sincerely jeffrey K. Gunderson MD

Submitter : **Ms. Catherine Ord** **Date: 08/30/2007**

Organization : **Newport Beach Fire Department**

Category : **Local Government**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

It is respectfully requested that CMS:

' Amend 42 C.F.R. ?424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported .
' Amend 42 C.F.R. ?424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
' Amend 42 C.F.R. ?424.36(b) (5) to add or ambulance provider or supplier after provider .

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

AMBULANCE SERVICES AMBULANCE INFLATION FACTOR.

NBFD has no objection to revising 42 C.F.R ?414.620 to eliminate the requirement that annual updates to the Ambulance Inflation Factor be published in the Federal Register, and to thereafter provide for the release of the Ambulance Inflation Factor via CMS instruction and the CMS website.

Thank you for your consideration of these comments.
Please see attached letter for more detailed information

Submitter : **Ms. Karen A. Jonas** **Date: 08/30/2007**

Organization : **Michigan Pharmacists Association**

Category : **Pharmacist**

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Please see the attached letter regarding our comments pertaining CMS-1385-P, Proposed Elimination of Exemption from NCPDP SCRIPT Standard for Computer-Generated Facsimile Transmissions Under Medicare Part D.

Thank you for the opporutunity to provide comments.

CMS-1385-P-12627-Attach-1.DOC

#12127

Michigan Pharmacists
ASSOCIATION

815 North Washington Avenue
Lansing, Michigan 48906-5198
www.michiganpharmacists.org
mpa@michiganpharmacists.org
FAX (517) 484-4893
(517) 484-1466

September 13, 2007

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: CMS-1385-P, Public Comments - Proposed Elimination of Exemption from NCPDP Script Standard for Computer-Generated Facsimile Transmissions Under Medicare Part D

This letter is being submitted on behalf of the pharmacist members of the Michigan Pharmacists Association (MPA) regarding our opposition to the proposed elimination of the exemption from NCPDP script standard for computer-generated facsimile transmissions under Medicare Part D. MPA serves over 3,000 pharmacy professionals, strives to be a leader in professional and scientific advancement by following its mission of encouraging and supporting its members as the professionals responsible for the delivery of patient-focused care.

It is the recommendation of MPA, that the Centers for Medicare & Medicaid Services (CMS) delay the proposed elimination of the exemption from NCPDP script standard for computer-generated facsimile transmissions under Medicare Part D until such time as the Drug Enforcement Administration (DEA) provides regulations or provisions for the electronic prescribing of controlled substances. While electronic prescribing is currently legal in all states for non-controlled substances, electronic prescribing of controlled substances is not legal. Prescriptions for controlled substances must therefore either be handwritten by the prescriber, computer-generated and manually signed then hand-delivered to the pharmacy, transmitted via facsimile or verbally communicated to the pharmacy.

CMS continues to promote the many advantages of electronic prescribing particularly as it relates to improved quality, efficiency and reduction in healthcare costs by actively promoting appropriate drug use, minimizing medication errors and providing coverage information. Advantages of a computer-generated prescription benefit the patient, as well as the Medicare Part D sponsor and CMS. The software to create computer-generated prescriptions supports formulary compliance, suggests low-cost alternative medications, promotes appropriate drug use and minimizes medication errors.

Since electronic transmission of a controlled substance prescription directly from the prescriber to the pharmacy is not legally permissible, the prescriber is left with inefficient, cumbersome options. The prescriber can either: call the pharmacy to verbally communicate the prescription, write a prescription order for a patient to personally deliver to the pharmacy or create a computer-generated prescription order that must be manually signed then transmitted directly to the pharmacy via facsimile or delivered to the pharmacy by the patient. By faxing computer-generated prescription orders for controlled substances the beneficiary, Medicare Part D sponsors and CMS would experience improved quality, efficiency and the probability of reduced costs when compared to the results of handwritten or verbal prescription orders.

With these concerns noted, MPA opposes the elimination of the exemption from NCPDP SCRIPT standard for computer-generated facsimile transmission under Medicare Part D until DEA provisions for the electronic prescribing of controlled substances is established.

Sincerely,

Karen A. Jonas, Pharmacist
Director of Professional Practice
kjonas@michiganpharmacists.org
(517) 377-0254

Submitter : **Ms. pam brooks** **Date: 08/30/2007**

Organization : **Ms. pam brooks**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Pam Brooks

Submitter : Mr. paul Gass **Date:** 08/30/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

thank you for your assistance and support of aneshethesia

Submitter : **Mr. Michael Jennings** **Date: 08/30/2007**

Organization : **MVP Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 30, 2007

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

I am a licensed physical therapist in the state of Washington who has been practicing since 1988. I am a practicing physical therapist and owner of an outpatient therapy company with multiple locations. I would like to encourage you and your colleagues to remove physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws.

My reason for this request can best be provided by specific example. We have clinics located in clusters serving particular geographical regions. In one of these areas, a large medical practice opened its own multi-specialty clinic with 80 physicians providing healthcare services to greater than 250,000 residents of the area. The physicians now own their own surgical facilities, physical therapy practice, diagnostic center, and other miscellaneous services housed within the same mega-size building with a mega-size parking lot that is always full.

These same physicians formerly referred to outpatient physical therapy practices within the region. Since opening their facility, our former patients have reported they are no longer able to attend physical therapy at our facilities because the physicians have requested they get their services from their own clinic instead. This direction of care into their own therapy practice is reinforced by a referral system that uses computer generated referrals within the Doctor s clinic system. The patient does not receive a written referral that can be taken at their will to other physical therapy providers. Since the opening of this facility, our patient volume has decreased to 40% of its prior level.

By contrast, in another geographical area, we have a large orthopedic practice that owns its own medical plaza where space is leased to independent medical practitioners including those providing physical therapy, radiology, and durable medical equipment. The patients receive written physical therapy referrals that allow the patient to go to any provider of their choice. This arrangement allows the patient access to the best of both worlds in that physical therapy services are available within the same building allowing for ease of access AND the patients retain the ability to seek care elsewhere if desired.

In summary, I strongly encourage Medicare to eliminate physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws. It is clear that patients can receive convenient access to physical therapy services WITHOUT physicians owning the practice. In addition, this guarantees that referrals for physical therapy will be written based upon patient need rather than for physician financial gain.

Please close this in-office ancillary services loop-hole and eliminate inherent financial incentive to refer their patients to the practices they have invested in and to over-utilize those services for financial reasons. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, over-utilization of physical therapy services under the Medicare program, and enhance the quality of patient care.

Thank you for your consideration of my comments and specific experience with this very important issue.

Respectfully,

Michael H. Jennings, MHS, PT
Physical Therapist
Phone: 253.582.8142
mjennings@mvppt.com

Submitter : **Dr. wayne king** **Date: 08/30/2007**

Organization : **Dr. wayne king**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,
Wayne King

Submitter : **Dr. Praveen Kalra** **Date: 08/30/2007**

Organization : **OUHSC**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter :

Date: 08/30/2007

Organization :

Category : Congressional

Issue Areas/Comments

ASP Issues

ASP Issues

test

#12633

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Dr. Joseph Roberts** **Date: 08/30/2007**

Organization : **Nash Anesthesia Associates, PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Mr. joe johnson** **Date: 08/30/2007**

Organization : **Mr. joe johnson**

Category : **Other Technician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Joe Johnson

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Lynn Casey-Maher CRNA
Name & Credential
857 Honeysuckle Ave
Address
West Chicago, Il 60185
City, State ZIP

Submitter : **Dr. Ronald Shelton** **Date: 08/30/2007**

Organization : **Dr. Ronald Shelton**

Category : **Physician**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

8/30/2007

The Honorable Herbert Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
Washington, DC 20201

Re: CMS 1385-P:2008 Medicare Fee Schedule, Section II.E.2
Coding Multiple Procedure Payment Reduction for Mohs Surgery

Dear Mr. Kuhn:

I subspecialize in Mohs micrographic surgery for skin cancer and reconstruction. In 1993, after being recruited by the Mount Sinai Medical Center in New York City, to create their Mohs surgical unit, I was on the full time faculty for five years, after which I went into private practice but retained my teaching position. I was told that I was the first Mohs surgeon in New York to accept Medicare. I have maintained that to this day. I believe in the fair and excellent treatment of our seniors.

Unfortunately, if any procedure of Mohs surgery, 17311, 17312, 17313, 17314, 17315, or the reconstruction codes are decreased further, I would not be able to perform more than one procedure on any patient. Many of these patients are quite elderly, and find it difficult to travel for treatment, requiring city services of ambulette, or significant inconvenience of having family members from out-of-town to come and bring them to their appointments. The Mohs codes are already discounted as the second stage (17312) is markedly less than the first stage (17311). If a second tumor requires reconstruction as well as the first, I guarantee that my work is no less excellent, nor demanding in the second surgery than the first, whether they are performed on two different days or the same. The overhead cost would not be compensated adequately if the reimbursement is decreased any further.

I am afraid that if the Mohs codes are no longer exempt from the Multiple Procedure Reduction Rule, many Medicare beneficiaries will suffer. The global cost to the patient and families and local government will increase with more office visits being necessary.

Sincerely yours,

Ronald M. Shelton, M.D.
260 East 66th Street
New York, NY 10021
212-593-1818
Fx 212-832-3990
dr.shelton@thenyac.com

Submitter : **Ms. Kristen Adams** **Date: 08/30/2007**

Organization : **Ms. Kristen Adams**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing, as an individual who is employed in healthcare, 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.

Although I did not work in Anesthesia when the RBRVS was instituted, I realize that 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.

Anesthesiology care has improved over the years, with decreasing mortality rates. To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. kelly johnson** **Date: 08/30/2007**

Organization : **Mr. kelly johnson**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. Douglas McKee** **Date: 08/30/2007**

Organization : **Mr. Douglas McKee**

Category : **Other Health Care Provider**

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. Here in south Texas approximately 85-90 percent of our patients are either Medicare or Medicaid. Unless teh rates are stabilized it will be increasingly difficult to attract and retain quality providers.

Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services, especially in our area of South Texas, 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,
Douglas McKee CRNA
Brownsville, TX 78520

Submitter : **Mrs. Julie Boe** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Practitioner**

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 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,
___Julie Boe, CRNA_____
Name & Credential
___5400 11th Street South_____
Address
___Fargo, ND 58104_____
City, State ZIP

Submitter : **Dr. Laura Kihlstrom** **Date: 08/30/2007**

Organization : **Dr. Laura Kihlstrom**

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.

I live and work in such an area. I spend 1/3 of my clinical time working in an inner city hospital. I could easily increase my income by 30% by choosing not to work there but in a plastic surgeon's office instead.

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.

Laura Kihlstrom, MD
Norfolk, VA

Submitter : **Ms. Robbyn Scriven** **Date: 08/30/2007**

Organization : **Oregon Imaging Centers**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

The Physician Work RVU-CPT 77080 (DXA)
The Direct Practice Expense RVU for 77080 (DXA)
Indirect Practice Expense for DXA and VFA
Deficit Reduction Act
Dear Mr. Weems:
I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.
As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:
a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;
b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:
? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;
? the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.
c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and
d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image

Submitter : Dr. George Clarke, MD **Date:** 08/30/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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.

G. Donald Clarke, MD

Submitter : Mr. Sean Wayne **Date:** 08/30/2007

Organization : Washington Nationals Baseball club

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Sean Wayne. I am a certified athletic trainer for the Washington Nationals Baseball club. I work as a athletic trainer in the clinical setting in the off-season. I have a Masters degree in Rehabilitation Sciences, and a Bachelors degree in Athletic Training. I am also a Certified corrective Exercise Specialist, and Performance enhancement specialist.

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,

Sean Wayne MS ATC; CES, PES
Athletic Trainer Washington Nationals Baseball Club

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have been a practicing physical therapist for 33 years and in independent practice for 24 years. 3years ago one of my major referral groups decided to have in house therapy. My patient load has dropped by over 30%. I have downsized my offiee and cut my pay to keep the praetice open. This is how it has personally affected me, but of greater concern to me is how it has affected patients and physical therapy. I have seen several patients who have received treatment at these physicians' office the following two cxamples ar representative of the reports I receive.

'There were 10 people in the exercise area when I was there. I had been exercising for 10 minutes before someone came up and told me I was performing the exercise wrong. This happened to me more than once. I did not improve like I thought I should, I kept wondering if doing the exercise wrong was actually making me go backwards. I was always exercising with a group of at least 8 and sometimes 12 people, I had very little individual attention, yet they charged me more than you do for working with me one on one.'

The 2nd example is a patient that had limited visits by his insurance company (15 per year). He had an anterior cruciate ligament repair. Full rehab usually takes 6 months. He stated they saw him 3 X a wcek until his visits were used up (5 weeks) got an extension and saw him an additional 5 weeks, then cut him off because he had no morc insurancc and he could not afford to pay. He is still not fully rehabed.

It is hetter to be able to sce the patient thru to full rehab, but if they have a limited number of visits what most independent practice therapist do is schedule the visits out based on the stages of healing. So I may see that patient for 3 or 4 visits send them home on a home program for 4 to 6 weeks. Come back when ready to progress to the next level of rehab based on the healing process/maturation see them 3 visits then they continue on the home program until ready for the next stage and so on til they are at full rehab.

Again these 2 patients are not unique , they are representative of the common stories we hear.

My final point is more of a question to consider. If this group of Physians typically referresd 4-6 patients a week to me and 2- 5 patient total to the other therapist in town combined, why when they started referring to themselves did ther referrals jump up to approximately 20 patients per week. 2ndly if they are apparently doing group exercise why are they charging as if they were doing individual exercise sessions?

Submitter : **Ms. Yvonne Lacaillade** **Date: 08/30/2007**

Organization : **Mansfield Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing this letter to express my concern regarding the "in-office ancillary services" arrangements that have impacted the delivery of quality physical and occupational therapy (PT & OT). The in-office ancillary services exception has created a loophole which has resulted in many physician-owned arrangements that provide substandard physical and occupational services. Physicians are in a position to refer Medicare beneficiaries to in-office PT & OT services in which they have a financial interest. There is an inherent financial incentive to OVER-UTILIZE SERVICES under the IN-OFFICE ANCILLARY SERVICES exception. Therapy treatments are repetitive in nature. Patients receiving outpatient physical and occupational therapy can just as easily return to a therapy clinic as to the physician's office. Thank you for considering these comments and eliminating this "in-office ancillary services."

Submitter : **Dr. CJ Chang** **Date: 08/30/2007**

Organization : **Sutter Gould Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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. Kimberly McKenzie** **Date: 08/30/2007**

Organization : **WellnessWorks**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

RE: Docket #1385-P Therapy Standards and Requirements, Physician Self-Referral Provisions

My name is Kimberly McKenzie. I work for WellnessWorks as a Corporate Health Consultant. I received my BS from The University of Southern Mississippi and also my MBA from William Carey University. I am a RKT (Registered Kinesiotherapist) and I am an instructor for Antonelli College on a part-time basis.

I am writing today to voice my opposition to the proposed therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and other facilities proposed in Federal Register issue #1385-P. As a Kinesiotherapist, I would be excluded from providing physical medicine and rehabilitation services under these rules.

I am concerned that these proposed rules will create additional lack of access to quality health care for my patients. This is particularly important because my colleagues and I work with many wounded Veterans, an increasing number of whom are expected to receive services in the private market. These Medicare rules will have a detrimental effect on all commercial-pay patients because Medicare dictates much of health care business practices.

I believe these proposed changes to the Hospital Conditions of Participation have not received the proper and usual vetting. CMS has offered no reports as to why these changes are necessary. There have not been any reports that address the serious economic impact on Kinesiotherapists, projected increases in Medicare costs or patient quality, safety or access. What is driving these significant changes? Who is demanding these?

As a Kinesiotherapist, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, and Registered status insure that my patients receive quality health care. Hospital and other facility medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards and accepted practices.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the health care industry. It is irresponsible for CMS to further restrict PMR services and specialized professionals.

It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to reconsider these proposed rules. Leave medical judgments and staffing decisions to the professionals. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Kimberly McKenzie, MBA, RKT, CHC

Submitter : **Ms. Michael Corbin** **Date: 08/30/2007**

Organization : **Ms. Michael Corbin**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,
Michael Corbin

Submitter : **Date: 08/30/2007**

Organization : **Vermont Sports Medicine Center**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a Certified Athletic Trainer and a Physical Therapist, licensed in the states of Vermont and New York. I am presently employed at the Vermont Sports Medicine Center, and I am also a professor for the State University of New York at Stony Brook. I have both a Bachelor's and a Master's degree in Athletic Training, and a second Bachelor's degree in Physical Therapy.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Patricia M. Patane, MS, ATC, PT, CSCS

Submitter : Mr. Bryan Jones **Date:** 08/30/2007

Organization : Medical College of Georgia

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Bryan Jones and I work at the Medical College of Georgia in Augusta, GA. I am the Sports Medicine Coordinator in which I supervise the athletic training program here at MCG. I am a certified athletic trainer and state licensed in Georgia and certified to practice athletic training in the state of South Carolina. I have a Bachelor s of Science in Health Science with a master in business administration.

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 would 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,
Bryan E. Jones, ATC, LAT, MBA

#12654

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Mrs. Pamela Mott **Date:** 08/30/2007

Organization : Greater Valley Emergency Medical Services, Inc.

Category : Other Health Care Provider

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

CMS-1385-P-12655-Attach-1.PDF

#12655

August 30, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, Maryland 21244-8018

Re: CMS-1385-P: "Geographical Price Cost Indices"

Dear Mr. Kuhn:

This letter serves as our comments on the "Geographical Price Cost Indices" section of the Proposed Rule (CMS-1385-P). Our organization strongly opposes any reductions in Medicare reimbursement for ambulance service providers which would have an adverse impact on patient access to vital emergency and non-emergency ambulance care. The Proposed Rule would unfortunately cause that exact effect in areas where providers would receive lower reimbursement as a result of the updated Geographical Price Cost Index (GPC) figures.

While we recognize the statutory requirement for CMS to update the GPCI, any reductions in reimbursement would be in direct contradiction to the findings of the May 2007 Government Accountability Office (GAO) report entitled "Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly" (GAO-07-383) which determined that Medicare reimburses ambulance service providers on average 6% below their costs of providing services and 17% for providers in super rural areas. For those ambulance service providers who would receive lower reimbursement as a result of the changes to the GPCI, the Proposed Rule will further exacerbate the problems already caused by below-cost Medicare reimbursement.

The GAO recommended that CMS monitor the utilization of ambulance transports to ensure that negative Medicare reimbursement does not impact beneficiary access to ambulance services particularly in super rural areas. We believe that the Proposed Rule would have a considerable impact on beneficiary access in all areas adversely affected by the changes in the GPCI. We implore CMS to take this into consideration as it finalizes the Proposed Rule and alleviate any harmful impact these changes in the GPCI will have on providers while ensuring that those providers who would benefit from the changes receive the proposed increases which are desperately needed.

Thank you for your consideration of these comments

Sincerely,

Pamela Mott, Executive Director
Greater Valley Emergency Medical Services, Inc.

Submitter : **Ms. Arrean Corbin** **Date: 08/30/2007**

Organization : **Ms. Arrean Corbin**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Sincerely,
Arrean Corbin

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I encourage the closure of the self-referral provision for physicians. I applaud the attempts to address this issue in the past which have helped for short periods until the next loophole is discovered. I feel that total closure would be the best alternative given the response and results with past modifications. It has been my experience that patients often times do not recieve optimum physical therapy care in these settings. It is more about the money than the quality of care provided to the patients. Patients are often required to go longer and receive less cost effective treatment, in essense over utilization. This is not to metion the use of non licensed personnel in the delivery of services. Patients have stated to me on many occasions that their physician stated they wanted them in their facility so that they could observe their therapy when in essense this does not take place. I have talked with therapist working in those type facilities and they admit that the physicians do not observe these patients. Their observation amounts to maybe speaking to the patient if the physician happens to pass through while the patient is there for therapy. In the majority of these cases the contact was initiated by the patients themselves.

The optimum care is best provided in an environment without influencial pressure or interferrence by the referring physician. It allows therapist to think and function objectively in providing the highest quality and most appropriate care for the patients based on thier training and clinical experience. This would prove to be cost effective due to increase in successful outcomes which benefit everyone in the end.

This change does not in anyway preclude or hinder the physician and therapist relationship in providing quality care for the patient in a team approach. It actually enhances the chance for the best outcomes in a more cost efficient manner. Ater all at the end of the day, it is the patient who deserves the best that we have to offer.

Submitter : **Mr. Keith Corser** **Date: 08/30/2007**

Organization : **Mr. Keith Corser**

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,

Keith Corser

Submitter : **Jonna Emmons** **Date: 08/30/2007**

Organization : **Jonna Emmons**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Ms. Laura Corser** **Date: 08/30/2007**

Organization : **Ms. Laura Corser**

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

Rc: CMS-1385-P
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Thank you for your consideration of this serious matter.

Sincerely,

Laura Corser

Submitter : **Miss. Lori Howard** **Date: 08/30/2007**

Organization : **Valdosta State University**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

I am a certified athletic trainer in a university setting. I teach in an accredited athletic training education program, supervise athletic training students in a clinical setting and treat patients. I have a Bachelor of Science degree in Athletic Training and a Masters degree in Sports Administration. I am nationally certified (since 1995)and state licensed to practice as an athletic trainer since 1995 when I began to practice. I am a unique healthcare provider who works under the direction of a physician to provide care in a rural area of Georgia. The university that I work for, Valdosta State University, is a regional university serving a 41 county area of south Georgia. I as well as many other certified athletic trainers in all work settings provide care to underserved populations who do not have regular access to healthcare. What we do makes a difference in our patients lives. Our jobs duties are very diverse and include pre-event taping and stretching, to on site emergency management of cervical spine injuries, fractures, and dislocations, to creating and applying therapeutic exercise plans, to assessment of general medical illnesses and conditions, to maintaining medical records. This is just a small sample of the duties and responsibilities a certified athletic manages.

I am writing 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 a lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation service, which as you know is not the same as physical therapy. My education, clinical experience, national certification exam, my continuing education and teaching ensure that my patients receive quality healthcare. State law and hospital medical professionals have deemed me qualified to perform these services and the 1385-P proposed regulations attempt to circumvent current 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 about the health of Americans, especially those in rural areas, to further restrict a patients ability to receive services. The flexible current standards of staffing in hospitals and other rehabilitaion facilities are pertinent in ensuring patients receive the best, most cost effective treatment available.

Since CMS seems to have come to thse proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of the 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,

Lori Howard
Certified Athletic Trainer
Valdosta State University
Valdosta, GA

Submitter : **Matthew Jones** **Date: 08/30/2007**

Organization : **Matthew Jones**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

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)

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Thank you for your consideration of this serious matter.
John Boncyk,MD

Submitter : **Gayle Jones** **Date: 08/30/2007**

Organization : **Gayle Jones**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have been a physical therapist for the past 20 years, and I have seen the professoin go through several cycles of physician self-referral. Over the course of the past 15 years, there have been more and more bold forrays into the physician self-referral realm without concern for the rights and best interest of patients. Patients have been treated by less qualified personnel in the physician's office because the physician is said to maintain 'closer supervision' and 'greater control' of the treatment given to those patients. I have spent time in clinic with several orthopedic surgeons, and I cannot imagine that they have time to leave their clinic area and walk to another part of the building in order to supervise their patients. In truth, physician supervision of physical therapy treatments, if it truly takes place in these practices, is neither necessary nor helpful to the patient or therapist. As a profession, we have extensive training and education if the evaluation and treatment of injuries and illnesses as well as differential diagnosis. Additionally, I have been told by physicians asking my opinion regarding starting their own physical therapy practice, that they believe it would be a good business move, not that they believe it to be in the best interest of their patients. About 4 years ago, I had a colleague who had a strong referral relationship with a pair of orthopedic surgeons because of the outcomes he had with their patients. When he turned down their offer to bring him into their office to treat their patients, his business dropped by about 75% over the next 2-3 months. He was told that the decision was 'just business.' I have been told by patients that they were asked to drive past several qualified therapists in order to go to their physician's therapist in a much less convenient location. This is contrary to the claim that it is more convenient to the patient to have these services 'incident to' their visit to the physician. In actuality, the physician affiliated clinics that I am familiar with have a 1-2 week waiting period to start therapy (compared to 1-2 days for non-affiliated practices that I know). As a result, patients are waiting longer to access therapy and are being asked to put up with longer drives to therapy, less qualified staff, and greater inconvenience.

In closing, I would like to thank you for consideration of these and other comments. I hope you will find that there is a reat potential for abusive relationships that do not seek to do what is best for the patients in the care of physicians utilizing their own or financially related physical therapy practices.

Submitter : **Chris Couch** **Date: 08/30/2007**

Organization : **Chris Couch**

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,

Chris Couch

Submitter : **Melissa Kizer** **Date: 08/30/2007**

Organization : **Melissa Kizer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Catherine Ord **Date:** 08/30/2007

Organization : Newport Beach Fire Dept

Category : Local Government

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

It is respectfully requested that CMS:

' Amend 42 C.F.R. ?424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported .
' Amend 42 C.F.R. ?424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
' Amend 42 C.F.R. ?424.36(b) (5) to add or ambulance provider or supplier after provider .

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

AMBULANCE SERVICES AMBULANCE INFLATION FACTOR.

NBFD has no objection to revising 42 C.F.R ?414.620 to eliminate the requirement that annual updates to the Ambulance Inflation Factor be published in the Federal Register, and to thereafter provide for the release of the Ambulance Inflation Factor via CMS instruction and the CMS website.

Thank you for your consideration of these comments. Please see attached letter for more detailed information

CMS-1385-P-12668-Attach-1.PDF

#12668

August 30, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions.

Dear Ms. Norwalk:

On behalf of Newport Beach Fire Department (NBFD), please accept our comments on the above mentioned proposed rule. NBFD provides 9-1-1 emergency ambulance services to the City of Newport Beach. The proposed rule would have a direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. We, therefore, greatly appreciate this opportunity for public comment.

BENEFICIARY SIGNATURE

NBFD commends CMS for recognizing that providers and suppliers of emergency ambulance transportation face significant hardships in seeking to comply with the beneficiary signature requirements. Ambulance services are atypical among Medicare covered services to the extent that, for a large percentage of encounters, the beneficiary is not in a condition to sign a claims authorization during the entire time the supplier is treating and/or transporting the beneficiary. Many beneficiaries are in physical distress, unconscious, or of diminished mental capacity due to age or illness. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

We believe strongly, however, that the relief being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and on the hospitals. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for ambulance services.

Current Requirement

When the beneficiary is physically or mentally incapable of signing, the industry has been following the requirements listed in the CMS Internet Only Manual, Pub. 100-02, Chapter 10, Section 20.1.2 and Pub. 100-04, Chapter 1, Section 50.1.6(A)(3)(c). These sections require the ambulance provider or supplier to document that the beneficiary was unable to sign, the reason and that no one could sign for the beneficiary.

Summary of New Exception Contained in Proposed Rule

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. If "provider" in this context was intended to mean a facility or entity that bills a Part A Intermediary, the language should be changed to also include "ambulance supplier". The proposed exception essentially mirrors the existing requirements that the beneficiary be unable to sign and that no authorized person was available or willing to sign on their behalf, while adding additional documentation requirements. Therefore, we believe that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed sub-division (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, we do not object to the requirements that an ambulance provider obtain (1) a contemporaneous statement by the ambulance employee or (2) documentation of the date, time and destination of the transport. Nor do we object to the requirement that these items be maintained for 4 years from the date of service. However, we do not see any reason to include these in the Regulation, as they are already required and are standard practice.

The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and

the time and date the patient was received by the facility. Our organization **strongly objects** to this new requirement as:

- Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.
- Hospital personnel will often refuse to sign <u>any</u> forms when receiving a patient.
- If the hospital refuses to sign the form, it will be the beneficiary that will be responsible for the claim.
- The ambulance provider or supplier would in every situation now have the additional burden of trying to communicate to the beneficiary or their family, at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.
- Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ER Admitting Record, etc.

We also strongly object to the requirement that ambulance providers or suppliers obtain this statement from a representative of the receiving facility *at the time of transport*. Since the proposed rule makes no allowances for the inevitable situations where the ambulance provider makes a good faith effort to comply, but is ultimately unable to obtain the statement, we believe this requirement imposes an excessive compliance burden on ambulance providers and on the receiving hospitals. Consider what this rule requires—the ambulance has just taken an emergency patient to the ER, often overcrowded with patients, and would have to ask the receiving hospital to take precious time away from patient care to sign or provide a form. Forms such as an admission record will become available at a later time, if CMS wants them for auditing purposes.

<u>Institute of Medicine Report on Hospital Emergency Department Overcrowding</u>

The Institute of Medicine Committee on the Future of Emergency Care recently released a report citing hospital emergency department overcrowding as one of the biggest issues in emergency health care. According to that report, demand on hospital emergency departments (EDs) increased by 26% between 1993 and 2003. During that same period, the number of EDs fell by 425. Combined with a similar decrease in the number of inpatient hospital beds, this has resulted in serious overcrowding of our nation's ED. A further consequence has been a marked increase in the number of ambulance diversions, with 50% of all hospitals—and nearly 70% of urban hospitals—reporting that they diverted ambulances carrying emergency patients to a more distant hospital at some point during 2003.

The report recommended that hospitals find ways to improve efficiency in order to reduce ED overcrowding. However, the requirement that ambulance providers or suppliers obtain a statement from a representative of the receiving hospital at the time

of transport would only compound the existing problem, by adding an additional paperwork burden. To meet this requirement, ambulance crews would be forced to tie up already overtaxed ED staff with requests for this statement. The Institute of Medicine report makes clear that this time would be more efficiently spent moving patients through the patient care continuum.

Purpose of Beneficiary Signature

a. Assignment of Benefits – The signature of the beneficiary is required for two reasons. The first purpose of the beneficiary signature is to authorize the assignment of Medicare benefits to the health care provider or supplier. However, assignment of covered ambulance services has been mandatory since April 2002. Furthermore, 42 C.F.R. §424.55(c), adopted November 15, 2004 as part of the Final Rule on the Physician Fee Schedule (67 Fed. Reg. 6236), eliminated the requirement that beneficiaries assign claims to the health care provider or supplier in those situations where payment can only be made on an assignment-related basis. Therefore, the beneficiary's signature is no longer required to effect an assignment of benefits to the ambulance provider or supplier.

CMS recognized this in the Internet Only Manual via Transmittal 643, by adding Section 30.3.2 to Pub. 100-04, Chapter 1. As a result, the beneficiary signature is no longer needed to assign benefits of covered ambulance services.

b. Authorization to Release Records – The second purpose of the beneficiary signature is to authorize the release of medical records to CMS and its contractors. However, the regulations implementing the HIPAA Privacy Rule, specifically 45 C.F.R. §164.506(c)(3), permit a covered entity (e.g. an ambulance provider or supplier) to use or disclose a patient's protected health information for the covered entity's payment purposes, without a patient's consent (i.e. his or her signature). Therefore, federal law already permits the disclosure of medical records to CMS or its contractors, regardless of whether or not the beneficiary's signature has been obtained.

Signature Already on File

Almost every covered ambulance transport is to or from a facility, i.e. a hospital or a skilled nursing facility. In the case of emergency ambulance transports, the ultimate destination will always be a hospital. These facilities typically obtain the beneficiary's signature at the time of admission, authorizing the release of medical records for their services *or any related services*. The term "related services", when used by hospitals and SNFs, can mean more than only entities owned by or part of the facility. We believe that ambulance transport to a facility, for the purpose of receiving treatment or care at that facility, constitutes a "related service", since the ambulance transports the patient to or from that facility for treatment or admission. Therefore, we believe a

valid signature will be on file with the facility. Additionally, for those transports provided to patients eligible for both Medicare and Medicaid, a valid signature is on file at the State Medicaid Office as a product of the beneficiary enrollment process.

Electronic Claims

It is also important to note that, as a result of section 3 of the Administrative Simplification Compliance Act and the implementing regulations at 42 C.F.R. §424.32, with very limited exceptions (e.g. providers or suppliers with less than 10 claims per month), ambulance suppliers must submit claims electronically. Thus, the beneficiary does not even sign a claim form. When submitting claims electronically, the choices for beneficiary signature are "Y" or "N". An "N" response could result in a denial, from some Carriers. That would require appeals to show that, while the signature has not been obtained, an alternative is accepted. As a result, many Carriers allow a "Y", even though the signature was not actually obtained, if one of the exceptions is met.

While this may be a claims processing issue, since you are now looking at the regulation, this would be a good time to add language indicating that the signature requirement will be deemed to be met if one of the exceptions to the requirement exists.

Program Integrity

It is important for CMS to realize that, for every transport of a Medicare beneficiary, the ambulance crew completes a trip report listing the condition of the patient, treatment, origin/destination, etc. AND the origin and destination facilities complete their own records documenting the patient was sent or arrived via ambulance, with the date. Thus, the issue of the beneficiary signature should not be a program integrity issue.

Conclusion

Based on the above comments, it is respectfully requested that CMS:

- Amend 42 C.F.R. §424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that "good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported".
- Amend 42 C.F.R. §424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient

(Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.

- Amend 42 C.F.R. §424.36(b) (5) to add "or ambulance provider or supplier" after "provider".

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

AMBULANCE SERVICES – AMBULANCE INFLATION FACTOR

NBFD has no objection to revising 42 C.F.R §414.620 to eliminate the requirement that annual updates to the Ambulance Inflation Factor be published in the Federal Register, and to thereafter provide for the release of the Ambulance Inflation Factor via CMS instruction and the CMS website.

Thank you for your consideration of these comments.

Sincerely,

Catherine Ord
EMS Manager

Submitter : **Mr. Clarence Williams** **Date: 08/30/2007**

Organization : **Williams Anesthetists, LLC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Please pass this provision! CRNAs like me are an integral part of the overall health care system and need this provision to help ensure that our quality care is still available!

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Practitioner**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

August 30, 2007

Dear Sir or Madam:
I currently work in an out-patient rehabilitation setting at the Center for Sports Medicine & Orthpaedics and have been employed in this office for over 25 years. I am dually credentialed as a physical therapist and an athletic trainer and, therefore, have a broad, unique perspective on this matter.

I am writing to express my strong opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities in 1385-P. While these proposed changes have not received proper, due condsideration, I am further concerned that these proposed rules will create an additional lack of access to qualitiy health care for the patients I serve and to whom I have dedicated my professional career.

As an athletic trainer, I am qualified to perform physical medieine and rehabilitative services, which is not the same as physical therapy. My college education, clinical experience, and national certification examination 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 thoughout the health care industry. It is irresponsible for CMS , which is purportedly concerned with the health of Americans, especially those in rural areas, to further restrict patient's ability to receive those services.

Since CMS appears to have come to these proposed changes without clinical or financial justification, I would strongly encourage 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 CMS withdraw the proposed changes related to hospitals, rural clinics and any Mediciare Part A or B hospital or facility.

Sincerely,

Robert Nevil, ATC, PT

Submitter : Mrs. Denise Webber **Date:** 08/30/2007

Organization : Stillwater Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

I would like to comment on the much needed review of anesthesia codes and highly support the increase suggested. It is becoming increasing difficult to provide services at the current reimbursement levels. Any increase would be well received.

Submitter : **Dean Slatev** **Date: 08/30/2007**

Organization : **Dean Slatev**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Sydney Couch **Date:** 08/30/2007

Organization : Sydney Couch

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
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P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Sydney Couch

Submitter : **Carrie Wall** **Date: 08/30/2007**

Organization : **Carrie Wall**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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P.O. Box 8018
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Thank you for your consideration of this serious matter.

Submitter : **Henry Slatev** **Date: 08/30/2007**

Organization : **Henry Slatev**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Submitter : Terry Covey **Date:** 08/30/2007

Organization : Terry Covey

Category : Health Care Professional or Association

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter

Sincerely,

Terry Covey.

Submitter : **Betty Slatev** **Date: 08/30/2007**

Organization : **Betty Slatev**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Reida Jones** **Date: 08/30/2007**

Organization : **Reida Jones**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Submitter : **Dr. Emily Smith Fischer** **Date: 08/30/2007**

Organization : **Dr. Emily Smith Fischer**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Ray Jones** **Date: 08/30/2007**

Organization : **Ray Jones**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Dr. Hossam Tantawy** **Date: 08/30/2007**

Organization : **Dr. Hossam Tantawy**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : Dr. Zaheer Pajnigar **Date:** 08/30/2007

Organization : KUMC, Dept. Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

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Submitter : **James Dyer** **Date: 08/30/2007**

Organization : **James Dyer**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Submitter : **Ms. Bernice Cunningham** **Date: 08/30/2007**

Organization : **Ms. Bernice Cunningham**

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
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Sincerely,
Bernice Cunningham

Submitter : **Regina Dyer** **Date: 08/30/2007**

Organization : **Regina Dyer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Submitter : **Mr. Ron Cruse** **Date: 08/30/2007**

Organization : **Mr. Ron Cruse**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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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,

Ron Cruse

Submitter : **James Dyer** **Date: 08/30/2007**

Organization : **James Dyer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Submitter : **Arthur Flewelling** **Date: 08/30/2007**

Organization : **Arthur Flewelling**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Mr. Donald Howard** **Date: 08/30/2007**

Organization : **Department of Veterans Affairs**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

RE: Docket #1385-P Therapy Standards and Requirements, Physician Self-Referral Provisions

My name is Donald Howard and I am a registered Kinesiotherapist and registered clinical exercise physiologist, currently employed by the Department of Veterans Affairs Medical Center, in Richmond Virginia. I have been a Kinesiotherapist for 29 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 exeluded from providing physical medicine and rehabilitation services under these rules.

I am concerned that these proposed rules will create additional lack of access to quality health care for my patients. This is particularly important because my colleagues and I work with many wounded Veterans, an increasing number of whom are expected to receive services in the private market. These Medicare rules will have a detrimental effect on all commercial-pay patients because Medicare dictates much of health care business practices.

I believe these proposed changes to the Hospital Conditions of Participation have not received the proper and usual vetting. CMS has offered no reports as to why these changes are necessary. There have not been any reports that address the serious economic impact on Kinesiotherapists, projected increases in Medicare costs or patient quality, safety or access. What is driving these significant changes? Who is demanding these?

As a Kinesiotherapist, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, and Registered status insure that my patients receive quality health care. Hospital and other facility medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards and accepted practices.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the health care industry. It is irresponsible for CMS to further restrict PMR services and specialized professionals.

It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to reconsider these proposed rules. Leave medical judgments and staffing decisions to the professionals. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Donald J. Howard , RKT, RCEP

Submitter : **Ms. Sanndra Cruse** **Date: 08/30/2007**

Organization : **Ms. Sanndra Cruse**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Lcslic V. Norwalk, Esq.
Acting Administrator
Centers for Mcdicarc 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 Reviciw)

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Thank you for your consideration of this serious matter.

Sincercly,

Sanndra Crusc

Submitter : **Jane Wingquist** **Date: 08/30/2007**

Organization : **Jane Wingquist**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Mike Mitchell** **Date: 08/30/2007**

Organization : **Mike Mitchell**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Mr. Lee Daniels** **Date: 08/30/2007**

Organization : **Mr. Lee Daniels**

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

Lee Daniels

Submitter : **Suzanne Mitchell** **Date: 08/30/2007**

Organization : **Suzanne Mitchell**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Chris McConnell** **Date: 08/30/2007**

Organization : **Chris McConnell**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Kim Daniels** **Date: 08/30/2007**

Organization : **Kim Daniels**

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

Rc: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Sincerely,

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Submitter : **harold Mitchell** **Date: 08/30/2007**

Organization : **harold Mitchell**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Submitter : Mr. JERRY ROBERTSON **Date:** 08/30/2007

Organization : WATAUGA ORTHOPAEDICS PLC

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

My name is Jerry L.Robertson. BS, MEd. I have worked in the PHYSICAL/HEALTH/REHABILITATION PROFESSION for the last 42 years. The first 38 years at the college/university setting and last 4 years in the orthopaedic clinic setting. In both settings, I EXPERIENCE WORKING WITH ALL AGES UNDER THE SUPERVISION OF PHYSICAN.

Submitter : **Dr. Kirsten J Simanonok** **Date: 08/30/2007**

Organization : **Dr. Kirsten J Simanonok**

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

Rc: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Respectfully,

Kirsten J Simanonok, MD

Submitter : **Rebecca Dyer** **Date: 08/30/2007**

Organization : **Rebecca Dyer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Baltimore, MD 21244-8018

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Submitter : **Marissa Oachs** **Date: 08/30/2007**

Organization : **MNSU**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Senior 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 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,

Marissa Oachs,
Athletic Training Student at Minnesota State University, Mankato

Therapy Standards and Requirements

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Sincerely,

Marissa Oachs,
Athletic Training Student at Minnesota State University, Mankato

Submitter : **Elizabeth Harrison** **Date: 08/30/2007**

Organization : **Elizabeth Harrison**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Alan Day** **Date: 08/30/2007**

Organization : **Alan Day**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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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

Alan Day

Submitter : **Mr. Jason Shelnutt** **Date: 08/30/2007**

Organization : **Georgia Urology**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Centers for Medicaid and Medicare

Access to high quality timely diagnostic results is a key to providing effective care to our patients at a lower overall cost to the Medicare program. Many of the proposed changes to the regulations implementing the Stark Laws would hinder our ability to provide appropriate care to our patients. Our comments below are a summary of the responses of the 33 urologists that work with our practice.

Many practices including ours provide pathology laboratories to facilitate high quality results reported in a timely fashion for the patients of our practice. We have part time and full time pathologists working at our facility each day. To require that all pathologists be full time in an undue burden to our practice and the individual pathologist. It will hinder incremental growth, obtaining coverage for time off and screen out qualified pathologists who would enjoy working with us part time but prefer to keep their skill base in other areas of pathology and some who for personal reasons choose to work less than full time. We do not understand how this would lower the cost of the Medicare program. We believe it will delay care for a patient with a significant illness perhaps adding to the cost of care.

Another proposed change is to the definition of a centralized building . We are a practice with 22 locations. We make a point of trying to deliver quality care to a patient in their community. As a result some our pathology services are furnished at one location in a facility within our city that is better suited for this purpose. You cannot provide this in a practice office due to the significantly different cooling and ventilation requirements. Doing so would jeopardize the process and our patients. We understand that some practices locate centralized buildings in different states and you may want to address that, but we request that you do not change the regulations in a manner that inadvertently hinders many quite legitimate operations, thereby delaying care and increasing the cost.

You have also proposed changes that would prohibit per click equipment rental arrangements with facilities where our physicians refer patients. We believe that would eliminate the availability of cryotherapy as a treatment option within our community. This is a very cost effective, appropriate treatment option which is not selected by a large number of our patients. A number of interested Urologists in our community have joined together and purchased the necessary equipment. The equipment is made available to many hospitals in Georgia and adjacent states, none of which are likely to make the substantial investment to make the service available on their own. Because of the variability of the need, hospitals cannot risk a fixed rate contract on such a low volume service. The changes you are proposing would eliminate this as a low cost treatement option in our state.

I appreciate your willingness to accept comments from parties who understand the consequences of your proposed changes. While we understand your intent, using such broad brush changes in the regulations would harm Medicare recipients by decreasing timely and effective care.

Submitter : **Michael Dyer** **Date: 08/30/2007**

Organization : **Michael Dyer**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. Ramiro Hernandez** **Date: 08/30/2007**

Organization : **Mr. Ramiro Hernandez**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

Dear Administator,

I am a Certified Registered Nurse Anesthetist (CRNA)and a member of the American Association of Nurse Anesthetists (AANA). I write because I have great cocern in the trending of anesthesia work valuation and reimbursement by Medicare. In recent years, the conversion factor (cf) has continually declined and has been lagging as much as 50% of other Part B providers. This continuing trend has grave consequences where anethesia services are already at a critical shortage. Critical shortage areas that see continuing Medicare cuts and no recovery of the cf for anesthesia services, coupled with higher Medicare payor mix are increasingly at risk.

As a chief CRNA in West Texas, I see first had the difficulty of attracting anesthesia providers to the area. The Hospital has to increasingly subsidize the anesthesia department in the face of decrasing Medicare remimbursement and higher Medicare payor mix.

I urge CMS to pass the proposed to boost the value of anesthesia work by 32%. This would go a long way in helping anesthesia providers continue to provide Medicare beneficiaries with access to anesthesia services.

Sincerely,

Ramiro N. Hernandez CRNA, MSN
Chief CRNA, Providence Mem. Hosp.

Submitter : **Terence Chilson** **Date: 08/30/2007**

Organization : **Terence Chilson**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Acting Administrator
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Thank you for your consideration of this serious matter.

Submitter : alice day **Date:** 08/30/2007

Organization : alice day

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
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Thank you for your consideration of this serious matter.

Sincerely

Alice Day

Submitter : **Dr. Gary Smith** **Date: 08/30/2007**

Organization : **Dr. Gary Smith**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

AcLeslie V. Norwalk, Esq.
ting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Gary W. Smith
8140 N. Mopac Expressway
Bldg. 3 Suite 210
Austin, Tx 78759

Submitter : **John Dyer** **Date: 08/30/2007**

Organization : **John Dyer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Submitter : Mrs. Lynn Littlejohn-Cyr **Date:** 08/30/2007

Organization : Wolford College

Category : Other Health Care Professional

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 & Mcdicaid 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 cnsure 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 havc 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. Howcver, the valuc of ancsthesia 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 valuc of ancsthcsia scrvicc 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 ratc (SGR) cut to Medicare payment, an averagc 12-unit anesthesia scrvice in 2008 will be reimbursed at a ratc about 17% below 2006 payment levels, and more than a third below 1992 payment lcvcls (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting rcquiring ancsthcsia services, and are the predominant anesthesia providers to rural and medically underserved Amcrica. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthcsia scrvices 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 thc valuation of ancsthcsia work in a manner that boosts Mcdicare anesthesia payment.

Submitter : **Date: 08/30/2007**

Organization : **Iowa Medical Society**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

CMS is applying unfair GPCI cuts to the technical component of imaging studies. The technical component imaging fees in Iowa or rural Missouri are much lower than in San Francisco, yet the practice expense costs are much more equivalent. For example, the TC fee for a brain PET scan is $1,268 in San Francisco, $725 in Iowa, and $691 in rural Missouri. Though rent and wage expenses are greater in San Francisco, the cost of MRI and PET scan equipment is a far greater portion of a clinic's budget than are the wages or rent costs. For one 175-physician multi-specialty clinic in central Iowa, its PET scan budget shows equipment costs are 77-78% of the budget. By cutting the TC payment for MRI and PET scans by almost half, when the majority of expenses are identical to those in California, CMS is unfairly penalizing low GPCI localities. Rural regions (low GPCI localities) are in jeopardy of losing the ability to do MRI or PET scans because of these unrealistic and unfair GPCI cuts.

Geographic Practice Cost Indices (GPCIs)

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GPCI practice expense (PE) adjustments are not determined accurately. The GPCI PE wage category proxies of using only four occupations are outdated and far from representative of the real wage costs for physicians in many localities. The GPCI PE rent category expenses are also inaccurate because they use as proxy the HUD apartment rental rates, which do not represent the relatively higher expenses in rural areas for rental of medical office space. Though there is admittedly no perfect data source, Medical Group Management Association (MGMA) data on office rent is quite at variance from the current system. For example, the percentage of total expenses in the MGMA survey shows rent is about 11-12% of the total expenses, wages about 52-53%, and equipment and supplied about 36-37%. The weighting by CMS of the categories, especially rent (at 28%), means that differences in rent expenses are overestimated. Improper weighting also results in diminishing the equipment and supply category (which is the same in all GPCI localities). With increasing costs of new electronic health records, this equipment category is not accurately weighted by CMS (at 29%). There are other costs that affect a physician's choice of practice location, such as outreach expenses and call burden, which are not even measured. The magnitude of these GPCI adjustments (as much as 38% differences in Medicare fees) has resulted in placing rural areas -- especially where outreach and call burdens are heavier -- at a disadvantage for recruitment and retention.

The California GPCI problems illustrate the problem of migration of physicians from lower GPCI localities to higher paid GPCI localities. Rural areas and low GPCI localities have understood this for many years. In 1996, physicians in Iowa -- and other states, e.g., Minnesota -- voted to eliminate the multiple GPCI localities and make the state a single payment locality because of the concern about physicians leaving the rural areas and migrating to larger cities.

Iowa physicians will strenuously object to any California GPCI remedy without a comprehensive review of the entire GPCI policy.

TRHCS--Section 101(b): PQRI

TRHCS--Section 101(b): PQRI

The PQRI reporting bonus payment is proposed to be about 1.5% of the total Medicare billing of the individual physician. This means that for an equal amount of RVU work -- after GPCI adjustments -- the physicians in lower GPCI localities will receive as much as 38% less PQRI payment for the same work, time, and effort used in providing quality care. Quality payments should not be geographically adjusted. The PQRI payment should be based on RVUs, not on dollars billed to Medicare.

Submitter : **William Dyer** **Date: 08/30/2007**

Organization : **William Dyer**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Paul Day** **Date: 08/30/2007**

Organization : **Paul Day**

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
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Paul Day

Submitter : **Alyssa Ramirez** **Date: 08/30/2007**

Organization : **Alyssa Ramirez**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
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Submitter : **Phillip Rose** **Date: 08/30/2007**

Organization : **Phillip Rose**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Submitter : **Eve Friedman** **Date: 08/30/2007**

Organization : **Eve Friedman**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Submitter : **Verlan Day** **Date: 08/30/2007**

Organization : **Verlan Day**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Sincerely

Verlan Day

Submitter : **Steven Gifford** **Date: 08/30/2007**

Organization : **Steven Gifford**

Category : **Individual**

Issue Areas/Comments

GENERAL

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

Organization : **Orthopaedics and Sports Medicine**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

In regards to the issue of disallowing physician owned physical therapy clinics we feel as though this would be detrimental to the patients and affect the quality of care they receive. As a group of orthopaedic surgeons that own a pt clinic we feel as though this would be an injustiee to the patients. We communicate well our therapist and are able to address concerns such as blood clots, complications, and non compliance immediately.

Our patient are able to choose where they want to do their physical therapy and many people choose to do it here because of convenience(i.e one bill) and for the continuity of care. We provide quality care by licensed physical therapist. We do agree that therapy should be provided by a licensed therapist and not by indviduals not licensed. Please reconsider taking therapy away from the clinic setting.

David W. Bobb MD
R Brad Vogel DO
William P Harris MD
Mark R Moses MD
Steven P Schultz MD

Submitter : **Michael Hollar** **Date: 08/30/2007**

Organization : **Michael Hollar**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Alex Baird **Date:** 08/30/2007

Organization : City of Hallandale Beach Fire Rescue

Category : Local Government

Issue Areas/Comments

Ambulance Services

Ambulance Services

It is sometimes very difficult to obtain a patient signature for medicare purposes when responding to a 911 emergency. Many patients are not in a condition to sign. Our first concern is for the patients' condition and immediate health issue. Obtaining a nurse's signature is also difficult as the hospital nursing staff has the same concerns for patient care as the field medics.
All patient records are official and can be verified by comparing hospital and ambulance records. Obtaining additional signatures to verify the patient was transported and care for should not be a concern when making payment for services.

Submitter : **Elizabeth Hyslop** **Date: 08/30/2007**

Organization : **Elizabeth Hyslop**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Barbara Dooley** **Date: 08/30/2007**

Organization : **Barbara Dooley**

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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Thank you for your consideration of this serious matter.

Sincerely,
Barbara Dooley

Submitter : Mr. Clarence Williams **Date:** 08/30/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

I support the measure to increase payment for anesthesia care by 32%!

CMS-1385-P-12730-Attach-1.PDF

#12730

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.

- 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,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Joseph Locke** **Date: 08/30/2007**

Organization : **Joseph Locke**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Melvin Nunn **Date:** 08/30/2007

Organization : Melvin S. Nunn, M.D.,Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment. I agree to the necessary increase for our Medicare reimbursement which is already too low to sustain clinical care!

#12732

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Dr. Doug Miller Miller, DPT, OCS **Date:** 08/30/2007

Organization : Rehabilitation Centers of Charleston

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

To whom it concerns,
Stark law as Congress ruled and intended is to prevent physicians to refer for profit. I understand actions are being made to make a loophole in this law to allow ancillary services, such as physical therapy, to be performed. To lawfully practice physical therapy one must attend and graduate from an accredited school of physcal therapy and then sit and pass a state licensure exam. Opening the door to allow ancillary services to be performed in a physician's office for his profit demeans the physical therapy profession and could endanger patients in that they may receive so called physical therapy services by individuals without adequate training, accreditation and/or licensure. Please help us protect the integrity of the physical therapy profession and the safety of our patients by not allowing a loophole to permit the possibility of physician referral for profit.

Submitter : **Arthur Mensch** **Date: 08/30/2007**

Organization : **Arthur Mensch**

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.

Submitter : **Tom Dudley** **Date: 08/30/2007**

Organization : **Tom Dudley**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Tom Dudley

Submitter : **John Park** **Date: 08/30/2007**

Organization : **John Park**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Rachael Smith** **Date: 08/30/2007**

Organization : **Rachael Smith**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Mehrdad Sharif** **Date: 08/30/2007**

Organization : **California Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Re CMS 1385-p
Anesthesia Coding

Dear Ms. Norwalk:

I strongly support the proposal to increase anesthesia payment under 2008 physician fee schedule and I am grateful that CMS has reeognized the gross undervaluation of anesthesia services.

Thank you for your consideration of this serious matter.

Sincerely,
Mehrdad Sharif,MD

Submitter : **Janice Schwalb** **Date: 08/30/2007**

Organization : **Janice Schwalb**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Allen Baudendistel, MD** **Date: 08/30/2007**

Organization : **Ballas Anesthesia, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Dr. Allen D. Baudendistel, MD

Ballas Anesthesia, Inc.

Submitter : **Dr. Francesca Niro** **Date: 08/30/2007**

Organization : **Yale Deptartment Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Francesca M. Niro, MD
Yale Department of Anesthesiology

Submitter : **Leslie Stockel** **Date: 08/30/2007**

Organization : **Leslie Stockel**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Submitter : **Kay Dudley** **Date: 08/30/2007**

Organization : **Kay Dudley**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Kay Dudley

Submitter : Mr. Daniel Sedory **Date:** 08/30/2007

Organization : University of New Hampshire

Category : Health Care Professional or Association

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am an athletic trainer and associate clinical professor of athletic training at the University of New Hampshire. I have been practicing as an athletic trainer since 1983 and have been teaching athletic training courses since 1986.

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,

Daniel Sedory, ATC

Submitter : **Diane White** **Date: 08/30/2007**

Organization : **Diane White**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Wendy Wong** **Date: 08/30/2007**

Organization : **Wendy Wong**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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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 : Gary Ellis **Date:** 08/30/2007

Organization : Gary Ellis

Category : Health Care Professional or Association

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Gary Ellis

Submitter : Mr. Steven Brown **Date:** 08/30/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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.

Submitter : **Shadynne de Armendi** **Date: 08/30/2007**

Organization : **Shadynne de Armendi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. John Ehrfurth** **Date: 08/30/2007**

Organization : **Marshfield Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

Medicare Telehealth Services

Medicare Telehealth Services

see attachment for total comments

#1275

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Philip deArmendi** **Date: 08/30/2007**

Organization : **Philip deArmendi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

Rc: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Linda Ellis** **Date: 08/30/2007**

Organization : **Linda Ellis**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.
Linda Ellis

Submitter : **Fernando deArmendi** **Date: 08/30/2007**

Organization : **Fernando deArmendi**

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.

Submitter : **Ms. Kelli Sabiston** **Date: 08/30/2007**

Organization : **Ms. Kelli Sabiston**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:
My name is Kelli Sabiston and I am a certified athletic trainer. I am also licensed to practice athletic training in Georgia, Florida, and North Carolina. Throughout my career, I have practiced in the high school setting, the rehabilitation clinic setting, and in the private sector. As of now, I am a consultant for American Specialty Health Services, a health benefit provider. I hold a Bachelor s degree from Wake Forest University and a Master s degree from the University of North Carolina. Like all athletic trainers, I must complete at least 80 hours of continuing education every three years in order to maintain national certification. As defined by the American Medical Association, I am an allied health care professional.

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,
Kelli B. Sabiston, MS, ATC, LAT
Shallotte, NC

Submitter : **Dr. Alfred Belen** **Date: 08/30/2007**

Organization : **Dr. Alfred Belen**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Respectfully,
Alfred Belen, M.D.

Submitter : **Marietica deArmendi** **Date: 08/30/2007**

Organization : **Marietica deArmendi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Jane Erlitz** **Date: 08/30/2007**

Organization : **Mercy Medical Center**

Category : **Occupational Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I work in a large medical center that provides both inpatient and outpatient therapy services. We have very experienced and skilled therapists who are able to provide therapy services. Over the past several years, several of the large orthopedic physician practices have hired therapists to provide therapy services in their buildings. While it is marketed as a benefit to their patients because of the continuity and proximity of the therapist and physicians, it is often discussed among the physicians as a "way to make money". In addition, these physicians are telling their patients they must go to their office for therapy because of all of the benefits it will provide them. Choice is not discussed and often if a patient speaks up that they would like to go elsewhere, they are discouraged. This is also echoed by the office staff in these practices. Bottom line is that patients do not feel they have a choice, feel they may be penalized if they go elsewhere, may have additional copayments if they go to their offices (something they are not made aware of up front), and the phsycians are profiting from this situation.

It is unethical to profit from a practice such as this and patients are not aware of choices that they have in outpatient services.

Submitter : Alex de Armendi **Date:** 08/30/2007

Organization : Alex de Armendi

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Thank you for your consideration of this serious matter.

Submitter : **Mrs. Barbara Henry** **Date: 08/30/2007**

Organization : **Culbertson Memorial Hospital/Rushville, IL**

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 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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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).
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Sincerely,

Barbara Jane Henry, CRNA 30318
106 Nansarah Drive
Jacksonville, IL 62650

Submitter : **Mark Ellis** **Date: 08/30/2007**

Organization : **Mark Ellis**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Mark Ellis

Submitter : Mr. Andrew Filion **Date:** 08/30/2007

Organization : Long Trail Physical Therapy

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Hello, my name is Andy Filion, I am a Certified Athletic Trainer working at Long Trail Physical Therapy in Burlington, Vermont. I also provide Athletic Training services for Burlington High School, through an outreach program with Long Trail.

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,

XXXXXX, ATC (and/or other credentials)

Submitter : Dr. Jon Fiebing **Date:** 08/30/2007

Organization : Traverse Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

My father was an Anesthesiologist and I followed in his footsteps,
but there may not be any more from my family unless you can help.

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 in advance, It would be nice if my family continued the tradition for another generation,
Sincerely Jon Fiebing

Submitter : **Dr. Ray Lansing** **Date: 08/30/2007**

Organization : **Bend Anesthesia Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Submitter : **Miss. Katherine Knight** **Date: 08/30/2007**

Organization : **DePaul University**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Good afternoon. My name is Katy Knight. I am a certified athletic trainer, licensed by the State of Illinois, working as a graduate assistant at DePaul University. I have earned a bachelor's of science degree from the University of Wisconsin-Madison in Kinesiology and am currently working towards a Mater's of Education in Educational Leadership here at DePaul University.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

Katherine D. Knight, ATC

Submitter : **Maria deArmendi** **Date: 08/30/2007**

Organization : **Maria deArmendi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Carlos deArmendi** **Date: 08/30/2007**

Organization : **Carlos deArmendi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : Dr. Michael Sacher **Date:** 08/30/2007

Organization : Michael Sacher DO PC

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

see attached comment.

CMS-1385-P-12770-Attach-1.TXT

#12770

MICHAEL L. SACHER, DO, FACP, FACC
Cardiac Nuclear Imaging Laboratory
100 Veterans Blvd.
Massapequa, NY 11758
(516) 882-9600

August 30, 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 testing. 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 the test.

In patients at high risk for sudden cardiac death, Medicare has expanded coverage of implantable cardiovert 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 that 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.

Sincerely,
Michael Sacher, DO

Submitter : **Aime deArmendi** **Date: 08/30/2007**

Organization : **Aime deArmendi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Carlos deArmendi** **Date: 08/30/2007**

Organization : **Carlos deArmendi**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Peter Hubbs** **Date: 08/30/2007**

Organization : **Spectrum Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Monica deArmendi** **Date: 08/30/2007**

Organization : **Monica deArmendi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Eugene fielder** **Date: 08/30/2007**

Organization : **Eugene fielder**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Eugene Fielder

Submitter : **Esperanza Collado** **Date: 08/30/2007**

Organization : **Esperanza Collado**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Rc: CMS-1385-P
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Submitter : **Allyson Collado** **Date: 08/30/2007**

Organization : **Allyson Collado**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Lcslie V. Norwalk, Esq.
Acting Administrator
Ccnters for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

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Submitter : **Jay Thomas** **Date: 08/30/2007**

Organization : **Jay Thomas**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Submitter : Mr. Andy Sterba **Date:** 08/30/2007

Organization : Athletico

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

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Sincerely,

Andy Sterba M.S., ATC

Submitter : **Marianna fielder** **Date: 08/30/2007**

Organization : **Marianna fielder**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Marianna Fielder

Submitter : Joyce Thomas **Date:** 08/30/2007

Organization : Joyce Thomas

Category : Individual

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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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.

Submitter : **Belinda Turner** **Date: 08/30/2007**

Organization : **Belinda Turner**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Submitter : Lee Turner **Date:** 08/30/2007

Organization : Lee Turner

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Johnny Thomas** **Date: 08/30/2007**

Organization : **Johnny Thomas**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Rachel Fielder** **Date: 08/30/2007**

Organization : **Rachel Fielder**

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
Ccnters for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

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Rachcl Fielder

Submitter : **Rhonda Thomas** **Date: 08/30/2007**

Organization : **Rhonda Thomas**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Anesthesia Coding (Part of 5-Year Review)

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Submitter : **Date: 08/30/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Justine Dautenhahn** **Date: 08/30/2007**

Organization : **Justine Dautenhahn**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Elizabeth Kennedy** **Date: 08/30/2007**

Organization : **Saint Peter's College**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Elizabeth Kennedy and I am a Certified Athletic Trainer at Saint Peter's College in Jersey City, NJ. I have been working in the athletic training field for four years and am concerned about the future of our profession.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Elizabeth Kennedy, MS, ATC

Submitter : **Bruce Saxon** **Date: 08/30/2007**

Organization : **Bruce Saxon**

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.

Submitter : **Jan Saxon** **Date: 08/30/2007**

Organization : **Jan Saxon**

Category : **Individual**

Issue Areas/Comments

GENERAL

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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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Submitter : **Sarah Perkins** **Date: 08/30/2007**

Organization : **Sarah Perkins**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Serviees
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Patricia Brewster** **Date: 08/30/2007**

Organization : **Southern Orthopaedic Specialists, LLC**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

RE: Comments to CMS-1385-P, RIN 0938-A065, Federal Register Notice Vol. 72, No. 133 issued Thursday, July 12, 2007
Southern Orthopaedic Specialists, LLC appreciates the opportunity to comment on the Centers for Medicare and Medicaid (CMS) solicitation for comments regarding amending the in-office ancillary exception of the Physician Self Referral Provisions. Southern Orthopaedic Specialists is a 14 physician private orthopaedic practice located in the metropolitan Atlanta area.

We are dedicated to providing the highest level of diagnostic musculoskeletal treatment and care. Part of our service continuum includes the desire for our patients to be seen and treated at providers that are convenient to the patients and that share our same high level of treatment protocols. We feel strongly that the physician s involvement in ancillary modalities such as physical and occupational therapy, Magnetic Imaging, CT and certain DME is crucial to the patient s successful treatment outcome.

Physician Self-Referral Provisions: In-Office Ancillary Exception
Southern Orthopaedic Specialists believes that the original intent of the In-Office Ancillary Exception which permits physicians to provide certain designated health services in conjunction with the diagnosis and treatment of medical conditions is currently both appropriate and effective; needing limited changes to protect the program s integrity.

We believe that CMS should not limit the incident-to services to include only services performed at the time of the office visit. In many instances, it may be more clinically appropriate for the patient to come back to the office for services at a time different from the office visit. Furthermore it is the practices belief that a physician can provide services that are specialized to a patients needs. For example, many orthopaedic practices have physical therapy in their office. The therapists are trained specifically to handle orthopaedic protocols. This creates a focused factory environment whereby the orthopaedic patient receives therapy by a therapist that only performs orthopaedic modalities, thus increasing the probability for a faster and more complete recovery then if the patient received therapy in the community.

Southern Orthopaedic Specialists favors CMS clarifying the Centralized Building exception. Specifically, the practice believes that physician groups with multiple locations should be able to utilize the Centralized Building Exception and the In-Office Ancillary Exception. The practice further believes that service provided pursuant to the Centralized Building Exception should only be allowed if the practice owns and actively manages the designated health service.

Sincerely,

Patricia L. Brewster
Chief Executive Officer

CMS-1385-P-12794-Attach-1.PDF

Submitter : **Donnie Perkins** **Date: 08/30/2007**

Organization : **Donnie Perkins**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Patrick Sexton **Date:** 08/30/2007

Organization : Minnesota State University

Category : Health Care Provider/Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I curently serve as the Director of Athletic Traning eDucation at Minnesota State University and I have been a Board Certified Athletic Trainer since 1985. We currently graduatc 18 students each year from our athletic training program. These graduate are highly qualified following intensive didaetic, laboratory, and clinical study and they are looking for positions in hospitals and clinics.

I am writing today to voice my strong opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will cause many colleagues to lose their jobs and my students will not be able to find the positions for which they are qualified!

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. The education, clinical experience, and national certification exam ensure that certified/licensed athletic trainers are qualified to provide care to a variety of patients. State law and hospital medical professionals have deemed athletic trainers as 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. In addition I find it more than disconcerting that a branch of the United States govenrment would work toward the elimination for jobs for which many highly qualified professionals currently occupy!

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,
Patrick Sexton EdD, ATC

Submitter : **Lonnie Fitzpatrick** **Date: 08/30/2007**

Organization : **Lonnie Fitzpatrick**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Lonnie Fitzpatrick

Submitter : Mr. Patrick Sheehy **Date:** 08/30/2007

Organization : Optimal Physical Therapy and Sports Performance

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have been a Pennsylvania licensed physical therapist for 19 years. I am also a private practice owner in Cranberry Twp., PA for 4 1/2 years. I witnessed abuse and over utilization of PT services in a physician owned clinic in the last 1980-early 1990s before Stark II significantly limited this referral for profit situation. Some how attorneys and doctors have found ways around this and physician owned clinics (PTOPs)are again popular in our area. Many patients are strongly pursuaded to use these POPTs instead of the facility they want and do not realize they can go elsewhere because other options are not presented. I have seen an approximate 70% decrease in orthopedic physician referrals to my practice in the past 2 years from 2 ortho groups that opened these PT practices. This coupled with University of Pittsburgh and Allegheny General Hospital systems owned physicians being strongly encouraged (and tracked)to keep all referrals for PT and other services within their hospital system and satellite PT clinics. It is my understanding that the POPTS and hopital systems are required to offer other options for PT services other than the options that financially benefit the referring doctor or group. This does not occur. I was contacted by a physical therapist recently who was leaving a local POPTS because the PT director was seeing patients for double the time frame each session that was expected including Medicare joint replacements and being charged over $300 per session. It is obvious that the PT director is probably incentivized financially on revenues since the staff PTs were given bonuses when they treated over a certain number of patients. The PT to PT aide ratio needs to be monitored by CMS for quality assurance. I strongly suggest that CMS monitor POPTS compared to private practice PT clinics in the Pittsburgh area for certain common diagnoses for cost of total PT treatment. The potential for fraud and abuse exists in the POPTS including with Medicare patients. Patients are given a false impression that if they attend PT at the POPTS that their doctor will be keeping a closer supervision level to the patient whereas in reality the doctor never steps into their clinic during patient hours. I know for a fact that POPTs front office staff have told patients this to make them attend. Please consider eliminating physical therapy as a designated health service furnished under the in-office ancillary services exception. I have also heard many physician owned PT clinics are using the reassignment of benefits laws to collect payment in order to circumvent the "incident-to" requirements. I feel eliminating the self-referral process would keep the quality of care at a higher level and lower expense to CMS as well as all other insurances due to competition of PT providers in area. Thank you for your time and consideration. Patrick Sheehy, MS, PT, President

Submitter : **Gretchen Wienecke** **Date: 08/30/2007**

Organization : **Gretchen Wienecke**

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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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 : **Robert Herre** **Date: 08/30/2007**

Organization : **Robert Herre**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Submitter : nancy Wienecke **Date:** 08/30/2007

Organization : nancy Wienecke

Category : Individual

Issue Areas/Comments

GENERAL

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Submitter : **Suzanne Fitzpatrick** **Date: 08/30/2007**

Organization : **Suzanne Fitzpatrick**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Suzanne Fitzpatrick

Submitter : **Dr. Abraham Mandel** **Date: 08/30/2007**

Organization : **Dr. Abraham Mandel**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

See attached letter.

CMS-1385-P-12803-Attach-1.DOC

#12803

Leslie V. Norwalk, Esq.
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Submitter : **Lankike Abeyewardene** **Date: 08/30/2007**

Organization : **Lankike Abeyewardene**

Category : **Physician**

Issue Areas/Comments

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Submitter : **Chris Forbes** **Date: 08/30/2007**

Organization : **Chris Forbes**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Centers for Medicare and Medicaid Services
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Chris Forbes

Submitter : **Nelun Perera** **Date: 08/30/2007**

Organization : **Nelun Perera**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Submitter : **Gerard Perera** **Date: 08/30/2007**

Organization : **Gerard Perera**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Submitter : Mr. Darrell Reed **Date:** 08/30/2007

Organization : University Hospitals

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Please find attached letter. I find the CMS trend to limit and modify staffing an increasing problem. This trend is not good for our physically active population and may be detrimental to the health of all americans.

CMS-1385-P-12808-Attach-1.DOC

12808

Dear Sir or Madam:

I am a nationally certified and state licensed Athletic Trainer in Ohio. I currently work for University Hospitals in an outpatient rehabilitation clinic as such I have the opportunity to perform rehabilitation services under the scope of my state license. I completed my Bachelor's degree in Biomedical Engineering with a Sports Medicine minor in 1989 which lead to my national board certification in May 1989. I was approved for licensure in Ohio in 1993.

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 ideally proposed, 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,

Darrell E Reed, MA, ATC

Submitter : **Rajendra Amin** **Date: 08/30/2007**

Organization : **Rajendra Amin**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Rc: CMS-1385-P
Ancsthcsia Coding (Part of 5-Year Review)

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Submitter : **Angela Forbes** **Date: 08/30/2007**

Organization : **Angela Forbes**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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Angela Forbes

Submitter : **Dr. Todd Letzring** **Date: 08/30/2007**

Organization : **Anesthesia Consultants of St. Petersburg**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Sincerely,

Todd Letzring, DO
4701 Duhme Rd. #1C
St. Petersburg, FL 33708
727-510-6285

Submitter : **Rohit Amin** **Date: 08/30/2007**

Organization : **Rohit Amin**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Submitter : **Rakesh Amin** **Date: 08/30/2007**

Organization : **Rakesh Amin**

Category : **Individual**

Issue Areas/Comments

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Submitter : **Mike Forbes** **Date: 08/30/2007**

Organization : **Mike Forbes**

Category : **Individual**

Issue Areas/Comments

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Mike Freeman

Submitter : **Sapna Amin** **Date: 08/30/2007**

Organization : **Sapna Amin**

Category : **Health Care Professional or Association**

Issue Areas/Comments

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Submitter : **Mr. Chris Junkins** **Date: 08/30/2007**

Organization : **American Physical Therapy Association**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P

Subject: Medicare Program; Proprosed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

Mr. Weems,

My name is Chris Junkins and I have been a physical therapist assistant for 31 years. I am co-owner of a physical therapy practice in Easley, South Carolina. I have been active in The American Physical Therapy Association for many years in different positions and I am currently Treasurer of the South Carolina Physical Therapy Association.

I am writing you today about the Physician Self-Referral Issues. I would like to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. I am sure you have reviewed the abusive nature of physician-owned physical therapy services. There is always the potential for fraud and abuse whenever physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. I have personally observed this in Easley. A physician who owned a physical therapy service would typically refer 7 to 8 patients a day to his service. It is against the law in South Carolina for a physical therapist or physical therapist assistant to work for a physician. After several years of finally enforcing this law this physician gave up his physical therpy service and contracted out physical therapy to an independently owned physical therapy practice. This physical therapist owned practice may receive 7 to 8 referrals in a week or two. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. Please eliminate physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception. In doing so CMS would reduce a significant amount of programmatic abuse, overutlization of physical therapy services under the Medicare program, and enhance the quality of patient care. I truly believe in quality of care and I know of many cases where patients were made to drive miles from their homes with severe back pain as well as other problems to be seen in the physician-owned physical therapy service instead of being referred to a physical therapy practice close to their homes.

In closing I would like to thank you for considering my comments. Feel free to contact me if you need further clarification of my comments.

Sincercly,

Chris Junkins,PTA

Cell 864-918-6360
work 864-8550344
email rcjunk5835@aol.com

Submitter : **Kellie Freeman** **Date: 08/30/2007**

Organization : **Kellie Freeman**

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.

Kellie Freeman

Submitter : **Christie Woodrow** **Date: 08/30/2007**

Organization : **Christie Woodrow**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Mel Woodrow** **Date: 08/30/2007**

Organization : **Mel Woodrow**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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P.O. Box 8018
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Thank you for your consideration of this serious matter.

Submitter : **Sherri Elder** **Date: 08/30/2007**

Organization : **Sherri Elder**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Mark Fryklund** **Date: 08/30/2007**

Organization : **Mark Fryklund**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Mark Fryklund

Submitter : **Dr. Robert Jones** **Date: 08/30/2007**

Organization : **Dr. Robert Jones**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

Re: TECHNICAL CORRECTIONS

I am personally concerned about the proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I currently do not have x-ray within my clinic and enjoy a great working relationship with a radiology group in the city I practice. I am writing in strong opposition to this proposal. I am concerned that by making this proposed change you will adversely affect relationships with chiropractors and radiologists. You do not prevent referrals to radiologist by any other provider why would you do it in this situation. In the Wilk vs. AMA court trial dealing with the AMA preventing nonmedical referrals to medical physicians the court determined that it was unjust. With this change you will in effect do what the courts opposed. I do not see the logic in your change. Why prevent a referral from a Chiropractor but it is okay for any other practitioner who does not do their own x-rays? This only causes poor patient management and duplication of services.

While subluxation does not need to be detected by an X-ray, X-rays are routinely used to rule out more serious contitions that may change the treament course of a patient. Conditions common in this age group that should be ruled out before manipulation may be various primary and secondary cancers, many arthritic and degenterative conditions, congenital abnormalities or bone intial impressions of bone densities. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

Overall costs will have to rise by limiting a Doctor of Chiropractic from referring for an X-ray study. The costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,

Robert C. Jones, DC
Albuquerque, NM
505-256-3648

Submitter : **Dr. Thomas Obst** **Date: 08/30/2007**

Organization : **University at Buffalo / Nurse Anesthetist Program**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medieare 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,
Thomas E. Obst, PhD, CRNA
Name & Credential
181 McNair Rd
Address
Williamsville, NY 14221
City, State ZIP

Submitter : **Leanne Snead** **Date: 08/30/2007**

Organization : **Leanne Snead**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

Rc: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Gary Snead** **Date: 08/30/2007**

Organization : **Gary Snead**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Laurie Fryklund** **Date: 08/30/2007**

Organization : **Laurie Fryklund**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
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Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Laurie Fryklund

Submitter : **Karen Ellyson** **Date: 08/30/2007**

Organization : **Karen Ellyson**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Submitter : **Robert Ellyson** **Date: 08/30/2007**

Organization : **Robert Ellyson**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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P.O. Box 8018
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Thank you for your consideration of this serious matter.

Submitter : Mr. Steven Ahlvers **Date:** 08/30/2007

Organization : NovaCare Rehabilitation

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Steve Ahlvers and I am a Certified Athletic Trainer, registered to practice Athletic Training in the state of Minnesota. I work for NovaCare rehabilitation, a division of the Select Medical Corporation. I have been a practicing athletic trainer for 10 years. I graduated from Minnesota State University-Mankato with a degree in Athletic Training. The Athletic Training program is Accredited by the Commission on Accreditation of Athletic Training Education.

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.

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.

In reading over the proposed changes and the requirements outlined for Physical Therapists and Occupational Therapists, I have noticed that the requirements and standards for Athletic Training are similar if not the same. There are Three sections of the rule that I will address. The first portion of the rule states, 'The proposed revised personnel qualifications in ? 484.4 for therapists and assistants must address minimum requirements for the provision of therapy services by qualified personnel who have attained the skills of therapists with education and training in the specific discipline in which they are practicing, but who are not licensed.' which would include athletic training. As mentioned previously, athletic training education is recognized by the AMA and the AMA in conjunction with the NATA has created CAATE.

The rule also states that. 'Rather, it is our intention to assure that Medicare payment is made only for physical therapy, occupational therapy, and SLP services provided by personnel who meet qualifications, including consistent and appropriate education and training relevant to the discipline, so that they are adequately prepared to safely and effectively treat Medicare beneficiaries.'. Athletic trainers' educational programs have stringent standards in the classroom, as well as a standardized national exam that demonstrates a Certified Athletic Trainer's ability to safely and effectively treat patients of all ages.

Lastly, the rule states that both PT's and OT's, 'must be licensed, certified, registered or otherwise regulated as an OT, and have graduated from an occupational therapist curriculum accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association (AOTA), and also
have successfully completed the certification examination developed and administered by the NBCOT.'. Athletic trainers are regulated by either registration or licensure, graduate from a curriculum accredited by CAATE and they also have completed a national certification exam administered by the Board of Certification of athletic trainers.

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,

Steve Ahlvers MAEd, ATC
Certified Athletic Trainer

Submitter : Dr. Edward Scheckowitz **Date:** 08/30/2007

Organization : Advanced Urology of South Florida

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-12831-Attach-1.DOC

#1283

Edward M. Scheckowitz, M.D., F.A.C.S.
5130 Linton Blvd. Ste. F6
Delary Beach, FL 33484
561-496-4444

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385- P
P.O. Box 8018
Baltimore, MD 21244- 8018.

Dear Mr. Kuhn:

I am a urologist who practices in a group practice setting in what I call the "coumadin capital of the world" - south Florida.

I am writing regarding the proposed changes published on July 12, 2007 that concern the Stark self-referral rule and the reassignment and purchased diagnostic test rules.

The changes proposed in these rules will have a serious impact on the way I my group practices medicine and will not lead to the best medical practices.

With respect to the in-office ancillary services exception, the definition should not be limited in any way. It is important for patient care for urologists to have the ability to provide pathology services in their own offices. It is equally important to allow urologists to work with radiation oncologists in a variety of ways to provide radiation therapy to patients.

In our area, we have very complicated older Medicare patients and our in-office services allow for us to receive immediate carefully supervised results. This clearly has enhanced our ability to provide optimal care.

Also, we have significant seasonal population changes (particularly after recent hurricane damage), thus the prohibition of per click payments for space and equipment rentals will prohibit providing some of these services.

The sweeping changes to the Stark regulations and the reassignment and purchased diagnostic test rules go far beyond what is necessary to protect the Medicare program from fraud and abuse.

My goal is simply to provide the same care and services that I only hope my own parents would receive.

The rules should be revised to only prohibit those specific arrangements that are not beneficial to patient care.

Thank you for your consideration,

Edward Scheckowitz

Submitter : **Dr. Gary DiLisio** **Date: 08/30/2007**

Organization : **Spectrum Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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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 arcas 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 anesthcsia 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. Kathryn Montague** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

1 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.

1 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.

1 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 thc valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
_Kathryn E. Montaguc CRNA_____
Namc & Crcdential
__6N267 Crcckside Dr. _____
Address
__St. Charles,Il. 60175_____
City, State ZIP

Submitter : Mr. Chris Thew **Date:** 08/30/2007

Organization : Kittitas Valley Community Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Chris Thew and I am a Certified Athletic Trainer, with a Master's Degree, working in the Physical Rehabilitation department of Kittitas Valley Community Hospital. I also am contracted to work at Ellensburg High School in Ellensburg, WA.

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,

Chris Thew, MA, ATC

Submitter : **Dr. Elizabeth Brennan** **Date: 08/30/2007**

Organization : **Dr. Elizabeth Brennan**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am a Santa Cruz county physician who has practiced in this area for 10 years. I have seen the effect of the Locality 99 issue here very clearly. We are unable to keep primary care physicians in this area. We are 30 minutes away from communities make 30% plus for the same services and our cost of living is equivalent. Physicians live here and practice elsewhere. In my group I am the last physician who was recruited and stayed for more than two years. I have been able to do this solely because of my husbands income. I have patients begging me to see them and cannot accommodate more in my practice. I am having increasing difficulty getting specialist to see my medicare patients and access has become a very grave issue.

I wish you to consider an immediate remedy to this inaccurate labeling that has been done.

Sincerely

Elizabeth Brennan, M.D.

Submitter : **Mr. Tom Hall** **Date: 08/30/2007**

Organization : **Mr. Tom Hall**

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,

Tom Hall

Submitter : Dr. RAMACHANDRAN RAMANI **Date:** 08/30/2007

Organization : YALE UNIVERSITY SCHOOL OF MEDICINE

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To whom it may concern,

I do not agree with the 9.9% cut on medicare and medicaid re-imbursement. I have been a PT for 2 years now and medicare is a large percentage of the patient population that we treat. If a cut were to take place in private practice settings for medicare services, there would also be a cut in the necessary care that these patients need. Medicare has suffered the most loss from medicare cuts and I feel that it needs to stop!!

Thanks, Jennifer Ondo PT

Submitter : **Mr. Tracy Vanderwiel** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
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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).
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Sincerely,
____Mr. Tracy H. Vanderwiel, CRNA___
Name & Credential
__1653 Redwood Ave._____
Address
__Hanover Park, IL 60133_____
City, State ZIP

Submitter : **Jacquelyn Smith** **Date: 08/30/2007**

Organization : **Jacquelyn Smith**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Dr. John Ehrfurth** **Date: 08/30/2007**

Organization : **Marshfield Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

Medicare Telehealth Services

Medicare Telehealth Services

please see attached document for complete comments from Marshfield Clinic and the Department of Neuropsychology and Neurology.

CMS-1385-P-12841-Attach-1.DOC

seems ill advised, then, to issue a global denial of the request to add neuropsychological testing codes to the list of approved telehealth services.

The average neuropsychologist uses no more than 25 measures in a battery of tests in any given case. A more typical figure would be 10 to 15 measures. We would estimate that fewer than 35 percent of the hundreds of available measures do not lend themselves to standardized administration via TeleHealth.

The question at hand is whether or not tests could be administered via Telehealth in a standardized fashion. We believe that many tests can be administered in a standardized manner via TeleHealth. We would include in this group of tests multiple measures of language, verbal reasoning, auditory attention, and memory/recall.

By way of illustration, one of the more commonly administered measures of generative verbal fluency, the Controlled Oral Word Association Test, could almost certainly be administered in fully standardized fashion via TeleHealth. This measure simply requires the patient to verbalize as many single words beginning with a given letter over a series of trials of 60 seconds duration. To administer this test the examiner must simply furnish the patient with a letter and then record responses.

One could make a similar argument in multiple other cases. For example, many of the subtests comprising the Wechsler Adult Intelligence Test III require only that the examiner ask a question in standardized fashion and then record the patient's verbal response.

Numerous memory measures (e.g. Logical Memory from the Wechsler Memory Scale-III, the California Verbal Learning Test, the Rey Auditory Verbal Learning Test, etc.) could be easily administered in standardized fashion via TeleHealth. As a group these verbal memory measures share in common the requirement of presenting instructions and content in a standardized manner, and then recording the patient's verbal response.

The guidelines pertaining to assessment given in the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct provide clear and specific direction in terms of the appropriate and/or ethical usage of psychological tests. In our view, these guidelines would prohibit administration of certain individual tests on a TeleHealth basis.

The psychologist is ultimately responsible for the selection of tests appropriate to varying referral questions, patient characteristics, and situational demands. Psychologists could ethically administer via audio/video link only those tests which lend themselves to standardized administration in this fashion. This is not simply a code of ethics published by our professional organization. Here in the state of Wisconsin, APA's Ethical Principles and Code of Conduct serves as the model for the regulations laid out in statute pertaining to the practice of psychology. Therefore, CMS should not propose a limitation on the number of tests available to be administered via TeleHealth, but should rely on the

existing professional guidelines and regulatory statues to monitor appropriateness of testing via TeleHealth.

No other professional discipline is required by CMS policy to sub-sort tests which may or may not be administered during a telehealth visit. A neurologist can conduct a Mini-mental exam and a pulmonary medicine specialist can watch the patient self-administer peak flows. We would encourage CMS to allow the neuropsychologist or physician to determine which neuropsychological tests are appropriate for telehealth and which tests are not.

Administering neuropsychological testing is often done by trained technicians. The fact is that more than 50 percent of neuropsychologists employ psychometric technicians who administer neuropsychological testing under general supervision. Those technicians administer testing determined by and ordered by the neuropsychologist or neurospecialty providers. Currently, the regulatory requirements for Diagnostic X-ray, Laboratory, and Other Diagnostic Tests (Jun 23, 2006, CMS Manual System, Pub 100-02 Medicare Benefits Policy, sec 80) indicates that general supervision means "the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure." In addition, the physician fee schedule manual does not require 96118-96119 to have direct supervision. The requirement is one of general supervision.

TeleHealth encounters do not occur without telepresenters (those persons on-site with the patient). In our TeleHealth operations, the telepresenter is a Registered Nurse. At no time during the proposed neuropsychological testing, would the patient be alone. Even in those circumstances where there is no psychometric technician on-site, a registered nurse would always be in the room with the patient, assisting the neuropsychologist or technician with testing. This scenario is exactly what occurs in Cardiology, Psychiatry, Oncology, and all other professional services currently approved for TeleHealth.

For those tests that cannot be administered in standardized fashion via TeleHealth, technicians could travel to, or maintain offices in, locations remote from the psychologist. Assuming the presence of a well-trained technician in the exam room with the patient, and high quality audio/video link between psychologist and patient, and psychologist and technician, it is fully reasonable to assume that virtually all commonly used tests, including the Wisconsin Card Sorting Test, could be administered in standardized fashion. This scenario - technician in remote location with patient, and psychologist in primary office linked to patient and technician via audio/video – is a perfectly acceptable practice model in the vast majority of cases. The scenario satisfies the requirement for "general" supervision of the technician by the psychologist, and affords the "unique interactive dynamic" between the patient and the psychologist/technician team.

We are requesting the addition of 96120, Neurobehavioral Testing by Computer, to be added to the list of TeleHealth CPT codes in CMS's reconsideration of 96118-96119. There are a variety of standardized tests available for computer administration used by clinicians throughout the country. These tests could, in most cases, be easily

administered via TeleHealth in that a telepresenter (see above) or technician, will be available.

To summarize, we believe many commonly used tests are appropriate for telehealth administration even without a technician on site. Indeed, there is empirical evidence to demonstrate that this, is in fact, the case.

In a study by Cullum et. al. (2006, Cullum CM, Weiner MR, Gehrmann HR, Hynan LS. Feasibility of Telecognitive Assessment in Denentia. *Assessment* Vol 13, p. 385-390), the researchers studied whether or not videoconferencing could be used to administer neurocognitive assessments. A battery of common neuropsychological tests were administered to persons with mild cognitive impairment or mild to moderate Alzheimer's disease. The Mini-Mental State Exam (MMSE) and the Clock Drawing Test were administered to patients aged 83 to 95 and compared in-person with videoconferencing examination. The testing administered by videoconferencing was successfully completed in all cases, and there was close agreement with test findings when administered in-person. Telecognitive testing was well tolerated by all participants.

Alberta Hospital Ponoka (Monteiro IM, Boksay I, Auer SR, Torossian C, Sinaiko E, Reisberg B. Reliability of routine clinical instruments for the assessment of Alzheimer's disease administered by telephone. *J Geriart Psychiatry Neurol.* 1998 Spring;11(1):18-24), was the site of a study where the feasibility of administering neuropsychological tests via videoconferencing was compared to face-to-face testing. Participants all over the age of 60 without neurological or psychiatric disturbance were tested under two experimental conditions – face-to-face and via videoconference at 336 or 384 kbps. Memory and learning, letter fluency, expressive word knowledge, reasoning, verbal attention, and visual-spatial processing were tested. Scores for expressive word knowledge were similar in the two test conditions.

In cases where a well-qualified technician is actually on site with the patient and high quality audio/video linkage between the psychologist and both patient and technician is available, virtually all testing could be accomplished in standardized fashion.

To exclude some tests and not others, or all tests in a blanket denial is counterproductive to CMS's objectives of equal access, quality of care, reduced errors and omissions, and reduction in cost.

In comments regarding the impact analysis of changes in the physician payment schedule CMS included the following statement regarding general telehealth expenditures: "To date, Medicare expenditures for telehealth services have been extremely low. For instance, in CY 2006, the total Medicare payment amount for telehealth services (including the originating site facility fee) was approximately $2 million. Moreover, previous additions to the list of Medicare telehealth services have not resulted in a significant increase in Medicare program expenditures. For example, the psychiatric diagnostic interview examination (as described by CPT code 90801) was added to the list

of Medicare telehealth services in CY 2003. The addition of CPT code 90801 resulted in an increase in Medicare payment amounts of approximately $100,000 in CY 2006." This provides strong, evidentiary support to assertions that paying for telemedicine services will not have any significant direct financial impact on the health care system. We see no substantial budgetary impact in adding neuropsychological testing codes 96118-96119, and 96120 as these codes are ancillary to the neurobehavioral status exam 96116 (similar to 90801) and would have little additional affect on the budgetary impact after the addition of 96116.

Please note that this request to approve neuropsychological testing codes 96118-96119 and 96120 has been signed by the Chair and members of the Neuropsychology Department, the Chair of the Department of Neurology, and the Division Medical Director responsible for both the departments of Neuropsychology and Neurology, at Marshfield Clinic, one of the largest multi-specialty health care organizations in the country. We are currently a CMS Physician Group Practice demonstration site, and have successfully concluded our first year with cost savings to CMS totaling $9.5 million dollars. Our attention is to quality improvement with cost savings and believe that adding neuropsychological testing will enhance our ability to provide quality care at a reduction in cost to CMS. We respectfully request CMS approve 96118-96119 and 96120.

John W. Ehrfurth, Ph.D., Chair, Department of Neuropsychology, Marshfield Clinic
L. Rebecca Campbell, MD, Chair, Department of Neurosciences, Marshfield Clinic
Stuart J. Waltonen, Ph.D., Department of Neuropsychology, Marshfield Clinic
Sarah R. Kortenkamp, Ph.D., Department of Neuropsychology, Marshfield Clinic
Gary S. Olsen, Ph.D., Department of Neuropsychology, Marshfield Clinic
William Yanke, MD, Division Medical Director, Central Division, Marshfield Clinic
Andrea F. Hovick, CSP, Team Leader, Depart. of Neuropsychology, Marshfield Clinic
Nina M. Antoniotti, RN, MBA, Ph.D., Director, TeleHealth, Marshfield Clinic

Submitter : **Kevin Brown** **Date: 08/30/2007**

Organization : **Kevin Brown**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Nick McKernan** **Date: 08/30/2007**

Organization : **Scott & White Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Dr. Nick McKernan
Resident Physician
Scott & White Hospital
Temple, TX

Submitter : Mrs. Tiffany Wills **Date:** 08/30/2007

Organization : Morris Community High School District #101

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

see attachment please

#12844

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Virginia Smith** **Date: 08/30/2007**

Organization : **Virginia Smith**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
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Thank you for your consideration of this serious matter.

Submitter : **Doug Elliott** **Date: 08/30/2007**

Organization : **Flexeon Rehabilitation**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern:

The potential for fraud and abuse exists whenever physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, espeicially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services ahve an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutilization of physical therapy services under the Medicare program, and enhance the overall quality of patient care which is the ultimate bottom line.

Sincerely,

Doug Elliott, MSPT
Flexeon Rchabilitation

Submitter : **Billy Fuller** **Date: 08/30/2007**

Organization : **Billy Fuller**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

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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.

Billy Fuller

Submitter : **Mr. Jarett Mason** **Date: 08/30/2007**

Organization : **DePaul University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am currently the Assistant Director of Sports Medicine and Head Men's Basketball Athletic Trainer at DePaul University. My undergraduate studies took place in the Division of Kinesiology at the University of Michigan, graduating with a bachelor of science double major in Movement Science and Athletic Training. I am currently finishing my graduate studies in Educational Adminsitration at Depaul University with an emphasis in Physical Education. I have been working as a Certified Athletic Trainer for seven years, and have experience in a variety of settings including high school, physical therapy clinics, and NCAA Division I universities. It is with this experience that I ask for you attention.

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, whieh you know is not the same as physical therapy. My education, clinical experience, and national certification 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,

Jarett M. Mason, ATC

CMS-1385-P-12848-Attach-1.DOC

Submitter : **Dr. Carol Greenspan** **Date: 08/30/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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To ensure that our patients have acccess to expert anesthesiology medical care, it is imperative the CMS follow through withthe 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.

Carol D. Greenspan, M.D.
Indianapolis, Indiana

Submitter : **Angie Fuller** **Date: 08/30/2007**

Organization : **Angie Fuller**

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.

Angie Fuller

Submitter : **Abhinava Madamangalam** **Date: 08/30/2007**

Organization : **Abhinava Madamangalam**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Madamangalam

Submitter : **Dr. Dan Wapner** **Date: 08/30/2007**

Organization : **SBAMG**

Category : **Physician**

Issue Areas/Comments

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Thank you for your consideration of this serious matter.

Dan Wapner MD

Submitter : **Dennis Gibson** **Date: 08/30/2007**

Organization : **Dennis Gibson**

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
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Thank you for your consideration of this serious matter.

Dennis Gibson

Submitter : Dr. Bonnie Weiner **Date:** 08/30/2007

Organization : Society for Cardiovascular Angiography and Interve

Category : Physician

Issue Areas/Comments

Background

Background

Due to the Sustainable Growth Rate, physicians now face drastic Medicare payment cuts totaling almost 40% over the next eight years. Yet, during this same time period, the Medicare Economic Index (MEI), which measures increases in medical practice costs, is expected to increase by about 20%. Physicians cannot absorb these drastic cuts. Payments to physicians today in 2007 are essentially the same as they were six years ago in 2001.

Only physicians and other health professionals face steep cuts under this flawed formula. Other providers, such as hospitals and nursing homes have payment updates that reflect the cost of inflation. In 2008, physicians and other health care practitioners whose payment rates are tied to the physician fee schedule face a 10% payment rate cut. The SCAI urges CMS to work with Congress to avert this cut and ensure that physician payment updates for 2008 and subsequent years accurately reflect increases in medical practice costs.

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Bundling of Echocardiography Add-on Code

SCAI shares the concerns of other cardiology groups and the whole house of Medicine over the unwarranted and blatantly unfair CMS proposal to bundle CPT code 93325 (Doppler echocardiography) with other echocardiography codes without increasing payments for those base codes.

There is real physician work associated with this add-on code and it must be recognized if the relative value fee schedule is going to remain credible. Additionally, data developed by the American Society of Echocardiography has shown that this add-on code is not uniformly being billed with all of the base codes so maintaining its status as an add-on code is the only way to fairly compensate echocardiographers for the work that they perform.

SCAI strongly urges CMS to withdraw this proposed bundling of 93325.

GENERAL

GENERAL

Conclusion

Thank you for the opportunity to comment upon this proposed rule. SCAI appreciates CMS continued willingness to work cooperatively with the physician community to strengthen the Medicare program and improve care for Medicare beneficiaries. Please feel free to contact Wayne Powell at 202-375-6341 or wpowell@scai.org with any questions.

IDTF Issues

IDTF Issues

Major Changes in IDTF and Physician Self-Referral Rules

CMS is proposing major changes in the way IDTFs and referral patterns but it hasn t demonstrated that a significant problem exists. Furthermore, CMS has not demonstrated that proper enforcement of existing laws and regulations would not be sufficient to handle any such problems. Without a clear demonstration of a significant and/or growing problem, we wonder how these confusing new regulations can be justified.

A full analysis of all the ramifications of these proposals during this comment period but respected and credible attorneys such as Thomas Crane (a lead author on the Stark I regulations) has identified a dizzying array of concerns that require much more thought and perhaps another notice and comment period.

While we strongly supports efforts to reduce fraud, waste, and abuse in the Medicare program, we believe that the proposed changes have not been justified or properly explained and should be withdrawn.

Resource-Based PE RVUs

Resource-Based PE RVUs

Diagnostic Catheterization Non-facility Practice Expense Inputs

At the February 2007 RUC Meeting, the Practice Expense Review Committee reviewed a request from CMS to establish non-facility inputs for the family of CPT codes 93501 through 93556 for cardiac catheterization. The ACC, in cooperation with the Society for Cardiovascular Angiography and Interventions and the

Cardiovascular Outpatient Center Alliance, developed PE inputs for the nonfacility setting for 13 of the 28 CPT codes in this family. The PERC considered the proposed new or updated PE input recommendations for 13 cardiac catheterization CPT codes.

The specialty societies recommended that the remaining 15 codes in the cardiac catheterization family remain carrier-priced, or be assigned an NA for the practice expense in the office setting. We thank CMS staff for their consideration and acceptance of this request.

Further we noted an error in the calculation of the indirect practice expense for the cardiac catheterization injection codes (CPT 93539 93545). The PE labor table incorrectly notes NA in the facility setting for this code series. As noted in a July 23, 2007 communication to CMS, the site of service indicator should be changed as the PE methodology automatically picks this up in the calculation of indirect practice expenses.

TRHCS--Section 101(b): PQRI

TRHCS--Section 101(b): PQRI

Recognizing Participation in Data Registries for PQRI

SCAI fully supports the development of ACC s NCDR data registries and believes that participation in such registries should be recognized in a any pay for reporting physician bonus system.

We also recognize that there are a host of very good regional data registries and that participation in such efforts should also be recognized as a part of CMS s pay for reporting system.

Participation in any robust data registry should be recognized in CMS s pay for reporting system.

Submitter : **Mrs. Laurie McKernan** **Date: 08/30/2007**

Organization : **Mrs. Laurie McKernan**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimorc, MD 21244-8018

Rc: CMS-1385-P

Anesthcsia Coding (Part of 5-Year Review)

Dcar 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 rccognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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Thank you for your consideration of this serious matter.

Mrs. Laurie McKernan,
Member of the Scott & Whitc Spousal Alliance Organization
Temple, TX USA

Submitter : **Abhinava Madamangalam** **Date: 08/30/2007**

Organization : **Abhinava Madamangalam**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
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Submitter : **Dr. Ho Dzung** **Date: 08/30/2007**

Organization : **SUNY Downstate**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Siobhan Fagan** **Date: 08/30/2007**

Organization : **Cedarville University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer currently working at Cedarville University. I have a Masters of Education and teach several classes in the Athletic Training Education Program here. Additionally I have experience in a variety of other venues including clinics, hospitals, and high schools.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Siobhan E. Fagan, MEd, ATC, LAT

Submitter : **Christopher Sours** **Date: 08/30/2007**

Organization : **CRNA**

Category : **Other Practitioner**

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 ean continue to provide Medicare beneficiaries with access to anesthesia serviees.
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 valuc 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,

Christopher Sours CRNA
713 W. Highland View Dr
Boise ID 83702

Submitter : **Ms. Robin Hall** **Date: 08/30/2007**

Organization : **Ms. Robin Hall**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Robin Hall

Submitter : **Kayla Gibson** **Date: 08/30/2007**

Organization : **Kayla Gibson**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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Thank you for your consideration of this serious matter.
Kayla Gibson

Submitter : **Ms. Elizabeth Brunner** **Date: 08/30/2007**

Organization : **AthletiCo Physical Therapy**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Elizabeth A. Brunner, I am a certified athletic trainer and I work for AthletiCo Physical Therapy in Chicago, Illinois. My job responsibilities are at the physical therapy clinic, along with a secondary school, Deerfield High School. I am a graduate of Western Illinois University with a Bachelor of Science in Kinesiology.

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.

Wile I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

Elizabeth A. Brunner , ATC

Submitter : **Mr. robert hhinkle** **Date: 08/30/2007**

Organization : **aana**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
_Robert Hinkle_____
Name & Credential
_42w830 whirlaway dr._____
Address
elburn il 60119_____
City, State ZIP

Submitter : **Mr. Donald Gibson** **Date: 08/30/2007**

Organization : **Grafton Volunteer Fire Department**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

As I understand there is a change being proposed that either the patient or hospital staff member must sign form or Medicare will not pay -- that the "patient unable to sign" and the EMTs signature will not be enough. There will be many problems with this new requirement:
1) a critical, unconscious, demented, aggitated, drunk, trauma ... patient will not be able -- or should be expected to sign the report
2) Hospital staff taking care of the patients stated above do not have time to sign a form that basically does not give any more credibility to the fact that the patient is unable to sign -- the EMT can state "unable to sign" just as responsibily

Submitter : **Phil Gabbard** **Date: 08/30/2007**

Organization : **Phil Gabbard**

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.
Phil Gabbard

Submitter : George Gorham **Date:** 08/30/2007

Organization : George Gorham

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

George Gorham

Submitter : **Mr. Christopher Huot** **Date: 08/30/2007**

Organization : **Minnesota State University Moorhead**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I have been a certified athletic trainer for over 10 ycars practicing in a variety of settings, univcrsity, high school, and in a sports medicine clinic. I currently work at Minnesota Statc University Moorhcad as an Assistant Professor in thc Athletic Training Educaiton Program. Although my current position is not affected by this revision, I have great concern for the present and future students of our program. The revisions could significantly reducc the number and location of viable positions for certified athletic trainers.

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 cxperience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed mc 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 thc 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 arc pertinent in ensuring patients receive the best, most cost-effective treatment available.

Sincc CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommcndations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Christopher J. Huot, MA, ATC, CSCS

Submitter : **Dr. Timothy Quill** **Date: 08/30/2007**

Organization : **Dartmouth Hitchcock Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS:

I am an academic anesthesiologist working in New Hampshire. 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. Academic anesthesiology is grossly under-funded and we really need this change.

Thank you for your consideration.

Timothy Quill, MD
New Hampshire

Submitter : **Dr. Karen Staggs** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Karen M. Staggs, M.D.

Submitter : **Sharon Gabbard** **Date: 08/30/2007**

Organization : **Sharon Gabbard**

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.

Sharon Gorham

Submitter : **Dr. Radha Arunkumar** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Anita Malhotra** **Date: 08/30/2007**

Organization : **Univ of 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)

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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,

Dr. Anita Malhotra

Submitter : **Ms. Lisa Percy** **Date: 08/30/2007**

Organization : **Ms. Lisa Percy**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Lisa Percy

Submitter : **Ms. Kayla Hensley** **Date: 08/30/2007**

Organization : **Ms. Kayla Hensley**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Kayla Hensly

Submitter : **Robert Gourley** **Date: 08/30/2007**

Organization : **Robert Gourley**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.
Robert Gourley

Submitter : Mr. Roger Hinds **Date:** 08/30/2007

Organization : New York Knicks

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir/Madam,
My name is Roger Hinds, Head Athletic Trainer for the NY Knicks. I currently am NATA and NASM certified and hold a license in the state of Texas.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehab in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for patients.
As an athletic trainer , I am qualified to perform physical medicine and rehab 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 rehab 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 recommendations of those professionals that are tasked with overseeing the day-to-day health care need 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,

Roger Hinds, ATC, LAT, PES, CES

Submitter : **Dr. Ling Qun Hu** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

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.

Ling Hu, M.D.

Submitter : **Rebecca Gourley** **Date: 08/30/2007**

Organization : **Rebecca Gourley**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Rebecca Gourley

Submitter : **Bill Grigsby** **Date: 08/30/2007**

Organization : **Bill Grigsby**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Bill Grigsby

Submitter : **Mr. Tracy Hensly** **Date: 08/30/2007**

Organization : **Mr. Tracy Hensly**

Category : **Individual**

Issue Areas/Comments

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Thank you for your consideration of this serious matter.

Sincerely,

Tracy Hensly

Submitter : Mr. Sean Cox **Date:** 08/30/2007

Organization : Summit PT and Rehab

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached letter.

Submitter : **Dr. Rajeshwar Malhotra** **Date: 08/30/2007**

Organization : **R.P. Malhotra, MD PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Dr. Raj Malhotra

Submitter : **Dr. Sarah Olson** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Sarah Olson, M.D.

Submitter : MARY GRIGSBY **Date:** 08/30/2007

Organization : MARY GRIGSBY

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Mary Grigsby.

Submitter : Dr. Terry Bradley **Date:** 08/30/2007

Organization : Dr. Terry Bradley

Category : Chiropractor

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

I am opposed to not reembursing chiropractic refereral for radialogy proceures. It is very discriminatory and reduces the patients ability to make health care decisions

Submitter : ARNOLD HAMILTON **Date:** 08/30/2007

Organization : ARNOLD HAMILTON

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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ARNOLD HAMILTON

Submitter : **Dr. Shashpal Malhotra** **Date: 08/30/2007**

Organization : **RP Malhotra MDPC**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Dr. Shashpal Malhotra

Submitter : **Beverly Hamilton** **Date: 08/30/2007**

Organization : **Beverly Hamilton**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Acting Administrator
Centers for Medicare and Medicaid Services
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Beverly Hamilton

Submitter : Mr. Earl Wesley **Date:** 08/30/2007

Organization : Baltimore Orioles

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment. Thank you.

Submitter : **Dr. Dmitri Souzdalnitski** **Date: 08/30/2007**

Organization : **Yale NHH**

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

Rc: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Dmitri Souzdalnitski, MD
Yale New Haven Hospital

Submitter : **Ken Hamilton** **Date: 08/30/2007**

Organization : **Ken Hamilton**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter

Ken Hamilton.

Submitter : **Mrs. Emily Coonradt** **Date: 08/30/2007**

Organization : **Lucas Therapies, PC**

Category : **Other Health Care Provider**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Emily Coonradt and I am an Athletic Trainer working in the clinical setting. I have also had experience in the high school and small college settings. I have my Bachelors degree (from Roanoke College, an accredited institution) as well as my Masters degree in Athletic Training from the University of Virginia. I am also nationally certified as an Athletic Trainer by the National Athletic Trainers Association Board of Certification and am licensed to practice as an Athletic Trainer in the state of Virginia. I am currently feeling forced by CMS to re-enroll in school to get my Physical Therapist Assistant degree, an ASSOCIATES DEGREE in order to solidify my future position in the same clinic with the same employment status that I have worked in for the last three years. I feel that it is extremely ridiculous that I have to go back to school for a two-year degree in order to keep doing my current job that already falls within my scope of practice that my Bachelors and Masters degrees, NATABOC certification, and state licensure provide.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restriet their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Emily P. Coonradt, MEd, ATC, LAT

Submitter : **Susan Hamilton** **Date: 08/30/2007**

Organization : **Susan Hamilton**

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
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Thank you for your consideration of this serious matter.
Susan Hamilton

Submitter : **Dr. Stephen Garcia** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologist**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Submitter : **Ms. Dottie kettenrig** **Date: 08/30/2007**

Organization : **Ms. Dottie kettenrig**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Sincerely,

Dottie Kettenring

Submitter : **Robert Harris** **Date: 08/30/2007**

Organization : **Robert Harris**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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Robert Harris

Submitter : **Dr. M Artin Mueller** **Date: 08/30/2007**

Organization : **UTMB**

Category : **Physician**

Issue Areas/Comments

GENERAL

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MArtin Mueller MD

Submitter : **Dr. Aditee Ambardekar** **Date: 08/30/2007**

Organization : **University of Pennsylvania**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Sincerely,
Dr. Aditee Ambardekar

Submitter : **Wanda Harris** **Date: 08/30/2007**

Organization : **Wanda Harris**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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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.

Wanda Harris

Submitter : **Mr. John McCoy** **Date: 08/30/2007**

Organization : **Mr. John McCoy**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Sincerely,

John McCoy

Submitter : **Robin Harris** **Date: 08/30/2007**

Organization : **Robin Harris**

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
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P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.
Robin Harris

Submitter : **Dr. Sumeet Chhabra** **Date: 08/30/2007**

Organization : **Jefferson University Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.
Sincerely,
Dr. Chhabra

Submitter : **Ms. Pamela Roundtree** **Date: 08/30/2007**

Organization : **Yale-New Haven Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Stark Law. I am the director of a hospital-based outpatient rehab facility and have seen the abuse of physician-owned physical therapy clinics first hand. In our area, there are 2 orthopedie groups that own P.T. practices. Since the opening of the POPTS, we have seen a significant decrease in the number of referrals from these physicians. The referrals we do receive are for those patients with Medicaid or no insurance. We are not-for-profit, so we must accept these patients and gladly do so. I have even had patients tell me that their physician told them that they HAD to come to their clinic for P.T., even when this meant a much further drive to another county. This is clearly deceiveing to the patient in their right to choose their healthcare provider and lcaves no doubt that the physician is involved in a 'referral for profit' situation.

I know that the care provided in a POPTS is in no way superior to the services provided in a non-POPTS. The physical therapists and physical therapist assistants all abide by the same regulations and receive the same education. Also, the physician has no more contact with his patients throughout their episode of care than he/she does in a non-connected clinic. We all know that most physicians are too busy with office visits and surgeries to make personal visits to their patients in P.T. even if the clinic is in the same building.

Furthermore, most patients require more than one P.T. visit. Therefore, the physcial therapy services provided are not 'incident-to' the physician office visit unless they are performed on the same day that the patient sees the physician. The diagnosis has been made by the physician and P.T. is part of the plan of care for that patient. There is too much opportunity for abuse with the physician certifing a plan of care that will only put money into his own pocket and possibly increase the utilization of therapy services. Please reconsider your decision to pay for physical therapy, or any rehabilitation, provided in a physician owned clinic.

Respectfully submitted.

Submitter : **Dr. marshall strode** **Date: 08/30/2007**

Organization : **Dr. marshall strode**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly suuport the proposed increase in anesthesia payments under 2008 Physician Fee Schedule

Submitter : **Shell Harris** **Date: 08/30/2007**

Organization : **Shell Harris**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.
Shell Harris

Submitter : Ms. Sara Brown **Date:** 08/30/2007

Organization : Ms. Sara Brown

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a professor of athletic training, working with entry-level students who seek employment as athletic trainers after graduation. I can attest as to the educational preparation and, as a member and past-president of the Board of Certification (the credentialing board for athletic trainers) the quality of the credentialing process for athletic trainers.

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 and those of my program graduates.

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,

Sara D. Brown, MS, ATC
Director, Programs in Athletic Training
Boston University

Submitter : **Randy Hendricks** **Date: 08/30/2007**

Organization : **Randy Hendricks**

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
Baltimorc, 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.

Randy Hendricks

Submitter : **Ms. Darla McCoy** **Date: 08/30/2007**

Organization : **Ms. Darla McCoy**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Darla McCoy

Submitter : **Amanda Hayes** **Date: 08/30/2007**

Organization : **Amanda Hayes**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Amanda Hayes

Submitter : **Jamie Slegel** **Date: 08/30/2007**

Organization : **Reading-Berks Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Impact

Impact

Dear Sir or Madam:

My name is Jamie Slegel. I am employed by a physical therapy clinic to provide athletic training services to a local school district. On a daily basis, I evaluate and treat dozens of middle school and high school athletes for a variety of athletic injuries and illnesses. I received my BS in Kinesiology/Athletic Training from The Pennsylvania State University in 1999. I also became certified by the National Athletic Trainers' Association Board of Certification at this time. I earned my MS in Athletic Training from Ohio University in 2001.

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,

Jamie W. Slegel, MS, ATC, CSCS

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I strongly support the proposal to extend the 30 day re-certification requirement to 90 days. To ease the documentary burden on providers, I am hoping you will pass this proposed change.

The 30 day re-certification is overly burdensome for physicians and therapists and is not an effective means of controlling utilization of therapy services.

CMS has adequate other requirements in place (referral, certification of the initial plan of care, specific medical necessity requirements, extensive documentation requirements, Local Coverage Determinations, Therapy Caps, CCI edits, etc.) and does not need the 30 day re-certification process in order to manage appropriateness of therapy care and utilization.

Submitter : **Mr. David Freeman** **Date: 08/30/2007**

Organization : **Sports Medicine Hattiesburg Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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Sincerely,
David Freeman, MS, ATC

Submitter : Mr. Kevin Corcoran **Date:** 08/30/2007

Organization : American Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12925-Attach-1.DOC

#12925

American
Chiropractic
Association

August 30, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8018
Baltimore, Maryland 21244-8018

Re: CMS 1385-P: Proposed Rule for Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2008 and Other Changes to Payment Under Part B

The American Chiropractic Association (ACA) is a professional society composed of doctors of chiropractic whose goal is to promote the highest standards of ethics and patient care, contributing to the health and well-being of millions of patients. The ACA currently has over 15,000 members, making it the primary representative of the chiropractic community.

Below are ACA's comments regarding CMS Proposed Rule 1385-P. Specifically, ACA is commenting on three facets of the rule: Diagnostic X-ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions (§ 410.32(a)(1)); Discussion of Chiropractic Services Demonstration; and the development and expansion of the Physician Quality Reporting Initiative (PQRI), a program created under the Tax Relief and Health Care Act of 2006 (Pub. L. 109-432).

- *Diagnostic X-ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests*

CMS Proposed Rule 1385-P, Technical Corrections

The Agency is proposing elimination of patient reimbursement for X-rays taken by a "non-treating physician," such as a radiologist, and used by a doctor of chiropractic to determine a subluxation. This reverses a policy adopted 12 years ago at the behest of ACA designed to protect the patient in terms of reimbursement for needed X-ray services. ACA strongly opposes this proposal.

The proposed rule change has to do with referring patients to a "non-treating" physician, such as a radiologist. As it stands now, a Doctor of Chiropractic can refer the patient to the radiologist and the radiologist could order the x-ray. That was covered by Medicare, and the patient was reimbursed. The proposed rule would eliminate this practice. There is already a Medicare standing rule that precludes coverage for services ordered by non-treating physicians—doctors of chiropractic had an exception to that rule. Now the Agency is proposing that the exemption granted chiropractic patients for x-ray is no longer necessary because x-rays are no longer required.

In a memorandum to all Associate Regional Administrators from the Director, Department of Health and Human Services (HHS) Office of Physician and Ambulatory Care Policy, dated April 11, 1996, the message states that *"This memo is follow-up to our memorandum of Nov 3, 1995 in which we [HHS] stated that if the test was ordered by a physician, but referred by a chiropractor, we should not deny payment for the x-ray. Our memorandum was intended to assure that services for a patient referred by a chiropractor to a physician who ordered tests and x-rays, would not be denied on the basis of referral by a chiropractor. (Emphasis ours) Nothing prohibits a chiropractor from referring a patient for services."*

The memo goes on to state: *"We can not, nor was it our intention to, apply a different set of standards for a radiologist ordering an x-ray, than for a physician ordering similar tests. (Emphasis ours) To sum up, the radiologist may order an x-ray for a patient referred by a chiropractor..."*

Thus, it is ACA's view that this proposal will adversely affect patient coverage. X-rays, when needed, are integral to the overall chiropractic treatment plan of Medicare patients, and unfortunately in the end, it is the beneficiary who will be negatively affected by this proposed change in coverage. The current X-ray Medicare protocol has served patients well, and there is no clinical reason for this proposed change. Additionally, if doctors of chiropractic are unable to refer patients directly to a radiologist, patients may be required to make additional and unnecessary visits to their primary care providers, significantly driving up the costs of patient care. Therefore, it is ACA's position that this proposal should be withdrawn immediately.

- *Discussion of Chiropractic Services Demonstration*

CMS Proposed Rule 1385-P, Chiropractic Services Demonstration

Here, the Agency is proposing to offset the cost of the Medicare chiropractic demonstration project with reductions to doctors of chiropractic alone and not reductions to all items and services included under Part B, as was congressional intent when the demonstration project was enacted in 2003.

The Medicare Chiropractic Demonstration Project began on April 1, 2005, and had far-reaching implications for both the chiropractic profession and the millions of beneficiaries as, currently; the only reimbursable service available to Medicare patients is manual manipulation of the spine to correct a subluxation.

Occurring in all of Maine and New Mexico, and parts of Illinois, Iowa, and Virginia, the chiropractic demonstration project allowed doctors of chiropractic to provide Medicare-approved services including exams, x-rays, and therapies. The project ended on March 31, 2007 and is currently under evaluation by the Agency and the entity assigned to analyze the demonstration program, Brandeis University.

ACA believes the Congressional intent in this area is clear: In funding the demonstration, the law directs the Secretary to *"provide for the transfer from the Federal Supplementary Insurance (Part B) Trust Fund ... of such funds as are necessary for the costs of carrying out the demonstration projects under this section."* (See §651(f)(A))

While the Agency relies on the language in subsection (B) that directs the Secretary to "ensure" budget neutrality, the language itself doesn't tell the Secretary how to do it – that directive resides in subsection (A) immediately above. The ACA is not opposed to budget neutrality; it only objects to the means by which the Agency plans to implement it.

ACA believes the Agency's plan to offset the demonstration's costs with payment reductions to existing chiropractic services only, and not with reductions to the totality of services payable under the Part B Trust Fund as directed, is flawed. ACA believes strongly that the totality of funds under Part B, not a discrete minority of services within it, should finance the demonstration program.

➢ *Consensus Organizations and Consensus-Based Process for Developing Measures*
CMS Proposed Rule 1385-P, TRHCA-SECTION 101(b): PQRI

Given the importance of having a transparent quality measures development, endorsement and implementation system as the foundation of the PQRI, the ACA appreciates the Agency's clarification of the respective roles of the National Quality Forum (NQF) and AQA Alliance. However, we urge the Agency to provide more guidance on how measures that are adopted by the AQA Alliance before December 2006, but not endorsed by NQF until after December 2006, be recognized under the 2008 PQRI. ACA recommends that the Agency allow such measures to be included, as removing these types of measures from the program in mid-year would be disruptive for participating Medicare providers, and leave gaps in data collection. We encourage the Agency to be more direct in the Final Rule and state expressly how such measures will be recognized.

Doctors of chiropractic are in a unique position as Medicare recognizes few CPT codes for chiropractic care (codes 98940-98942). For this reason, none of the proposed 2008 PQRI measures are applicable for use by doctors of chiropractic. We understand that the *Quality Insights of Pennsylvania's* structural measures regarding health information technology (HIT) adoption and use may be applicable to doctors of chiropractic. The ACA is working with *Quality Insights of Pennsylvania* to see how the specifications of such a measure may be modified to recognize chiropractic services. However, it is important to point out that most chiropractic offices are too small to justify the costs associated with HIT adoption. Therefore, even if such a measure is restructured to recognize the adoption and use of HIT in the delivery of recognized Medicare chiropractic codes, it is likely that a low volume of reporting would occur.

CMS is encouraged to improve the utility of the PQRI by augmenting the scope of services provided by eligible professionals to whom PQRI measures apply. For doctors of chiropractic, the prioritization of a measurement set in the area of back pain is critical in expanding the utility of the PQRI.

ACA understands that *Quality Insights of Pennsylvania* is in the process of moving into Phase II of its measures development initiative to expand the number of quality measures available for recognized Medicare providers. We look forward to the Agency's support in facilitating the development of quality measures through *Quality Insights of Pennsylvania* that recognize chiropractic care.

We encourage the Agency to list the numerator and denominator specifications for each measure in the Final Rule. The applicability of the proposed measures to various Medicare providers is not transparent unless such specifications are listed. Small differences regarding the inclusion or exclusion of particular CPT codes in the denominator will largely determine which health care practices should increase their staff and financial resources necessary to successfully participate in the 2008 PQRI.

ACA supports the careful development of a mechanism for submitting data on quality measures through a data registry or electronic health record. However, the ability of most Medicare providers, like doctors of chiropractic, to participate in such reporting depends on several factors. These include, but are not limited to: Measures applicable to back pain must eventually be included in the PQRI, only then will doctors of chiropractic be afforded the opportunity to participate in a national quality reporting and data gathering initiative.

The adoption of HIT in the chiropractic office is not widespread as most are one-person offices with limited resources to expend on purchasing the hardware and software necessary to participate in a medical registry; and

Technology support must be provided by the Agency to allow Medicare providers to participate in data registry reporting. Specifically, the development of appropriate algothriums that accurately compute quality measures reporting. Moreover, the Agency must set the standard framework for a national data registry that allows Medicare providers who do not have specific data registries to participate, as well as those specialty societies that have data registries the opportunity to link-up with the Agency's data registry system.

The Agency's five options for utilizing data registries are commendable. It is from the perspective that not all Medicare providers are prepared for data registry adoption and use that ACA supports the exploration of blending elements from the proposed options. For example, Option 5 calls for a registry data dump for Medicare beneficiaries for all information in a provider's registry for the service period of interest. This option may be beneficial for a medical specialty that has a robust data registry, but not so practical for a specialty that does not have wide adoption of HIT. Therefore, blending elements of Option 5 with elements from Option 1 (having the registries provide the quality-data codes requested for the PQRI measures plus the beneficiary code) allows smaller Medicare providers the opportunity to participate in small scale registry reporting. Overall, the Agency must provide the infrastructure support necessary to support robust Medicare provider participation in data registry reporting.

In conclusion, we support a data registry reporting system that is transparent and open to all Medicare providers, both large and small. Ultimately, monitoring the frequency of Medicare provider use of data registries, as well as the accuracy of data collection, will determine what mechanisms employed by the Agency are successful in improving the quality of care delivered to Medicare beneficiaries.

Thank you in advance for your consideration of our comments. ACA stands ready to work with CMS in its efforts to improve the quality of care provided to our nation's Medicare beneficiaries. Please contact John Falardeau at 703-812-0214, or by email, jfalardeau@acatoday.org if you should need additional information or clarification regarding ACA's comments.

Sincerely,

Kevin P. Corcoran
Executive Vice President

Submitter : **Ms. Brandy Mathis** **Date: 08/30/2007**

Organization : **Ms. Brandy Mathis**

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,

Brandy Mathis

Submitter : **Troy Hensarling** **Date: 08/30/2007**

Organization : **Troy Hensarling**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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Troy Hensarling

Submitter : **Dr. Mark Yoa** **Date: 08/30/2007**

Organization : **University of Pennsylvania**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
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Sincerely,
Mark Yoa, M.D.

Submitter : **Joy Hensarling** **Date: 08/30/2007**

Organization : **Joy Hensarling**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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Thank you for your consideration of this serious matter.
Joy Hensarling

Submitter : **Jimmy Hodges** **Date: 08/30/2007**

Organization : **Jimmy Hodges**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Thank you for your consideration of this serious matter.

Jimmy Hodges

Submitter : **Ms. Cynthia Dennis** **Date: 08/30/2007**

Organization : **Ms. Cynthia Dennis**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Sanskara, Inc
PO Box 2896
Sitka, AK 99835
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:
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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,
Cynthia Dennis, CRNA PO Box 2896, Sitka, AK 99835
Name & Credential

Submitter : Dr. C. Ann Conn **Date:** 08/30/2007

Organization : ASIPP

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

C. Ann Conn MD
7015 Hwy 190 E Serv Rd
Covington, LA 70433

Submitter : **Mr. Melvin Burns** **Date: 08/30/2007**

Organization : **Elk Creek Ranch**

Category : **Private Industry**

Issue Areas/Comments

Coding-- Payment For IVIG Add-On Code

Coding-- Payment For IVIG Add-On Code

Anesthesea--the ones who put you to sleep are the ones who wake you up. Everybody wants to be awakened. They need the more correct (higher) fees.

Submitter : Deborah Brewster-McClellan **Date:** 08/30/2007

Organization : Deborah Brewster-McClellan

Category : Other Health Care Provider

Issue Areas/Comments

Background

Background

August 30, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,
Deborah Brewster-McClellan, BSN, RN, BS, SRNA
7115 Yellow Hammer Rd
Zuni, VA 23898

Submitter : **Laurie Kendall-Ellis** **Date: 08/30/2007**

Organization : **Laurie Kendall-Ellis**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

My comments are in relation to the Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule.

I am a physical therapist and have been for almost 30 years. During that time I have seen many changes in the Medicare program in terms of reimbursement and services. Physician in-house ancillary services have always, in my opinion, corraled the Medicare population into receiving services that may not be indicated. Physician's do not allow patients to know that they have a choice when receiving care. In fact they lead the patient down to the physical therapy office that they own and appointments are made on the spot. I have first hand knowledge of patients asking to go to an other entity for their care and the physician has stated that they will lose him/her as their doctor if that is the choice they make. This would make any patient nervous but especially the geriatric population.

Loop holes of putting a physical therapy office in someone elses name, not providing patients a choice of where to receive their care, frightening patients into compliance, not adhering to Medicare in-house ancillary services regulations are concerns.

My comments are intended to highlight the nature of physician-owned physical therapy services. I support the removal of PT services from the list of permitted services under the in-office ancillary exception. Those that have the power to refer due to regulations should not abuse that power. Unfortunately I have seen it happen far too often. Please close the loop holes and eliminate this practice. We need the freedom of choice to return to the patient.

Submitter : **Sarah Paff** **Date: 08/30/2007**

Organization : **Sarah Paff**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Jeremy McVay** **Date: 08/30/2007**

Organization : **University Rehabilitation**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

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Greetings. I am writing to CMS to encourage remove of the exception to the federal physician self-referral laws. In Rhode Island, every major orthopedic group owns their own physical therapy practice. This has led to physicians controlling the volume of patients a physical therapist sees. Quality of care is reduced in my experience (working in this setting). My concern is that the in-office ancillary services exception to the Stark law is being misconstrued and has created a thriving environment for fraud and abuse. The case is clear and the solution is obvious - physical therapy services should be excluded from the in-office ancillary services exception! Thank you for your time.

Submitter : Dr. Jeremy McVay **Date:** 08/30/2007

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Category : Physical Therapist

Issue Areas/Comments

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Submitter : Dee Hodges **Date:** 08/30/2007

Organization : Dee Hodges

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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Dec Hodges

Submitter : **Ms. avantika Cadambi** **Date: 08/30/2007**

Organization : **Ms. avantika Cadambi**

Category : **Other Health Care Professional**

Issue Areas/Comments

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Thank you,
Avantik Cadambi CRNA

Submitter : **Ron Hood** **Date: 08/30/2007**

Organization : **Ron Hood**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

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Centers for Medicare and Medicaid Services
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Ron Hood

Submitter : **Dr. Heinrich Brinks** **Date: 08/30/2007**

Organization : **Community Hospital of the Monterey Peninsula**

Category : **Hospital**

Issue Areas/Comments

Background

Background

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Baltimore, MD 21244-8018

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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 arcas 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.

Heinrich Brinks, M.D., Monterey, California
831 521 4000

Submitter : **Mr. Stephen Price** **Date: 08/30/2007**

Organization : **Mr. Stephen Price**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Sincerely,

Stephen Price

Submitter : Mr. Jason Lowe **Date:** 08/30/2007

Organization : Mr. Jason Lowe

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healtheare 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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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,
__Jason S. Lowe MS, CRNA_
Name & Credential
___16328 Little Road_____
Address
___Stewartstown, PA 17363__
City, State ZIP

Submitter : **linda Hood** **Date: 08/30/2007**

Organization : **linda Hood**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Thank you for your consideration of this serious matter
Linda Hood

Submitter : **Date: 08/30/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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Department of Health and Human Services
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Sincerely,
Jason Combs CRNA MSN

337 Cedar Hill Dr
Birmingham, Al 35242

Submitter : Steve McClellan **Date:** 08/30/2007

Organization : Steve McClellan

Category : Individual

Issue Areas/Comments

Background

Background

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Sincerely,

Steven McClellan
7115 Yellow Hammer Rd
Zuni, VA 23898

Submitter : **Chris Jones** **Date: 08/30/2007**

Organization : **Chris Jones**

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.
Chris Jones

Submitter : **Ms. Karen Roberts** **Date: 08/30/2007**

Organization : **Ms. Karen Roberts**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Karen Roberts

Submitter : **Mr. Brian Oppel** **Date: 08/30/2007**

Organization : **Jackson Park Physicians**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer, working as a physician extender in a family practice in Seymour, IN. I provide physical medicine to patients with a variety of musculoskeletal conditions. However I previously worked in a rural hospital rehabilitation facility providing care for 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. 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,

Brian Oppel, ATC

Submitter : **Kelley Jones** **Date: 08/30/2007**

Organization : **Kelley Jones**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.
Kelley Jones

Submitter : **Dr. marshall strode** **Date: 08/30/2007**

Organization : **Dr. marshall strode**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Pennsylvania:
I strongly support the proposed increase in anesthesia payment under 2008 Physician Fee Schedule

Submitter : **Mr. Vitaliy Aronzon** **Date: 08/30/2007**

Organization : **Mr. Vitaliy Aronzon**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Sincerely,
Vitaliy Aronzon

Submitter : **Mrs. Laura Burch** **Date: 08/30/2007**

Organization : **UHHS**

Category : **Physician Assistant**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Submitter : **Mr. Todd Slocumb** **Date: 08/30/2007**

Organization : **Mr. Todd Slocumb**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Sincerely,

Todd Slocumb

Submitter : **Kathi Jones** **Date: 08/30/2007**

Organization : **Kathi Jones**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Thank you for your consideration of this serious matter.
Kathi Jones

Submitter : **Betty Brewster** **Date: 08/30/2007**

Organization : **Betty Brewster**

Category : **Individual**

Issue Areas/Comments

Background

Background

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,

Betty Brewster
7115 Yellow Hammer Rd
Zuni, VA 23898

Submitter : **Jaime Jones** **Date: 08/30/2007**

Organization : **Jaime Jones**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Centers for Medicare and Medicaid Services
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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.
Jaime Jones

Submitter : **Ms. Lisa Slocumb** **Date: 08/30/2007**

Organization : **Ms. Lisa Slocumb**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Sincerely,

Lisa Slocumb

Submitter : **Phil Jones** **Date: 08/30/2007**

Organization : **Phil Jones**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.
Phil Jones

Submitter : **Dr. Inna Maranets** **Date: 08/30/2007**

Organization : **Dr. Inna Maranets**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Inna Maranets, MD

Submitter : **Mr. Chad Eickhoff** **Date: 08/30/2007**

Organization : **Mayo Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Chad Eickhoff, I am the Coordinator of Athletic Training Services for Mayo Clinic Sports Medicine in Rochester Minnesota. I hold a master's degree in Education and I am a Certified Athletic Trainer. I work with mostly younger patients, and have been doing so for the past 11 years. I evaluate, treat, and help manage the patients' injuries. I feel strongly that Athletic Trainers are highly trained allied health professionals and have the ability to provide outstanding injury care including evaluation, and treatment to patients of all ages including 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. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Chad Eickhoff, MA, ATC, LAT, CSCS
Coordinator of Athletic Training Services
Mayo Clinic Sports Medicine Center
Mayo Clinic
200 1st Street SW
Rochester, MN 55905
(507) 266-3461

Submitter : **Rebecca Whitman** **Date: 08/30/2007**

Organization : **Marietta College**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,

I am a senior athletic training student at Marietta College in Marietta, Ohio. I am writing 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.

I have spent four ycars and over $100,000 to gain a bachelors of science degree in athletic training. I havc had over 1,000 hours of direct hands on patient care experincc, and in a fcw months, I will sit for a national certification exam and then apply for state licensure. I am thus qualified to perform physical medicine and rehabilitation services in a clinical setting that is different than physical therapy. It is my fear that if the proposed changes occur, my future patients will have decreased access to quality helthcare. Additionally, the job market for educated, qualified healthcare professionals, such as athletic trainers, will be unnecesarily limited.

I feel that CMS, as an institution concerned with the quality of healthcare Americans are receiving, is irresponsible to further restrict poeples' ability to receive therapy scrvices from qualified allied healthcare professionals, such as a certified athletic trainer.

Thc current, flexible standards of staffing in hospitals and other rehabilitative facilities are essential in ensuring patients recieve quality, cost-effective healthcare.

Since CMS has proposed these changes without clinical or finacial justification, I encourage you to consider reccomendations of those professionals that are tasked with overseeing daily helthcare needs of their patients. I request that you withdrawl the proposed changes related to hospitals, rural clinics, and any medicare Part A or Part B hospital or rehabilitation facility.

Thank you for your time,

Rebecca Whitman, ATS

Submitter : **Date: 08/30/2007**

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:

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Marilyn Jones** **Date: 08/30/2007**

Organization : **Marilyn Jones**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.
Marilyn Jones

Submitter : **Dr. Craig Steiner** **Date: 08/30/2007**

Organization : **West Chester Anesthesia Assoc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CMS-1318-P
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

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Submitter : **Barry Gleason** **Date: 08/30/2007**

Organization : **Barry Gleason**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Mr. Jeff Sullivan** **Date: 08/30/2007**

Organization : **Mr. Jeff Sullivan**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Jeff Sullivan

Submitter : Dr. Jack Cronenwett **Date:** 08/30/2007

Organization : Vascular Study Group of Northern New England

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#12974

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Dr. Will Costello** **Date: 08/30/2007**

Organization : **Vanderbilt Department of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Submitter : **Dr. Edward Norman** **Date: 08/30/2007**

Organization : **North Pinellas Anesthesia**

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
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Edward A. Norman, MD

Submitter : **Wight Jones** **Date: 08/30/2007**

Organization : **Wight Jones**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Wight Jones

Submitter : Joyce Jones **Date:** 08/30/2007

Organization : Joyce Jones

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.
Joyce Jones

Submitter : **Dr. James Fay** **Date: 08/30/2007**

Organization : **UTMB Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : Mrs. Sandra Watson **Date:** 08/30/2007

Organization : Sunshine Physcial Therapy Clinic

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

I would like to comment on the removal of Physical Therapy from the In-office Ancillary Services. Recently one of our referring physicians opened up his own Therapy Clinic in another building near his office. We have seen the dramatic impact this has caused our clinic. Referrals are down 40%, and several other therapy clinics in the area have been forced to close their doors. The concern that I have is this physician is directly benefiting financially from referring his patients to his therapy facility. Isn't this a direct violation of the intent of the Stark Physician Self-Referral law? How objective can he be with the patient's therapy, when the referring physician is now benefiting from the referral to therapy? When a lay-person like me reads the law, it seems clear to me. This referral for profit loophole is an affront to the true intent of the law. The patient deserves to have appropriate therapy for the proper amount of time, provided by a therapist that isn't under the gun by their boss (the referring physician) for profit. The medical community isn't allowed to code to get paid. Then why should a referring physician be allowed to refer his patient to his own facility for additional services that they will directly benefit from financially? Yes, I know there are audits completed by Medicare. How many physicians will slip in under the radar screen and treat their patients with in-office ancillary physical medicine services inappropriately? Our facility is a non-profit organization. We treat a wide-range of patients both free and paying as well as those with insurance. Our therapy is guided by medical necessity, not profit. I strongly urge the federal regulators to close this loophole and protect the full intent of the Stark Law. Trained therapists deserve to work in an environment guided by the principal of therapy based on medical necessity rather than the referring physician s bottom line. We live in an era where physicians are getting richer and richer. They now have the ability to utilize this loophole to get richer more quickly. Physicians deserve to be reimbursed for their valuable services. They do not deserve to take advantage of this loophole, line their own pockets, and possible provide inadequate or inappropriate therapy that doesn't benefit the patient. Profit seems to be the reason that these referring physicians are providing this ancillary service, and our regulators are allowing them to do it. Stop the physician s ability to refer patients to their own therapy clinic. Uphold the Stark Law as Congress originally intended. Send physicians in this country a message that profit will not drive every aspect of patient's care in this country!

Submitter : **Mrs. Shannon Beall** **Date: 08/30/2007**

Organization : **Mrs. Shannon Beall**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
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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,

Submitter : **Dr. Geraldine Daumerie** **Date: 08/30/2007**

Organization : **University of Pennsylvania**

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.
Dr. Geraldine Daumerie

Submitter : **Ken Aduddell** **Date: 08/30/2007**

Organization : **Ken Aduddell**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Ken Aduddell

Submitter : **Dr. Janaki Meyappan** **Date: 08/30/2007**

Organization : **University of Pennsylvania**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.
Dr. Janaki Meyappan

Submitter : **Cockrill Gwen** **Date: 08/30/2007**

Organization : **Cockrill Gwen**

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

Rc: CMS-1385-P
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Thank you for your consideration of this serious matter.

Ken Aduddell

Submitter : **Ms. Shannon Sullivan** **Date: 08/30/2007**

Organization : **Ms. Shannon Sullivan**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Shannon Sullivan

Submitter : Mrs. Lynn Horgan-Pisarski **Date:** 08/30/2007

Organization : US Physical Therapy/Allegiance Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1385-P-12987-Attach-1.DOC

#12987

ALLEGIANCE

PHYSICAL THERAPY

3300 Saw Mill Run Blvd.
Suite B
Pittsburgh, PA 15227

Phone: (412) 885-5090 **FAX: (412) 885-5093**

September 13, 2007 **Re: CMS-1385-P**

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, MD 21244

Dear CMS Representative:

I am writing this letter to express my concern regarding the proposed Medicare Physician Fee Schedule (MPFS) revision that will dramatically affect the reimbursement of Physical & Occupational Therapy services provided to elderly patients in my community.

This proposed method for reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care.

I understand that the AMA, the American Physical therapy Association and the American Occupational Therapy Association, as well as other organizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these patients' right to adequate and necessary medical care.

Sincerely,

Lynn Horgan-Pisarski

Submitter : **Mrs. Audra George** **Date: 08/30/2007**

Organization : **Summit PT and Rehab**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached letter.

CMS-1385-P-12988-Attach-1.DOC

#12988

Physician Self-Referral Issues

Address to:

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

Subject:

Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

I am a physical therapist in an outpatient clinic in Claremore, Oklahoma. I have practiced for about a year and a half seeing all types of patients with orthopedic problems.

I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. My clinic has already seen and experienced problems with these rules and regulations, where physicians stop referring patients to our clinic and start referring to themselves. I feel that it is morally and legally wrong for physicians to refer patients to their own PT clinics, just so they can get the monetary "kick back". Patients should be sent to the clinic that best suits them and their injuries. These physician self referrals seem abusive and fraudulent to the medical system and most of all the patients. The ability to refer patients to your own physical therapy clinic should be and must be stopped.

Sincerely, Audra George, MPT

Submitter : **Misti Aduddell** **Date: 08/30/2007**

Organization : **Misti Aduddell**

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.
Wade Cockrill

Submitter : **Felicia Boykins** **Date: 08/30/2007**

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:
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Sincerely,
__Felicia Boykins, CRNA
Name & Credential
7325 Desierto Luna___
Address
El Paso, TX 79912__
City, State ZIP

Submitter : **Dr. Christopher Vije** **Date: 08/30/2007**

Organization : **University of Pennsylvania**

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.
Dr. Christopher Vije

Submitter : **Wader Cockrill** **Date: 08/30/2007**

Organization : **Wader Cockrill**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.
Anne Cockrill

Submitter : **Joe Heaton** **Date: 08/30/2007**

Organization : **Joe Heaton**

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
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Joe Heaton

Submitter : Ms. Ann Kaplan **Date:** 08/30/2007

Organization : Pharmaceutical Research and Manufacturers of Ameri

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12994-Attach-1.PDF

#12994

PhRMA

August 30, 2007

VIA HAND DELIVERY AND E-MAIL
http://www.cms.hhs.gov/eRulemaking

Acting Deputy Administrator Herbert Kuhn
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1385-P; Comments Regarding the Proposed Physician Fee Schedule Rule for Calendar Year 2008

Dear Mr. Kuhn:

The Pharmaceutical Research and Manufacturers of America (PhRMA) is pleased to submit comments on the Medicare proposed physician fee schedule (MPFS)rule published by the Centers for Medicare and Medicaid Services (CMS).[1] PhRMA is a voluntary nonprofit organization representing the country's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for cures.

PhRMA has a long-standing interest in ensuring that Medicare beneficiaries have access to the most appropriate therapies, both in physicians' offices and other outpatient and inpatient settings. Given the importance of Medicare's payment system in supporting beneficiaries' access to appropriate care, we appreciate and support CMS' ongoing efforts to identify opportunities for improving the accuracy of Average Sales Price (ASP) calculations, the resulting ASP-based payment rates, and other policies affecting Medicare Part B drugs. Our comments on the proposed rule principally focus on the section on "Bundled Price Concessions." In addition, we discuss CMS' proposal concerning the transport of drugs acquired under the Competitive Acquisition Program (CAP) and discuss physician submission of claims for administering CAP drugs.

---

[1] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008; Proposed Rule, 72 Fed. Reg. 38122 (July 12, 2007).

Finally, we have also addressed CMS' proposal to create a process for determining changes to the list of recognized compendia used to support Medicare coverage of medically accepted indications of off-label uses of anti-cancer medicines and the section on the physician quality reporting initiative.

* * *

A. Bundled Price Concessions

CMS has proposed to revise the methodology for determining the ASP for Part B drugs by defining "bundled" arrangements and requiring that drug manufacturers allocate bundled price concessions when reporting ASPs. CMS' proposal is based in part on MedPAC's January 2007 report to Congress,[2] which recommends that "the goal should be to ensure that ASP reflects the average transaction price for drugs."[3] In that report, MedPAC presented two options for allocating bundled price concessions. On the one hand, MedPAC opined that application of the Medicaid bundling rule, with some adjustments, might be simpler to administer than another alternative; however, it also remarked that the Medicaid bundling approach "might not capture contingent discounts" and that an approach that allocated bundled discounts to reflect the contingencies in a contract would "more accurately reflect[] the transaction price of drugs" when a discount for one drug or multiple drugs is contingent in whole or in part on the purchase of another drug.[4] Nevertheless, MedPAC did not state a preference for one particular approach over the other.

As CMS points out, MedPAC advised that the reporting requirements for allocating discounts should be clear and capable of being implemented in a timely fashion by manufacturers. CMS also stated that the final MPFS rule "may reflect the final Medicaid policy on bundled sales . . . to the extent that it is appropriate for ASP and the public has had the opportunity to comment on how the final Medicaid policy for bundled sales, if appropriately adopted for ASP purposes, would affect the calculation of ASP."[5] As CMS also notes, "there is a potential for great variation in the structure of bundled arrangements and in the characteristics of products included in those arrangements."[6]

---

[2] MedPac, Report to Congress, Impact of Changes in Medicare Payments for Part B Drugs (January 2007).

[3] 72 Fed. Reg. 38122, 38150 (discussing MedPAC report).

[4] Id. (discussing MedPAC report).

[5] Id. at 38151.

[6] Id.

If CMS decides to implement a new treatment of "bundled arrangements" under ASP, PhRMA supports an approach that would provide appropriately consistent treatment of bundled sales between AMP and ASP. Predictability and transparency are essential for compliance reasons and are particularly important if CMS wants to promote consistency in the treatment of bundled price concessions for purposes of ASP reporting. Furthermore, because section 1847A (d) of the Social Security Act permits substitution of 103 percent of AMP for ASP-based payment in certain instances, it is imperative that CMS finalize a definition of bundled arrangement that is transparent, preserves beneficiary access to innovative therapies and maintains economic fairness. However, as both CMS and MedPAC have noted, there are differences in AMP and ASP, how each is used and the types of products included. If CMS uses the same definition, it should carefully examine what those differences may be and how they need to be reflected in the definitions for the two programs.

Moreover, PhRMA has serious concerns about the bundling provisions in the final Medicaid rule. Whether considered in the AMP and Best Price context or in the ASP context, the Medicaid rule's bundling provisions are not clear enough to be ready for implementation. The rule's definition of a bundled sale is confusing and potentially overbroad, and key questions about how to interpret that definition and allocate discounts on bundled sales remain unresolved. CMS and manufacturers alike must strive for clarity and certainty in the rules applicable to government pricing calculations; extending the Medicaid bundling definition to the ASP context without further clarification could undermine this objective.

The definition of a bundled sale from the proposed rule is as follows:

> an arrangement regardless of physical packaging under which the rebate, discount, or other price concession is conditioned upon the purchase of the same drug or biological, or other drugs or biologicals or some other performance requirement (for example, the achievement of market share, inclusion or tier placement on a formulary, purchasing patterns, prior purchases) or where the resulting discounts or other price concessions are greater than those that would have been available had the bundled drugs been purchased separately or outside the bundled arrangement. [7]

The proposed rule also states in connection with the "Basis of Payment" that:

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[7] Id. at 38226, proposed new 42 C.F.R. § 414.802.

> For the purposes of paragraph (a)(2)(i) of this section, the total value of price concessions on all drugs sold under a bundled arrangement must be allocated proportionally according to the dollar value of the units of each drug sold under the bundled arrangement.[8]

These sections are substantially the same as the final AMP rule definition of bundled sale. The new definition of a bundled sale is confusing, and could be construed to sweep in many common contractual arrangements that previously would not have required a reallocation of discounts under the Medicaid rebate agreement[9] or any ASP guidance.[10] Although PhRMA and other commenters raised these concerns in response to the proposed Medicaid rule, the language of the final rule had minimal revisions and manufacturers remain apprehensive about the ability to apply this definition in a consistent, meaningful and practical manner. Below we briefly describe examples of some of the areas where greater clarity is needed. PhRMA is also preparing separate comments to CMS on the Medicaid rule that will provide further detail about the unresolved questions associated with that rule's bundling provisions, and we would urge CMS to review those comments in evaluating ASP bundling issues since it proposes to extend the Medicaid approach to ASP calculations. Issues that require further clarification include:

- Whether a contract with multiple products, without any contingencies of any type, is considered a bundled arrangement.
- What happens when there are contingent and non-contingent drugs within the bundled arrangement?
- In a case where the products in a bundled sale have some discounts that are contingent on a purchase or performance requirement and some discounts that are not contingent on anything, whether manufacturers

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[8] Id., proposed new 42 C.F.R. § 414.804(a)(2)(iii).

[9] 42 C.F.R. § 447.502 (emphasis added.) By contrast, the prior Medicaid definition of bundled sale, contained in the Medicaid Rebate Agreement, provides that:

> "Bundled Sales" refers to the packaging of drugs of different types where the condition of rebate or discount is that more than one drug type is purchased, or where the resulting discount or rebate is greater than that which would have been received had the drug products been purchased separately." (Medicaid Rebate Agreement, § I(e).)

[10] CMS should take into account that the application of this definition, particularly if there is a lack of clarity, may result in different interpretations by manufacturers and even if similarly interpreted could have varying impacts on different products, e.g., it is possible that some ASPs may increase and some may decrease, depending on the reasonable assumptions previously made.

must allocate non-contingent discounts (as well as contingent discounts) across all the products in the bundled sale arrangement or whether the incremental discount that is actually contingent on a purchase or other requirement is allocated?

As noted above, the proposed ASP rule and the Medicaid rule define a bundled arrangement as an arrangement in which the rebate, discount, or other price concessions may be conditioned upon "*some other performance requirement (for example, the achievement of market share, inclusion or tier placement on a formulary).*"[11] We are concerned that this language may be construed too broadly.

To reduce some of the confusion, a bundled arrangement should be defined as an arrangement regardless of physical packaging under which the rebate, discount, or other price concessions is conditioned upon the purchase of the same drug or biological, other drugs or biologicals, the achievement of market share, or inclusion or tier placement on a formulary.

There are a number of other examples of issues that may not have been considered in connection with the extension of the Medicaid bundling rule for ASP. First, what happens when a bundled arrangement includes both drug products for which ASP is reported, and drug products which are not ASP eligible? How are those discounts allocated? CMS should provide guidance in such situations.

Another example of how the Medicaid bundling rule may not work well in the ASP context arises from language in the Medicaid rule preamble indicating that CMS might expect certain volume and/or market share arrangements to be allocated across periods (e.g., if the discount in the 2nd quarter is based on market share during the 1st quarter, then the additional discount earned for meeting certain market share requirements in the 1st quarter might be allocated across both periods).[12] If applied in the ASP context, such an approach may require recalculation of the 1st Quarter ASP, because the impact of the bundling allocation would not be known until after the 1st Quarter ASP was filed. CMS should clarify whether a recalculation of the first quarter ASP is required, or whether manufacturers may use the rolling average methodology for lagged price concessions.

As the discussion above illustrates, further clarity is required before extending the new Medicaid bundling rule to ASP calculations (or, for that matter, before applying the new rule in the Medicaid context). Specifically, we request that CMS: (1) address with

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[11] 42 C.F.R. § 447.502 (emphasis added).

[12] See 72 Fed. Reg. 38122, 39159.

more specificity the meaning of certain language in the final Medicaid rule; and (2) provide more meaningful examples of what is and is not a bundled sale within the context of the final rule definition. Given the importance of achieving clarity on these issues, PhRMA also urges CMS to delay the effective date of any bundling provisions added to the ASP regulations beyond January 1, 2008, so that CMS and manufacturers have the opportunity to work through all of the outstanding questions regarding the bundling provisions in the Medicaid rule and to develop a concrete common understanding of how those bundling provisions would work in practice.

B. CAP

CMS currently requires that CAP drugs be shipped directly to the location where they will be administered. However, in the proposed rule CMS requests comments on the feasibility of "narrowing the restriction on [the physician] transporting CAP drugs where this is permitted by State law and other applicable laws and regulations."[13] PhRMA is pleased with CMS' efforts to improve the CAP program and supports the easing of restrictions on transporting CAP drugs, where permitted by State and other applicable law and regulations. Easing these restrictions and allowing patients to receive care at satellite offices or in the home could increase patient access to needed medications.

As another step to improve the CAP, we recommend that CMS consider withdrawing the current requirement that physicians electing CAP must agree to file a claim within 14 calendar days of drug administration. This requirement may no longer be critical in light of changes made by section 108 of the Medicare Improvements and Extension Act, which is Division B of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA). That section requires that payment for drugs and biologicals supplied by the CAP vendor be made upon receipt of a claim for those products. The MIEA-TRHCA also requires CMS to establish a post-payment review process to assure that payment is made for a drug only if the drug has been administered to a beneficiary. Prior to this legislation, a CAP vendor could not get paid until the physician's drug administration claim was matched with the claim for the drug submitted by the CAP vendor.

In the initial CAP final rule, CMS made clear that the requirement that the physician submit the claim for drug administration services within 14 days was designed to allow the CAP vendor to be paid in a timely manner for drugs it had shipped. As the MIEA-TRHCA has now removed the claims match predicate to the CAP vendor's payment, the underlying rationale for the 14-day bill submission requirement is no longer necessary. To make the program more workable for physician practices that do not customarily submit bills in this timeframe, we recommend that CMS withdraw this

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[13] Id. at 38158.

requirement for physicians electing the CAP program. This step should also make the program more attractive to prospective CAP physicians.

C. Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals In an Anti-Cancer Chemotherapeutic Regimen

PhRMA appreciates the proposal by CMS to create a process for determining changes to the list of recognized compendia used to support Medicare coverage of medically accepted indications of off-label uses of anticancer medicines. This step reflects the growing recognition of the need for CMS to recognize additional authoritative compendia to ensure timely patient access to beneficial, medically appropriate cancer therapies.[14]

The statutorily required compendia system serves Medicare patients well by helping them gain access to medically appropriate therapies. However, several steps could be taken – including the recognition of additional compendia – that would improve the functioning of this system.

PhRMA therefore supports CMS' initiation of an open, transparent, and timely process for recognition of additional drug compendia under the relevant provision of Medicare law, Section 1861(t)(2) of the Social Security Act. However, we are recommending several changes to the process to ensure that it facilitates timely recognition of additional authoritative compendia.

Importance of Patient Access to Off-Label Drug Uses

Introduction of compendia into the Medicare statute in 1994[15] represented a clear policy choice to cover, in appropriate circumstances, the off-label anti-cancer drug uses that physicians prescribe for their Medicare patients. The purpose of this policy was to address barriers to cancer patients' access to medically appropriate off-label uses. The importance of access to these treatments is no less important, and no less recognized,

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[14] "Reimbursement for Cancer Treatment: Coverage of Off-Label Drug Indications, American Society of Clinical Oncology, *Journal of Clinical Oncology*, July 1, 2006, 24:3206-3208. National Patient Advocate Foundation comments to CMS on draft decision memo for anticancer chemotherapy for colorectal cancer (CAG-00179N), Dec. 22, 2004.

[15] *See* Social Security Act §1861(t)(2)(B) (42 U.S.C. §1395x(t)(2)(B)).

today. As the National Cancer Institute has noted, off-label uses of medicines often represent the "standard of care" for cancer patients.[16]

Current Medicare-Recognized Compendia

Of the three compendia recognized in the original 1994 Medicare statutory provision, two remain in operation today – *United States Pharmacopoeia-Drug Information* (USP-DI) and the *American Hospital Formulary Service-Drug Information* (AHFS-DI). A recent amendment[17] to this 1994 provision inserted "or its successor publications" after the reference to USP-DI to ensure that USP-DI remained a recognized compendium in light of its acquisition by Thomson Healthcare. Thus, it is important for CMS to continue to recognize the Thomson DrugPoints compendium as the successor to USP-DI.[18] We urge CMS in the final rule to publicly recognize that Thomson DrugPoints is the successor publication to USP-DI under Section 1861(t)(2).

A 2005 survey of oncologists and oncology practice managers sponsored by the Association of Community Cancer Centers, the Biotechnology Industry Organization and PhRMA reaffirms that CMS should have a high level of confidence in the compendia currently designated by statute. Of the 28 oncologists surveyed, 17 said they rely on compendia for clinical decision making. The publication cited most frequently was USP-DI, followed by AHFS-DI.[19]

Both USP-DI/Thomson and AHFS-DI use sound approaches to making decisions on changes to their compendia. They combine evaluation of available evidence with input from outside experts to ensure medically appropriate treatment options are available to patients and physicians. For these reasons, PhRMA urges CMS to retain Thomson DrugPoints and AHFS-DI as approved compendia.

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[16] "Understanding the Approval Process for New Cancer Treatments," National Cancer Institute, http://www.nci.nih.gov/clinicaltrials/learning/approval-process-for-cancer-drugs/page5, accessed August 22, 2007.

[17] Section 6001(f) of the Deficit Reduction Act of 2005, amended both Social Security Act §1861(t)(2)(B)(ii)(I) and Social Security Act §1927(g)(1)(B)(i)(II).

[18] Thomson Healthcare has owned the USP-DI compendium since 2004 and this year transitioned the publication to the DrugPoints name.

[19] John E. Feldman, MD, FACP, "Off-Label Use of Anticancer Therapies: Physician Prescribing Trends and the Impact of Payer Coverage Policy," Covance Market Access Services, September 2005.

Process for Recognition of Additional Compendia

In addition to maintaining current compendia, we urge CMS to act expeditiously to recognize additional compendia. While we appreciate the steps CMS is proposing to take in the proposed rule to establish a process for recognizing more compendia, the approach proposed by CMS may unnecessarily delay recognition of additional compendia.

Medicare has operated without the benefit of the full complement of statutorily recognized compendia for several years. In order to alleviate current concerns about the lack of a sufficient number of recognized Medicare compendia and its potential to prevent beneficiaries from gaining timely access to medically appropriate care, we recommend that CMS take two steps: (1) act on pending requests for compendia recognition as soon as possible, rather than re-initiating review of these requests and (2) take steps to improve the efficiency of the new process it proposes for reviewing additional compendia.

Since early last year, CMS has carefully evaluated at least six clinical compendia. This review included a technology assessment conducted by the Agency for Healthcare Research and Quality (AHRQ) and evaluation and input from CMS' Medicare Evidence Development and Coverage Advisory Committee (MedCAC). In light of this extensive analysis and public review and input, CMS should act before the end of 2007 on any requests for recognition that it has received from publishers of the compendia subject to the AHRQ and MedCAC review process.

In particular, we reiterate our request made in February 2006[20] for CMS to recognize the *NCCN Drugs and Biologics Compendium*™ as soon as possible. This compendium – sponsored by the National Comprehensive Cancer Network – was among those evaluated by the AHRQ and MedCAC and is an authoritative, evidence-based listing of on-label and off-label cancer drug uses.

In addition, CMS should take steps to streamline and clarify the compendia review and decision- making procedures it is proposing. For example, we suggest that CMS consider reducing the post-comment period proposed for agency review – up to 120 days. We note that in evaluating Medicare national coverage issues, CMS publishes a final decision memo not later than 60 days after close of public comments. The agency also should clarify the sequence of steps intended in connection with the 30- and 45-day periods identified for acceptance and review of external requests for compendia changes.

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[20] Written comments submitted by PhRMA to CMS and the Medicare Coverage Advisory Committee, Feb. 27, 2006.

Criteria for recognition of additional compendia

To support the goals of timely access to high-quality care, continued discovery of new medicines and new uses for existing medicines, Congress recognized the value of a plurality of decision-makers in evidence-based policy-making. Reflecting the fact that evidence that is less-than-definitive can often provide a basis for Medicare coverage – particularly in areas where evidence emerges at the forefront of medical progress – the compendia-based system provides a mechanism that combines review of evidence with other factors, such as expert input, and employs multiple review organizations.

We support CMS' goal of maintaining a robust, evidence-based compendia policy, and we support a number of the compendia characteristics identified by the agency. We agree, for example, that any approved compendium should have an extensive breadth of listings; should achieve rapid throughput for inclusion of new listings; and should be publicly transparent in evaluating drug uses.

However, we are concerned that the criteria CMS is proposing for evaluation of compendia are unduly restrictive and could hinder timely recognition of additional evidence-based drug compendia. PhRMA believes that approved compendia should be based on the best available evidence; should draw on expert input in reaching medical judgments; and should be flexible in applying evidence to recognize beneficiaries' need for access to treatments for life-threatening diseases such as cancer. We recommend that CMS reformulate the criteria as a shorter list of broader criteria. Such an approach could achieve the same goals as a more detailed list, but give compendia publishers greater flexibility in how they meet them.

Important aspects of decision-making for compendia listing include: 1) being timely, because cancer is a life-threatening disease and oncologists require up-to-date therapies, 2) being evidence-based so that the appropriate therapies are available and 3) being pragmatic, in recognition of the fact that evidence is developed incrementally. Providing for listed compendia to reflect these characteristics will help assure that access to potentially lifesaving medicines is not unnecessarily delayed.

If CMS retains the current list of criteria, PhRMA requests several clarifications to ensure that authoritative compendia are recognized by CMS in a timely manner.

Compendium definition:

The language in the CMS proposal pertaining to the definition of "compendium" may be unduly restrictive. Specifically, requiring that a compendium be "indexed by drug" rather than "indexed by disease" places form over substance. CMS should determine approved listings on the basis of thoughtful criteria that speak to medical content and scientific evidence, rather than on the form in which that content is presented. We request that the agency delete this requirement in the final rule.

Process for including additional listings:

PhRMA appreciates CMS' proposed compendia characteristics that support timely, transparent processes for including new compendia listings, and making publicly available the criteria for weighing evidence and the process for making recommendations. We recommend that CMS modify the proposed characteristic "quick throughout from application for inclusion to listing" to say "quick throughput on inclusion of new listings." This will better reflect the various procedures compendia publishers use to incorporate new evidence-based listings into their publications.

Disclosure of conflicts of interest:

PhRMA supports CMS inclusion of a characteristic to ensure that potential conflicts of interest are disclosed and appropriately managed. CMS should provide more detail on the organizational locus of the "conflicts of interest" against which an approved compendium must guard. Given the need for compendia to draw on medical experts, who may be affiliated with a diverse set of entities and who may offer varying perspectives, it would also be important to specify disclosure of a potential conflict as one means for satisfying this criterion.

D. Physician Quality Reporting Initiative

PhRMA appreciates the opportunity to comment on the proposed rule regarding the Physician Quality Reporting Initiative (PQRI). PhRMA supports the appropriate use of sound performance measures as a means to improve the quality of health care and medical outcomes for Medicare beneficiaries.

Selection of Measures

PhRMA commends CMS for the selection and use of measures in the PQRI that are well grounded in current evidence and stakeholder consensus. Use of such measures, including measures to encourage adherence, appropriate use and monitoring of medications and vaccines, can improve patient outcomes and help control health care costs. For example, a recent study found that heart failure patients who received beta-blocker therapy had treatment costs $3,959 lower than those of patients who did not take these medicines. Patients treated with beta-blockers needed fewer overnight hospital stays and had increased survival of about three-and-a-half months.[21]

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[21] PA Cowper et al., "Economic Effects of Beta-Blocker Therapy in Patients with Heart Failure," *The American Journal of Medicine* 116, no. 2 (2004): 104-111.

Other recent studies have reported better health outcomes for patients, including Medicare patients, when prescription drugs were utilized and cost offsets between prescription medicines and other health services were realized. This research indicates the importance of a measurement system that promotes appropriate utilization of medicines and vaccines. Examples of these studies:

- A 2006 study showed that when asthma treatment guidelines were followed, use of medicines to control asthma increased 47%, and, in turn, outpatient and emergency visits decreased by 56% and 91%, respectively.[22]
- An evaluation of the impact of Medigap prescription drug coverage on the use of Medicare-covered hospital and physician care found that in 2005, a $1 increase in prescription drug spending was associated with a $1.63-$2.05 reduction in Medicare Part A and Part B spending.[23]
- A 2006 study in the *New England Journal of Medicine* reports that seniors in a Medicare+Choice plan with an uncapped prescription drug benefit had higher pharmacy costs, better adherence to prescribed drug therapy, better clinical outcomes (e.g., lower blood pressure, lower cholesterol and lower blood glucose), lower hospital and emergency costs, and lower mortality than patients in the same plan with a drug benefit capped at $1,000 per year.[24]
- A 2006 study showed the increasing rates of pneumococcal vaccination will save lives and reduce health spending by reducing length of inpatient hospital stays, ventilator support and ICU days.[25]
- A 2001 study showed that influenza vaccination was associated with a significant reduction in hospitalizations and deaths among persons over 65 years old.[26]

CMS should continue to rely on up-to-date, evidence-based consensus measures that can improve longer-term outcomes like reduced hospitalization.

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[22] M Cloutier et al., "Asthma Guideline Use by Pediatricians in Private Practices and Asthma Morbidity," *Pediatrics*, Nov 2006; 118(5):1880-7

[23] B. Shang, "The Cost and Health Effects of Prescription Drug Coverage and Utilization in the Medicare Program," Doctoral Dissertation, Pardee RAND Graduate School, October 2005, available at www.prgs.edu.

[24] Hsu et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine*, 1 June 2006.

[25] Fisman DN,Abrutyn E, Spaude KA, Kim A, Kirchner C, Daley J. Prior pneumoccocal vaccination is associated with reduced death, complications, and length of stay among hospitalized adults with community acquired pneumonia. *Clin Infect Dis JT:* Apr 15 2006; 42(8): 1093-1101.

[26] Nordin, et a., "Influenza Vaccine Effectiveness in Preventing Hospitalizations and Deaths in Persons 65 Years or Older in Minnesota, New York, and Oregon: Data from 3 Health Plans, " The Journal of Infectious Diseases, 2001; 184: 665-70.

Consensus-Based Organizations

Division B of the MIEA-TRHCA states that any measures selected for inclusion in 2008 must have been adopted or endorsed by a consensus-based organization, and it references two specific organizations, the National Quality Forum and the AQA (formerly the Ambulatory Care Quality Alliance). According to the National Technology Transfer and Advancement Act (NTTAA) and the Office of Management and Budget (OMB) Circular A-119, a voluntary consensus-based organization is defined by openness, balance of interest, due process, an appeals process, and consensus among stakeholders. These attributes are key to ensuring that measures submitted to the Secretary have been adequately evaluated by stakeholders who agree that the measures will provide valid, meaningful results in a feasible, scientific-based manner.

PhRMA strongly supports CMS' reliance on measures adopted or endorsed by a consensus-based organization for measures used in PQRI in 2008 and in future years.

The National Quality Forum (NQF) meets these criteria, as it was specifically designed to comply with the requirements. PhRMA supports the role of NQF as a consensus body of various stakeholders as well as its important role as an endorser of practice standards and quality measures. In principle, PhRMA supports the use of NQF-endorsed measures in the PQRI.

In principle, PhRMA also supports CMS' reliance on measures adopted by the AQA Alliance in selecting measures for PQRI in 2008. The AQA, a quality alliance primarily focused on ambulatory care, also plays an important role as an adopter of physician-level quality measures.

However, as noted by CMS, the AQA as currently structured and operated does not meet the criteria for a voluntary consensus-based organization as described by the NTTAA and OMB Circular A-119. AQA utilizes some of the practices that define a voluntary consensus-based organization: openness, balance of interest, and consensus. But, it does not have a formal due process or appeals structure. As consensus does not require unanimity, it is important that the minority positions have the opportunity to voice positions and to appeal decisions. All of the criteria defining voluntary consensus-based organizations work together and are necessary to provide a process that allows stakeholders to cooperate in their efforts on adopting consensus standards. Additionally, it is important to note that AQA is currently in the process of considering changes to its structure and operation. Depending on any changes made, AQA could be closer to satisfaction of NTTAA and OMB criteria but also potentially further away from those standards. If changes were made to exclude some stakeholders from meaningful participation, it would unlikely be that the openness, balance of interest, and consensus criteria would be met.

PhRMA strongly believes that, in order for CMS to continue relying on AQA in updating PQRI measures in 2009 and beyond, AQA must adopt changes that enable it to meet the criteria for a voluntary consensus standard organization. As a member of AQA, PhRMA is working in support of this goal. CMS should monitor AQA's ongoing reorganization process to ensure that the alliance meets these NTTAA and OMB requirements for voluntary, consensus-standard bodies. Because of the important work that AQA is tasked with performing, it is critically important that it meets all of the criteria of being a true voluntary consensus standard organization. Moreover, CMS may need to reconsider its use of AQA measures if its restructuring causes it to move further from maintaining the characteristics of a voluntary consensus standard body that were in effect in December 2006 when AQA was referenced in the MIEA-TRHCA, as noted in the preamble. Additionally CMS is not limited to using measures endorsed or adopted by NQF or AQA; if measures are selected from other organizations, those organizations should also meet the criteria for a voluntary consensus standard organization.

Measure Maintenance Practices

Quality measures are based on standard practices in health care and evaluate the health care provider's ability to provide good patient care. The standard practices in health care are continually evolving in response to changes in scientific knowledge and medical technology. To ensure that quality measures do not become a barrier to medical progress, the measures also must evolve to remain current with the standard practices and to promote proper care. Thus, measure developers must have a maintenance process established to review and update quality measures. The process should be transparent so that anyone wishing to supply data on new scientific evidence or new technologies can do so. As CMS considers further measure updates in 2009 and beyond, it should give preference to measures developed by organizations that have established sound measure maintenance and update procedures.

Suggestions for Measure Development Projects

As measures are used in PQRI, gaps in the measures portfolio will become apparent. PhRMA urges CMS to work with a voluntary consensus-based organization, such as NQF, to identify priorities in filling these measurement gaps. Measure developers can them develop the identified concepts into measures and submit the measures for endorsement by NQF. One gap in the existing base of measures concerns medication therapy management (MTM) programs. Part D plans must offer MTM services to eligible beneficiaries who have multiple chronic diseases, use multiple medications, or exceed the cost threshold. These beneficiaries can benefit from additional assistance with understanding their medications and coordination of care

through an MTM program. However, many Part D beneficiaries are not aware of these services and do not realize that they are eligible for them.[27] Measures that evaluate how often patients are referred to and use these programs could promote the use of these services. While not the full set of measures that should be considered for MTM programs, this would be a starting point in this area.

* * *

PhRMA hopes that these comments will be useful to CMS in developing the final physician fee schedule rule for 2008. We look forward to further dialogue on opportunities to enhance beneficiaries' access to care through improvements in the ASP-based payment system, and hope that CMS will not hesitate to contact us with any questions, comments, or requests for additional information.

Sincerely,

Richard I. Smith
Senior Vice President for
Policy, Research, and Strategic Planning

Ann Leopold Kaplan
Assistant General Counsel

Maya Bermingham
Assistant General Counsel

27 Based on a survey conducted by the University of the Sciences in Philadelphia's Health Policy Institute & Advanced Concepts Institute and presented at the AMCP Annual Meeting, April 2007.

Submitter : **Dr. Gregory Weller** **Date: 08/30/2007**

Organization : **University of Pennsylvania**

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.
Dr. Greg WEller

Submitter : **Ms. Kelly Walsh** **Date: 08/30/2007**

Organization : **University of California, Santa Barbara**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-12996-Attach-1.DOC

#12996

Dear Sir or Madam:

My name is Kelly Walsh. I am currently employed as an Assistant Athletic Trainer at the University of California, Santa Barbara. At UCSB I work specifically with the men's and women's cross country teams and women's softball team. In addition to directing and facilitating the health care of these athletes, I am part of a sports medicine staff that provides exemplary services to prevent, evaluate, treat, and rehabilitate athletic related injuries and illnesses. I graduated from the athletic training education program at Northeastern University's Bouvé College of Health Sciences, a top program in the country. I've been certified as an athletic trainer since I graduated in 2001. I am also a candidate for a master's degree from California University of Pennsylvania. I will graduate this December, earning my degree in Exercise Science and Health Promotion with an emphasis in Performance Enhancement and Injury Prevention.

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,

Kelly Walsh, ATC, LAT

Submitter : Mrs. Audra George **Date:** 08/30/2007

Organization : Summit PT and Rehab

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached letter.

CMS-1385-P-12997-Attach-1.DOC

#12997

Physician Self-Referral Issues

Address to:

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

Subject:

Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

I am a physical therapist in an outpatient clinic in Claremore, Oklahoma. I have practiced for about a year and a half seeing all types of patients with orthopedic problems.

I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. My clinic has already seen and experienced problems with these rules and regulations, where physicians stop referring patients to our clinic and start referring to themselves. I feel that it is morally and legally wrong for physicians to refer patients to their own PT clinics, just so they can get the monetary "kick back". Patients should be sent to the clinic that best suits them and their injuries. These physician self referrals seem abusive and fraudulent to the medical system and most of all the patients. The ability to refer patients to your own physical therapy clinic should be and must be stopped.

Sincerely, Audra George, MPT

Submitter : **Dr. Barbara McAneny** **Date: 08/30/2007**

Organization : **New Mexioc Oncology Hematology Consultants, ltd**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

attachment on several topics

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **DeeAnne Heaton** **Date: 08/30/2007**

Organization : **DeeAnne Heaton**

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.
Aeting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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 complieated 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.
Dee Anne Heaton

Submitter : **Dr. Charles Idom** **Date: 08/30/2007**

Organization : **North Georgia Urology Center**

Category : **Congressional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Ladies and Gentlemen:

RE: Physician Self-Referral Provisions

As a physician practicing in Dalton, Georgia with North Georgia Urology Center, LLC I am acutely aware of both the clinical and cost issues that are important to the Medicare beneficiary and CMS. As a urologist, I have been involved with providing my patients with other cutting edge therapies for urological disease. Services that would not have been widely available to the Medicare beneficiary without the involvement of urology joint ventures that dramatically expanded patient access by taking the risk of providing costly services. Yet in the July 2, 2007 released 2008 Physieian Professional Fee Schedule proposal, CMS attacks the substance of the very joint ventures that by all accounts have saved Medicare millions of dollars.

I would ask CMS to differentiate beneficial therapeutic joint ventures which are not of themselves DHS from the questionable diagnostie ventures that physicians and hospitals may have propagated. With certainty both CMS and the urology community can say that our therapy joint venlures have broadened access to new technology for Medicare patients, brought needed efficiency to the market, and simultaneously saved CMS hundreds of millions of dollars. To jeopardize such a time tested and proven model would seem foolhardy, even in CMS's rational attempt to eliminate some bad behavior.

Sincerely,
Dr. Charles B. Idom, Jr. MD, F.A.C.S
President
North Georgia Urology Center

Submitter : **Ms. Arleta Still** **Date: 08/30/2007**

Organization : **Ms. Arleta Still**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Arleta Still

Submitter : **Andrew Heaton** **Date: 08/30/2007**

Organization : **Andrew Heaton**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Andrew Heaton

Submitter : Dr. Martin Harrison **Date:** 08/30/2007

Organization : Physician Anesthesia Services P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-13003-Attach-1.DOC

#13003

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely, Martin R. Harrison M.D.

Submitter : **Bruce Hopkins** **Date: 08/30/2007**

Organization : **Bruce Hopkins**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.
Bruce Hopkins

Submitter : **Dr. John Westfall** **Date: 08/30/2007**

Organization : **Hill Country Memorial Hospital**

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.

John D. Westfall, M.D.

Director of Anesthesiology, Hill Country Memorial Hospital

Submitter : **Ms. hhhh jjjjj** **Date: 08/30/2007**

Organization : **lll**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Ms. Anne Marie Bicha** **Date: 08/30/2007**

Organization : **American Gastroenterological Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

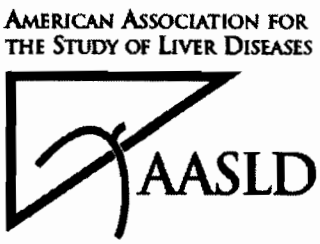
GENERAL

GENERAL

See Attachment.

CMS-1385-P-13007-Attach-1.PDF

13007



August 30, 2007

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
7500 Security Boulevard
Baltimore, MD 21244-8018

Re: CMS 1385-P--Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008

Dear Mr. Kuhn:

The American Gastroenterological Association (AGA) is the nation's oldest not-for-profit medical specialty society, and the largest society of gastroenterologists, representing more than 16,000 physicians and scientists who are involved in research, clinical practice, and education on disorders of the digestive system.

The American Association for the Study of Liver Diseases (AASLD) is a professional society composed of more than 2,900 physicians, researchers and allied health professionals dedicated to hepatobiliary discoveries and patient care. As the leading organization focused solely on advancing the science and practice of hepatology, the AASLD is recognized as the United States, and international, leader in this field.

The AASLD and AGA appreciate the opportunity to provide CMS with our comments on the proposed rule for physician payments for 2008 that was published in the *Federal Register* on July 12, 2007. Unlike previous fee schedules, this proposed rule devotes much attention to the development and expansion of the Physician Quality Reporting Initiative (PQRI), a program created under the Tax Relief and Health Care Act of 2006 (Pub. L. 109-432). Recognizing the Agency's emphasis on the need to improve the quality of care delivered to our nation's Medicare beneficiaries, we would like to focus these comments on the PQRI and make recommendations on what processes should be improved to ensure broad participation from all Medicare health care providers.

TRHCA-SECTION 101(b): PQRI:

Consensus Organizations and Consensus-Based Process for Developing Measures

Given the importance of having a transparent quality measures development, endorsement and implementation system as the foundation of the PQRI, the AASLD and AGA appreciate the Agency's clarification of the respective roles of the National Quality Forum (NQF) and AQA Alliance. However, we urge the Agency to provide additional guidance on how measures that are adopted by the AQA Alliance before December 31, 2007, but not endorsed by NQF until after December 31, 2007, will be recognized under the 2008 PQRI.

Based on our experience, the expectation that AQA coordinate implementation of NQF endorsed measures is flawed, since funding for NQF is inconsistent and project driven. For gastroenterology, a series of hepatitis C measures were developed in 2006 in conjunction with the AMA Physician Consortium for Performance Improvement (PCPI) and were adopted by the AQA in May 2007. However, neither the PCPI nor our societies have received any clarification as to when the NQF will be able to consider them. As a result, it is unclear whether these hepatitis C measures will be recognized under the 2008 PQRI.

We recommend that the Agency allow such measures to be included in the 2008 PQRI, as removing these and similar types of measures from the program would be disruptive for participating Medicare providers and leave gaps in data collection. We encourage the Agency to be more direct in the final rule and state expressly how such measures will be recognized.

Proposed 2008 PQRI measures

CMS is encouraged to improve the utility of the PQRI by augmenting the scope of services provided by eligible professionals to whom PQRI measures apply. For digestive disease specialists, the prioritization of a measurement set in other areas besides the treatment of hepatitis C is critical in expanding the utility of the PQRI.

Appeals Process

While the Act states that NQF complies with OMB A-119, our experience with NQF has not included an appeals process. It is not clear whether NQF, by allowing measure developers to respond to their Technical Advisory Panel (TAP) recommendations, means for such response to meet that requirement. If a measure developer does not take the initiative to respond, it does not appear that a formal appeal opportunity is otherwise provided. The Act also points out that the NQF process includes an evaluation step that includes an appeals process. Again, that has not been our experience. Therefore, we request that CMS provide guidance to professional societies and other measure developers on what type of appeals mechanism is available when measures are not accepted by NQF.

List measures' specifications in the Final Rule

We encourage the Agency to list the numerator and denominator specifications for each measure as close to the final rule date as possible. The applicability of the proposed measures to

various Medicare providers is not transparent unless such specifications are listed. Small differences regarding the inclusion or exclusion of CPT codes in the denominator will largely determine whether health care practices will need to increase staff and financial resources to successfully participate in the PQRI program.

Registries

AASLD and AGA support the careful development of a mechanism for submitting data on quality measures through a data registry or electronic health record. However, the ability of most Medicare providers, including hepatologists and gastroenterologists, to participate in such reporting depends on several factors. These include, but are not limited to:

1) The widespread adoption of health information technology (HIT) in the Medicare provider community; and
2) Technology support must be provided by the Agency to allow Medicare providers to participate in data registry reporting, such as the development of appropriate algorithms that accurately compute reporting for quality measures. Moreover, the Agency must set the standard framework for a national data registry that allows Medicare providers who do not have specific data registries to participate, as well as to provide those specialty societies that have data registries the opportunity to link-up with the Agency's data registry system.

The Agency's five options for utilizing data registries are commendable. It is from the perspective that not all Medicare providers are prepared for data registry adoption and use that AASLD and AGA support the exploration of blending elements from the proposed options. For example, Option 5 calls for a registry data dump for Medicare beneficiaries for all information in a provider's registry for the service period of interest. This option may be beneficial for a medical specialty that has a robust data registry, but not so practical for a specialty that does not have wide adoption of HIT. Therefore, blending elements of Option 5 with elements from Option 1 (having the registries provide the quality-data codes requested for the PQRI measures plus the beneficiary code) allows smaller Medicare providers the opportunity to participate. Overall, the Agency must provide the infrastructure support necessary to facilitate robust Medicare provider participation in data registry reporting.

In conclusion, we support a data registry reporting system that is transparent and open to all Medicare providers, both large and small. Ultimately, monitoring the frequency of Medicare provider use of data registries, as well as the accuracy of data collection, will determine what mechanisms employed by the Agency are successful in improving the quality of care delivered to Medicare beneficiaries.

Hepatitis A&B Vaccines

In this rule, the proposal lists a single measure for hepatitis A & B vaccinations in patients with hepatitis C. The measure had actually been revised and approved by the PCPI to be two separate measures (one for each vaccine). For reasons that are unclear, a single measure was approved by the AQA. As we will be requesting this technical issue be clarified at the upcoming October

2007 AQA meeting, we recommend that the Agency list these as two separate measures in the final rule.

Colorectal Cancer Screening Measure

The AASLD and AGA are pleased that CMS has included a colorectal cancer screening measure in the 2008 PQRI measure set. We commend the Agency for recognizing the public health implications of colorectal cancer screening, and the quality impact of increasing screening rates for Medicare beneficiaries.

Section 5103 of the Deficit Reduction Act of 2005 provides for waiver of the Part B deductible for beneficiaries obtaining a colorectal cancer screening procedure, including a colonoscopy or sigmoidoscopy. However, the Agency has chosen to interpret the benefit so that when a beneficiary without symptoms is referred for a screening colonoscopy, and a lesion or neoplasm is found on examination, the physician is then responsible for collecting a co-payment after the fact. While we do not believe this was the intent of the Congress, the Agency's interpretation of this has created significant confusion for both beneficiaries and physicians.

We request that the co-payment be waived when the beneficiary is referred for a screening colonoscopy, regardless of whether a screening or diagnostic/therapeutic colonoscopy procedure is performed, as long as the physician reports the appropriate ICD-9-CM code to indicate the primary reason for the procedure was colorectal cancer screening. This way beneficiaries will get screened and the patient's financial situation does not directly impact a provider's performance on this measure.

Thank you in advance for your consideration of our comments. The AASLD and AGA stand ready to work with CMS in its efforts to improve the quality of care provided to our nation's Medicare beneficiaries. Please contact Jennifer Shevchek, AASLD, at 202-484-1100, or jshevchek@dc-crd.com, or Anne Marie Bicha, AGA Director of Regulatory Affairs, at 240-482-3223 or abicha@gastro2.org, if we may provide any additional information on these comments.

Sincerely,

Gregory Gores, MD
President, American Association for the Study of Liver Diseases

Mark Donowitz, MD

Mark Donowitz, MD, AGAF
Chair, American Gastroenterological Association

Submitter : **Ms. Debbie Thompson** **Date: 08/30/2007**

Organization : **Ms. Debbie Thompson**

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

Rc: CMS-1385-P
Anesthesia Coding (Part of 5-Ycar Review)

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Thank you for your consideration of this serious matter.

Sincerely,

Debbie Thompson

Submitter : **Sherry Hopkins** **Date: 08/30/2007**

Organization : **Sherry Hopkins**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.
Sherry Hopkins

Submitter : **Ms. Karen Kostecki** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Practitioner**

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
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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 E. Kostecki, MS, CRNA_____
Name & Credential
6325 13th Street North_____
Address
Fargo, ND 58102_____
City, State ZIP

Submitter : **Date: 08/30/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I want to voice my strong opposition to Docket #1385-P Therapy Standards and Requirements, Physician Self-Referral Provisions.
The APTA has for years tried to push the idea that only a physical therapist is qualified to perform rehabilitation services. They have begrudingly acknowledged the existance of Occupational Therapy but are still vigorously trying to suppress the rights of other practioners to perform rehabilitation. These practioners include Atheletic Trainers, Kinesiotherapists and Exercise Physiologists.

One must admit that a properly educated, registered Physical Therapist is indeed highly capable and able to serve patients very well, but the aforementioned groups are equally capable and have the credentials and certifications to prove it. A mininum of a bachelors degree is required for all these careers and the training includes hands-on experience and certification as well as regular continuing education.

The APTA however is seeking to prove that only PT's should provide rehab services., and are trying to monopolize the market
APTA mandated not too long ago that all PT's have a minimum of a masters degree and are pushing for doctorate degrees. This sounds really good and APTA has done this in the name of improved patient care and access, however is it really neeessary, or a means by which to justify higher salaries and reimbursement? As for patient access, this stands to make the issue worse, as smaller facillities such as private rehab hospitals, assisted living facillities and nursing homes will likely not be able to afford a staff of M.S. level PTs and DPT's. Besides the fact that attracting and retaining therapists in such settings will be even more difficult, as the work tends to be mundane (though necessary) and those with such advanced degrees will be seeking more exciting opportunities.

The point is: it simply does not require a masters degree or higher to do what most therapists do in most rehab situations. While some rehab situations are more complicated than others, therapists of several varieties including physical therapists have been working with bachelors degrees for decades and doing a great job.
The fact that Atheletic Trainers, Kinesiotherapists and Exercise Physiologists are still doing it is obviously seen by the APTA as a threat to their plans. These practioners are have already proven themselves to be properly trained and capable to practice, and it is wrong to try to inhibit them from helping our nations sick and injured.

Submitter : **Kermit McMurray** **Date: 08/30/2007**

Organization : **Kermit McMurray**

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.
Kermit McMurray

Submitter : **Dr. Ryan Casey** **Date: 08/30/2007**

Organization : **UTMB Department of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Dr Ryan Patrick Casey MD
Department of Anesthesiology, UTMB
Galveston, Tx 77550

Submitter : **Dr. Richard Brummett, Jr.** **Date: 08/30/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Richard R. Brummett, Jr., M.D.

Submitter : **Mr. Vance Thompson** **Date: 08/30/2007**

Organization : **Mr. Vance Thompson**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Vance Thompson

Submitter : **Dr. Mary Barnum** **Date: 08/30/2007**

Organization : **Springfield College**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

The view I am sharing with you within this letter is based on the experience and knowledge I have gained in my 20 years as a Certified Athletic trainer. During this time period, I have been employed in an orthopedic clinic as an orthopedic technician and high school out reach health care provider, and in my more current position as college professor and director of a CAATE accredited athletic training education program.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation serviees, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. As a teacher and director of a highly successful and widely rccognized athletic training education program, I can say with strong conviction that the educational standards are stringent, ensuring that those entering the profession are well prepared.

Furthermore, 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 aceess 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 reeeive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most eost-effeetive 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 respeetfully 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. Mary G. Barnum ATC, LAT EdD
Assistant Profcssor, Exercise Science and Sport Studies
Dirccor, Athletic Training Education Program
Springfield College, Springfield MA 01009

Submitter : **Kermit Mcmurray** **Date: 08/30/2007**

Organization : **Kermit Mcmurray**

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.
David Melchert

Submitter : **Dr. Justin Davis** **Date: 08/30/2007**

Organization : **UTMB- Galveston**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Aeting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Wendi Schaffitzel** **Date: 08/30/2007**

Organization : **Summit PT and Rehab**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached letter.

CMS-1385-P-13019-Attach-1.DOC

#13019

Physician Self-Referral Issues

Address to:

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

Subject:

Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

I am a physical therapist and member of the APTA from Claremore, OK.

I am not against physician owned physical therapy clinics. Nevertheless, I have a comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. My concerned is that physician-owned physical therapy clinics and self referral; if allowed may discourage patients from choosing where and from whom they receive their treatment. The patients may feel undue pressure from their physician to receive treatment from "his" therapy clinic even if a more convenient or "preferred" therapy clinic would have been the patient's first choice.

Sincerely, **Wendi Schaffitzel, PT**

Submitter : Mr. Blair Childs **Date:** 08/30/2007

Organization : Premier Inc.

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1385-P-13020-Attach-1.PDF

#13020

PREMIER

April 30, 2007

12225 El Camino Real
San Diego, CA 92130

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F 858 481 8919

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Charlotte, NC 28266-8800

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F 704 357 6611

444 N Capital Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

premierinc.com

Malcolm Baldrige National Quality Award 2006 Award Recipient

BY HAND DELIVERY
Also submitted electronically to http://www.cms.hhs.gov/eRulemaking

Mr. Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P, Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions

Dear Mr. Kuhn:

On behalf of the 1,700 leading not-for-profit hospitals and health systems allied in Premier, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the CY 2008 Medicare Physician Fee Schedule and other Part B policies published in the July 12, 2007 *Federal Register*. Premier is a strategic alliance of approximately 200 independent, not-for-profit health systems that operate or are affiliated with more than 1,700 hospitals and 46,500 healthcare sites nationwide.

Our comments primarily focus on provisions of the rule relating to Medicare Part B drug payments, as Premier has a vested interest in ensuring that patients have access to life-saving drugs and that any policy changes do not unintentionally cause inappropriate patient shifting from physician offices to hospitals.

Payment for IVIG Add-On Code for Preadmission-Related Services: Premier supports the continuation of the intravenous immune globulin (IVIG) Preadmission-Related Services code G0332 through the remainder of 2008 with the payment rate set at the same level of practice expense relative value units (PE RVUs) as CY 2007. We believe that this payment continues to be necessary to address the costs associated with acquiring IVIG. We also note that the proposed rule for the hospital outpatient prospective payment system (PPS) would continue payment for preadmission-related services and we emphasize that its continuation in the physician office is important.

Part B Drug Payment, ASP Issues: Premier is concerned that bundled arrangements distort the calculation of the average sales prices (ASPs) used for Medicare reimbursement. Although ideally there would be NO BUNDLED ARRANGEMENTS, CMS must at least ensure that the ASP calculations appropriately allocate the discounts and rebates in bundled arrangements to each individual. For most bundled arrangements, the simplest allocation method is to apply the aggregate dollar amount discounts and rebates for the bundle to each drug in the bundle according to each drug's proportion of dollar sales to total dollar sales for the bundle. As the Medicare Payment Advisory Commission (MedPAC) noted in its March 2007 report to Congress, however, this allocation formula may not produce accurate ASPs for bundles involving a drug with essentially no market competition, such as the white blood cell growth factor. Premier encourages CMS to address this situation with an appropriate special exception to the general proportional allocation formula. Also, the general proportional allocation formula is very similar but not the same as the allocation rule used for the Medicaid average manufacturer price (AMP) calculation.

Part B Payment, Clotting Factor Furnishing Fee: Premier supports the continuation of the "Clotting Factor Furnishing Fee" for 2008 updated by the consumer price index (CPI). Hospitals that provide care to patients with clotting factor problems are faced with storage and preparation issues with these products, as well as the need to stock different brands, based on current patient clinical preference. In some cases, like trauma or surgery, there is an emergent need to stop the bleeding quickly. The Clotting Factor Furnishing Fee helps hospitals cover the preparation time, supplies in preparation and storage expense of these life-saving products, as well as the time spent in ordering/obtaining the brand product necessary to treat a patient.

Competitive Acquisition Program Issues: Premier supports CMS' recommendations to allow physicians to use the Competitive Acquisition Program (CAP) to obtain small doses of bevacizimab outside the CAP in pre-filled syringes. This option would be available where a local carrier's coverage determinations allowed such a practice and when it is consistent with applicable laws and regulations. We believe the proposed policy would be beneficial to our member hospitals which provide continuum of care to patients and which also may own physician office practices.

Proposed Revisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease Facilities: Beginning in CY 2006, the Medicare Modernization Act (MMA) required that CMS establish an annual update to the drug add-on to reflect estimated growth in the expenditures for

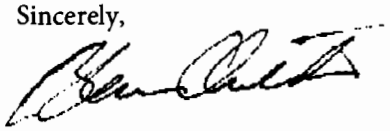
separately billable drugs and biologicals furnished by end-state renal (ESRD) facilities. CMS, using the same estimating methodology as was used in CY 2007, is proposing a total drug add-on adjustment to the composite rate of 15.5 percent for CY 2008. Premier supports the proposed growth update to the drug add-on adjustment to the composite rates as well as the proposed update to the geographic adjustments to the composite rates. Many hospitals treat End-Stage Renal Disease in an ESRD facility. We support the overall composite payment change to hospital based ESRD facility increase of 1.0 percent. It is important that drugs such as erythropoiten, iron, and vitamin D analogs are covered sufficiently as part of the separate billable drugs and biologicals. Anemia, which causes fatigue in these patients, can be a debilitating side effect of renal disease and its treatment. Erythropoiten and iron can be measured for appropriate clinical levels-RBC, Hemoglobin, Hematocrit, Total Iron Binding Capacity, Ferritin level.

Compendia for Determination of Medically Accepted Indications for Off Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen: Premier supports the recognition of additional compendia as authorized under Section 1861(t)(2)(B) of the Act as well as the determination that CMS should establish a formal process, including public comments, to consider additions and deletions to the list of approved compendia. Anti-cancer research is progressing at a rapid rate and treatments are changing constantly. We support the expansion of the compendia list to include at least the following peer reviewed journals: American Journal of Medicine, Annals of Internal Medicine, JAMA, Journal of Clinical Oncology, Blood, Drugs, NEJM, and Lancet. We also support replacing the USP-DI with Thomson Micromedex. Finally, Premier supports the set of desirable characteristics for compendia selection identified by the Medicare Coverage Advisory Committee (MedCAC) and we approve of the proposed formal process for considering future changes to the recognized compendia.

Section 110-Reporting of Anemia Quality Indicators: Premier supports the proposed January 1, 2008, implementation of the requirement to document a patient's hemoglobin or hematocrit levels for beneficiaries undergoing cancer treatment and other indications for erythropoietin stimulating agents (ESAs). Data from these claims will be used to monitor the prevalence, responses to anti-anemia drugs, and outcomes. In response to the question of whether this reporting should be expanded, Premier supports extending the reporting requirement to CKD/ESRD. These reporting requirements will help to assure minimal side effects in patients and also the appropriateness of use as established by FDA-ODAC and CMS.

In closing, Premier appreciates the opportunity to comment on the CY 2008 Medicare Physician Fee Schedule proposed rule. Please do not hesitate to contact Margaret Reagan, corporate vice president of Premier at 202-879-8003 if you would like to discuss these comments further.

Sincerely,



Blair Childs
Senior vice president, Public Affairs

Submitter : Mr. Joseph Mccloskey **Date:** 08/30/2007

Organization : ADPI

Category : Health Care Industry

Issue Areas/Comments

Ambulance Services

Ambulance Services

see attachment

GENERAL

GENERAL

See attachment

#13021

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mrs. April Alford** **Date: 08/30/2007**

Organization : **Clarksdale Orthopedics**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer employed in an physicians' orthopedic office. The orthopedic surgeon's that I work for are extremely happy with the services I am able to bring to their clinic. I have obtained a master's degree and passed the national board of certification for athletie training. I also have licensure in the State of Mississippi.

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 qualificd to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Thank you for your time.

Sincerely,

April Alford, MEd,ATC

Submitter : **Deanna Melchert** **Date: 08/30/2007**

Organization : **Deanna Melchert**

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
Deanna Melchert

Submitter : **Craig Sheetz** **Date: 08/30/2007**

Organization : **Craig Sheetz**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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Thank you for your consideration of this serious matter.
Craig Sheetz

Submitter : Dr. Eric Havemann **Date:** 08/30/2007

Organization : UTMB

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Submitter : **Judy Sheetz** **Date: 08/30/2007**

Organization : **Judy Sheetz**

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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Judy Sheetz

Submitter : Dr. Stanton Honig **Date:** 08/30/2007

Organization : The Urology Center, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS should work with Congress to fix the Sustainable Growth Rate to prevent the upcoming 10% cut to physicians who provide services to Meicare beneficiaries. Drastic cuts will total 40% over the next 8 years. Over the same period, the Medicare Economic Incex (MEI) will increase 20%. How long will physicians be forced to ask for a legislative fix from Congress?

Although no specific proposals exist from CMS, any change to the Stark "in-office" ancillary exception would unduly harm the ability of urologists to provide efficiencies and needed services to patients. Services provided under the exception are important to healthcare delivery. CMS should not further limit this already complex and burdensome regulation.

Under the proposed rule regarding reassignment and diagnostic testing, the only technical or professional services a medical group could mark up would be those performed by the group's full time employees. This would significantly hurt the ability of group practices with in-office imaging equipment to utilize independent contractors and part-time employees to perform professional interpretation services. We understand CMS desire to prevent "mark-ups" and gaming the system but offices with in-office imaging equipment utilize indcpendent contractors and part-time employees to perform high-quality professional interpretation services.

Prohibition of "under arrangements" rule will prohibit the provision of that are provided to a hospital through a joint venture in which you have an ownership interest, (such as radiation therapy or lasers). This will be detrimental to patient care because of access to these services are expensive in our community and across the country. In addition, CMS has taken efforts through a variety of diferent regulations through the years to eliminate duplication of services. If CMS or Congress were to prevent or further limit the ability to Joint venture with hospitals or other practices it may create an environment that would induce physicians to provide more services in-house under the practice exclusion. Each practice group will buy their own equipment or subject patients to return to the more costly and inefficient hospital providers.

We understand the importance of striking a balance between eradicating fraud and abuse and promoting efficiency and protecting patient access to care. As a urologist, these regulations, if implemented would have a negative effect on innovation, efficiency and patient access to care. Please consider suggested changes and withdraw these proposals.

CMS should not be considering making significant changes to Stark rules on an annual basis or for inclusion in the Physician Fee Schedule. Too many financial and business arrangements, legal contracts and services are involved to be altered on a yearly basis or through a piecemeal approach. In sum, the proposedd rule creates two levels of uncertainty: (1) significant lack of clarity within the specific proposals themselves; and (2) general instability due to the prospect of annual changes to Stark.

Submitter : **Mrs. Brent Foster** **Date: 08/30/2007**

Organization : **Summit PT and Rehab**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached letter.

CMS-1385-P-13028-Attach-1.DOC

13028

Physician Self-Referral Issues

Address to:

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

Subject:

Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

My name is Brent Foster and I am a clinic coordinator and staff physical therapist at an outpatient in Claremore, OK. I have practiced for a little over two years now and look forward to a long career as a physical therapist.

I am writing today to express my concerns regarding the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. Over the past several months I have seen the effects of the loopholes in the previous rules and have witnessed there effect on a number of patients and our clinic. Probably the most irritating case was when a Dr. told one of my patients that he was behind schedule in his rehab and thought it would be best if he were to attend a physical therapy clinic in Tulsa, OK that was part of his group. Not only did the Dr. lie to the patient, who was ahead of schedule according to the Dr. provided protocol, but he also made the patient waste his time and money by making the patient drive an extra 40 minutes and waste his gas. There are many other cases I could elaborate on, but due to time I will not go into all the details.
This is a very important issue and could greatly affect the future of our profession.

Thank you for your time and consideration.

Sincerely, Brent S. Foster MPT

Submitter : Jon Austin **Date:** 08/30/2007

Organization : Jon Austin

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.
Jon Austin

Submitter : **Mr. Mark Andrews** **Date: 08/30/2007**

Organization : **Mr. Mark Andrews**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 30, 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,

_Mark Andrews, CRNA
200 Woodland DR.
Pinehurst, NC 28374

Submitter : **Dr. william brosnahan** **Date: 08/30/2007**

Organization : **Associated Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

This e-mail is in support of the proposed increase in the medicare rate for anesthesiology. We have been under valued for years and the four dollar increase helps to fix this problem. Our reimbursement for medicare patients is 30 percent that of private insurance patients. Please consider this request.

Sincerely,
William J. Brosnahan M.D.

Submitter : Ms. Margaret O'Kane **Date:** 08/30/2007

Organization : National Committee for Quality Assurance (NCQA)

Category : Health Care Industry

Issue Areas/Comments

TRHCS--Section 101(b): PQRI

TRHCS--Section 101(b): PQRI

NCQA is providing comments and recommendations on the 2008 PQRI program.

CMS-1385-P-13032-Attach-1.DOC

#1 3132

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National Committee for Quality Assurance Comments on Medicare's Physician Quality Reporting Initiative (PQRI):

CMS Rulemaking (CMS-1385-P)

August 30, 2007

Issue Identifier: "T" Division B of the Tax Relief and Health Care Act – Medicare Improvements and Extension Act of 2006

The National Committee for Quality Assurance (NCQA) supports the goals of the Medicare Physician Quality Reporting Initiative (PQRI). Measuring physician performance using recognized, standardized, evidence-based measures will result in more meaningful information needed for quality improvement and increased accountability among the nation's physicians. While the PQRI is limited to physicians treating Medicare beneficiaries, it has the potential to improve care for all patients. As the private sector explores ways to encourage physicians to improve care and make better use of health care services through programs such as pay for performance, the common challenge is how to align these efforts to produce the best results. The Centers for Medicare & Medicaid Services (CMS) has the opportunity to help define the acceptable approaches for physician-level measurement and reporting that will likely impact the direction of future private initiatives.

NCQA places a high value on collaborating with others to identify best practices and minimize burden associated with measurement and data collection. One example of this has been our work with the American Medical Association (AMA) convened Physician Consortium for Performance Improvement® (PCPI) on developing a common set of physician level measures that are part of the 2007 PQRI measure set. NCQA and PCPI continue to work on a number of significant new physician-level measures. We have also been working with the American Board of Internal Medicine (ABIM) on a common set of principles for our respective work in the development and adoption of physician level measures. We have worked together to develop a streamlined process for the use of NCQA's Physician Recognition programs as part of ABIM's maintenance of certification (MOC) programs. The value of this partnership is to allow physicians to meet their board certification requirements while pursuing recognition for clinical excellence through one process.

We believe that the proposed rule takes too narrow an approach regarding measures eligible for inclusion in the 2008 PQRI measurement set. The current emphasis on the reporting of measures versus the actual performance of physicians themselves is also

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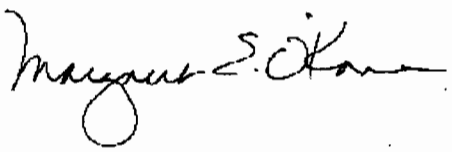
reason for concern. We believe that CMS will have greater flexibility to improve the quality of physician care for Medicare beneficiaries by utilizing existing data collection approaches beyond those included in the proposed rule. Our attached comments spell out a number of ways that we believe the proposed rule can be strengthened to achieve these critical goals. NCQA stands ready to work with CMS to make these changes and to advance our common goal of higher quality care for all Americans.

Sincerely,



Margaret E. O'Kane
President

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NCQA Comments and Recommendations

NCQA comments are specific to the PQRI program and the associated process for including physician measures in the 2008 program. We support a standardized and streamlined process for choosing measures. That requires the use of organizations such as the NQF and the AQA which, together, can serve as objective evaluators of reliable, appropriate and feasible measures for physician performance measurement and reporting.

Issue Identifier - TRHCA--SECTION 101(b): PQRI

P. 407: *Entities eligible for measure submission* - NCQA strongly supports the language in this section. We believe that measures should NOT be limited to those submitted by a single physician specialty. In fact, there is a strong argument that single physician specialty submissions may result in confusion and overlapping measures since in many instances multiple specialties provide the same procedures or care.

P. 419: *Entities eligible for measure submission* - We strongly endorse and agree with the formulation that "we (CMS) do not interpret the MIEA-TRHCA to place special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations." For example, NCQA's process of measure development and approval includes a broader and more balanced representation of clinical and scientific expertise, as well as input from users of measurement such as consumer, purchaser and plans, than is the case with single physician specialty organizations.

P. 424-427: *Measure approval process* - We take strong issue with the proposed language regarding inclusion of new PQRI measures for 2008. The proposed rule appears to establish two separate but unequal processes for inclusion in this important list. It is contrary to the careful assessment of the relative roles and capabilities of NQF and AQA to propose including yet unendorsed measures from the AMA/PCPI, or Quality Insight of Pennsylvania, in the 2008 PQRI, even with the caveat that they *" achieve NQF endorsement* **OR** *AQA adoption by November 15, 2007"* while proposing a different standard for other organizations. On page 428 it appears as if measures from other sources, including NCQA, would be subject to a higher standard, namely that "*We propose to include in the final 2008 PQRI measures other measures endorsed by NQF that were not included in the 2007 PQRI quality measures but that are relevant to Medicare beneficiaries ... Specifications necessary for reporting of these measures will be completed by November 15, 2007 and posted on the CMS web site.*" It appears as if the intent of this is to include measures, both structural and "non physician", from QIP, or the AMA/PCPI, that *may achieve* NQF endorsement, while others would need full NQF

endorsement by the November 15 cut off date. Further, we take strong issue with CMS if the intent of the citation of QIP is intended to limit the consideration by NQF of structural measures or "non physician" measures to those produced by QIP.

P. 424: *Structural measures* - It is unclear why it is necessary to have separate measures for "non physicians" such as those listed in Table 18. If they are different from existing NQF endorsed measures, it would seem undesirable to set different parameters based on the type of clinician. If they are essentially identical, it is unlikely they would be endorsed by either NQF (which is on record as striving for measure concordance) or by AQA which to our knowledge, does not include most "non physician" clinicians. Moreover, to allow these measures, which have not gone through any phase of NQF review, to be short circuited into the 2008 PQRI program would seem to set a very harmful precedent. Finally, and most importantly, CMS is aware of the existence of NCQA structural measures which have undergone extensive testing, are in broad use, and have been submitted to AQA for approval, and which NQF is awaiting funding to review. To exclude consideration of these measures if they are AQA approved, while allowing the inclusion of measures from QIP, would seem highly questionable.

P. 430-432: *Data collection approaches* - The description of the sampling procedure for programs as "information about a defined population of individual persons or events, collected using an observational study design in a systematic way, in order to serve a predetermined scientific, clinical, or policy purpose" is too narrow. There does not appear to be any provision for sampling, or even for inclusion of non Medicare patients in the data submitted. In order to avoid redundant data collection we urge a broader definition of allowable sampling. Any methodology should be sound and produce results that are representative of the physician's practice including Medicare beneficiaries but not necessarily limited to Medicare beneficiaries. We believe CMS has the opportunity to explore options other than registries that can yield a better end result through the evaluation of performance, not just reporting. Efficient, reliable measurement means that the physician does not measure every patient or episode, but uses a rigorous, validated sampling approach. The use of sampling, validation, and assessment against comparison thresholds is actually a higher bar than what is proposed in PQRI. CMS should not hold back progress by forcing the physician community to use older less efficient data collection methods when better methods are available.

P. 433: *Data collection approaches* - The five registry options outlined in the proposed rule do not take into consideration the availability of existing physician measurement programs such as the NCQA physician and practice recognition programs. These long-standing programs use a sampling methodology that allows NCQA to make a sound judgment about a physician's performance while minimizing the data collection burden.

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CMS should amend the definition of registries to allow physicians and practices recognized under these programs to be considered as meeting the PQRI requirements.

Measure Tables 16-22: *NCQA recommended measures* - We are encouraged that CMS is committed to using measures that have been endorsed by AQA or NQF, across a broad array of specialties and clinical topics. Success for PQRI will depend on measures being available for the broadest array of physicians and other clinicians as possible. To that end, we request that CMS include the measures listed below in Table 1 in the PQRI program for 2008. The NCQA Back Pain measures are undergoing NQF review, and have been submitted to the NQF membership for member comment. The PPC Structural measures have been submitted for AQA review. We also support CMS's inclusion of the measures in Table 2 as additional measures for consideration for use in PQRI 2008. These measures have been developed by nationally recognized measure developers, including NCQA and the AMA-PCPI, and all have been submitted for AQA review.

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Table 1: NCQA MEASURES Recommended for the PQRI 2008

Back Pain (Back Pain Recognition Program)
Measure #1: Back Pain Measurement Set (Aggregate Measure)
Measure #2: Initial Visit
Measure #3: Physical Exam
Measure #4: Mental Health Assessment
Measure #5: Appropriate Imaging for Acute Back Pain
Measure #6: Repeat Imaging Studies
Measure #7: Medical Assistance with Smoking Cessation
Measure #8: Advice for Normal Activities
Measure #9: Advice Against Bed Rest
Measure #10: Recommendation for Exercise
Measure #11: Appropriate Use of Epidural Steroid Injections
Measure #12: Surgical Timing
Measure #13: Patient Reassessment
Measure #14: Shared Decision Making
Measure #15: Patient Education
Measure #16: Post-Surgical Outcomes
Measure #17: Evaluation of Patient Experience
Physician Practice Systems (Physician Practice Connections Program)
Measure #1: Physician Practice Connections (Aggregate measure)
Measure #2: Use of E-Prescribing Systems
Measure #3: Alerts for Drug-Drug Interactions
Measure #4: Use of Patient Registries
Measure #5: Use of Electronic Health Records
Measure #6: Reminders for Preventive Care at Point of Service
Measure #7: Lab Test Tracking
Measure #8: Staff Assigned to Execute Standing Orders
Measure #9: Patient Reminders
Measure #10: Patient Self-Monitoring
Measure #11: Use of Feedback Reports for Quality Improvement

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Table 2: Additional Measures for Consideration for PQRI 2008

Dermatology *(AAD/AMA PCPI/NCQA)*
Measure #1: Process of care measures for Melanoma – Bundled Measure #2: Continuity of Care – Recall System Measure #3: Coordination of Care – communication with primary care physician Measure #4: Overuse measure – Imaging for patients with stage 0 or 1A Melanoma
HIV/AIDS *(NCQA/AMA PCPI/IDSA/HRSA)*
Measure #1: Medical visit in an HIV care setting Measure #2: CD4+cell count and HIV Viral Load Measure #3: PCP prophylaxis (as an indicator of OI prophylaxis) Measure #4: Adolescent and adult clients with AIDS who are prescribed HAART Measure #5: Pregnant women with HIV infection who are on antiretroviral therapy Measure #6: TB (PPD) Screening Measure #7: STD Screening Measure #8: Vaccinations Measure #9: High Risk Behavior Measure #10: Appropriate Periodic Health Examinations
Nuclear Medicine (SNM/AMA PCPI/NCQA)
Measure #1: Radionuclide bone imaging; metastatic disease to the bone Measure #2: Radionuclide bone imaging; osteomeyelitis Measure #3: Radionuclide bone imaging; occult trauma
Eye Care *(AAO/AMA PCPI/NCQA)*
Measure #1: Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care Measure #2: Primary Open-Angle Glaucoma: Counseling on Glaucoma Measure #3: Cataracts: Postoperative Complications within 30 Days Following Cataract Surgery Measure #4: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery Measure #5: Cataracts: Comprehensive Pre-operative Package for Cataract Surgery with IOL Placement Measure #6: Cataracts: Counseling on Cataract Prevention Revised Measure #7: Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplements

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Geriatrics *(AGS/AMA PCPI/NCQA)*
Revised Measure #1: Advance Care Plan
Measure #2: Falls: Risk Assessment
Measure #3: Falls: Plan of Care
Radiology *(ACR/AMA PCPI/NCQA)*
Measure #1: Classification of risk for nephrotoxicity in contrast media administration
Measure #2: Monitoring patients at risk for nephrotoxicity: Measurement of serum creatinine
Measure #3: Nephropathy prophylaxis for patients receiving contrast enhanced imaging procedures
Measure #4: Use of acetylcysteine for patients receiving contrast enhanced imaging procedures
Measure #5: CT radiation dose reduction
Measure #6: Report of exposure time for fluoroscopic procedures
Measure #7: Mammography screening – additional assessment
Measure #8: Mammography screening - use of BIRADS codes
Measure #9: Mammography screening - Communication with the physician managing ongoing care
Measure #10: Stenosis measurement in carotid imaging reports - Broadening of clinical indications
Chronic Kidney Disease *(RPA/AMA PCPI)*
Measure #1: Blood Pressure Measurement
Measure #2: Plan of Care for Elevated Blood Pressure
Measure #3: ACE Inhibitor (ACE) or Angiotensin Receptor Blocker (ARB) Therapy
Measure #4: Laboratory Testing (Calcium, Phosphorus, PTH and Lipid Profile)
Measure #5: Plan of Care – Anemia
Measure #6: Influenza Vaccination
Measure #7: Referral for Permanent Vascular Access
Oncology *(ASTRO/ASCO/AMA PCPI)*
Measure #1: Cancer stage documented
Measure #2: Hormonal therapy for stage IC-III, ER/PR positive breast cancer
Measure #3: Chemotherapy for Stage III colon cancer patients
Measure #4: Plan for chemotherapy documented before chemotherapy administered
Measure #6: Treatment summary communicated – Radiation Oncology
Measure #7: Normal tissue dose constraints specified
Measure #8: Pain Intensity Quantified
Measure #9: Plan of Care for Pain

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Measure #10: Pathology report – Medical Oncology Measure #11: Pathology report – Radiation Oncology
Anesthesiology and Critical Care *(ASA/AMA PCPI)*
Measure #1: Stress ulcer disease (SUD) prophylaxis considered in ventilated patients Measure #2: Perioperative temperature management for surgical procedures under general anesthesia
Atrial Fibrillation *(ACC/AHA/AMA PCPI)*
Measure #1: Assessment of thromboembolic risk factors Measure #2: Chronic anticoagulation therapy Measure #3: Monthly INR measurement
Perioperative Care *(AMA PCPI)*
Measure #1: Perioperative cardiac risk assessment (History) Measure #2: Perioperative cardiac risk assessment (Current symptoms) Measure #3: Perioperative cardiac risk assessment (Physical examination) Measure #4: Avoidance of electrocardiogram overuse Measure #5: Perioperative continuation of beta-blockers

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Submitter : **Erin Austin** **Date: 08/30/2007**

Organization : **Erin Austin**

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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Thank you for your consideration of this serious matter.
Erin Austin

Submitter : **Carol Barnes** **Date: 08/30/2007**

Organization : **Carol Barnes**

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.
Carol Barnes

Submitter : **Ms. Katherine Coburn** **Date: 08/30/2007**

Organization : **Connectivity**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 30, 2007
Dear Sir or Madam:

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.
I own Connectivity, LLC in Eagle, Idaho. I have been an active Certified Athletic Trainer for 20 years, working in a variety of settings from Spine Institutes, Sports Medicine Clinics and traditional athletic training settings to now owning my business. My education and experience qualify me to give excellent care to each patient and client I see.
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 and clients.
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 and clients 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,
Katherine A. Coburn, ATC, PTA, CSCS, CMT

Submitter : **Dr. Stuart Levy** **Date: 08/30/2007**

Organization : **Dr. Stuart Levy**

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:

This is critical to my field of Anesthesiology!
I want 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. The increase is long overdue. Without the increase it will not be long before patients will suffer from a decrease in Medicare participation and access.

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. At my large hospital we are having difficulty recruiting new anesthesiologists. The reason is the number of Medicare patients we have relative to the outside surgicenters, whose patients are younger.

In order 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.

Stuart J. Levy, M.D.
26 Tammy Hill Trail
Randolph, NJ 07869
SL414@aol.com

Submitter : **Cecil Beagles** **Date: 08/30/2007**

Organization : **Cecil Beagles**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.
Cecil Beagles

Submitter : **Matthew Twetten** **Date: 08/30/2007**

Organization : **American Academy of Orthopaedic Surgeons**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-13038-Attach-1.TXT

#1 3038

AAOS
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
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www.aaos.org

August 30, 2007

Herb Kuhn
Acting Director
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8018

Subject: CMS-1385-P Medicare Program: Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008

Dear Mr. Kuhn:

The American Association of Orthopaedic Surgeons (AAOS) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Revisions to Payment Policies Under the Physician Payment Schedule and Other Part B Payment Policies for Calendar Year 2008, published in the July 12, 2007 *Federal Register*.

RESOURCE-BASED PE RVUs

A. Utilization Assumptions for Equipment in Determining Practice Expenses:
The AAOS agrees with CMS that it is important to review the assumptions used to compute equipment costs within the practice expense payment methodology. Moreover, with the implementation of the bottom-up approach and the ongoing physician practice information survey process, we believe that the entire practice expense payment methodology should be reviewed and, if appropriate, updated.

The current assumption that any piece of equipment is in use 50% of the time has been shown to not be reflective of actual practice patterns. The Medicare Payment Advisory Commission conducted a pilot review of medical practices in three cities and found radiology equipment being utilized at a rate above 100%. Given these data, we believe CMS should consider a higher rate for equipment usage based on actual physician practice patterns. The AAOS supports the implementation of differential equipment usage rate assumptions as a possible alternative to the 50% standard currently in use.

B. Non-facility Practice Expense RVUs for Arthroscopic Procedures:
CMS has requested input on whether or not non-facility practice expense relative value units (PE RVUs) should be assigned to five diagnostic arthroscopic procedures: CPT codes 29805, 29830, 29840, 29870 and 29900. Since orthopaedic surgeons are the main providers of these procedures, the AAOS welcomes the opportunity to offer guidance to CMS on this issue.

At the September 2006 AMA/Specialty Society Relative Value Scale Update Committee (RUC) meeting, the AAOS recommended not assigning non-facility PE RVUs to the diagnostic arthroscopy procedures. We do not recall any opposition to this recommendation. The RUC and CMS accepted the recommendation, and these procedures did not get non-facility PE RVUs.

It has come to our attention that a group of physicians is requesting non-facility practice expense pricing for diagnostic arthroscopy. It is our understanding this group has approached CMS directly to address this issue without working with the AAOS or any other national medical specialty or sub-specialty society. The AAOS believes the proper method for reviewing practice expense requests is through the RUC, with multi-specialty input and support.

The AAOS has carefully reviewed and considered the pros and cons of assigning non-facility PE RVUs to these procedures. It is the unanimous opinion of our expert panel that CMS not approve non-facility PE RVUs for these and other diagnostic arthroscopy procedures. We believe the safest setting for these procedures remains the facility setting for the following reasons. If complications arise during these procedures, the facility setting gives physicians more clinical options to deal with them. Furthermore, if one of these procedures is done in an office setting and a surgically treatable lesion is found, the patient would need to be moved to a facility, prepared again for surgery, including being anesthetized again, and then undergo a second procedure, most of which could have been avoided if the diagnostic procedure had been done in the facility in the first place.

In addition, the AAOS believes patients will face other significant risks because untrained practitioners may begin to perform these procedures in the non-facility setting. The facility setting only allows credentialed practitioners to perform these procedures. In the non-facility setting, there is no method to ensure providers have adequate training.

In April 2001, CPT code 29900 was RUC surveyed. After the survey took place, the AAOS recommended, and the RUC and CMS accepted, a service description clearly stating this was a facility-based procedure. There was no direct or indirect reference to non-facility services. In addition, utilization data then and now does not support non-faciltiy PE RVUs for this and the other diagnostic arthroscopy procedures.

If evidence is presented establishing the safety and efficacy of these procedures in the office setting and a method is established to ensure that only qualified providers perform them in the office setting, the AAOS will re-consider its position.

GEOGRAPHIC PRACTICE COST INDICES (GPCIs)

The AAOS believes the 1.000 GPCI floor has been a very important tool in maintaining fair reimbursement for practitioners in underserved areas. Many of the payment localities with a GPCI of less than 1.000 are in rural areas, where it is difficult to recruit and retain health care providers, especially surgical specialists such as orthopaedists.

Recent efforts by CMS and the Congress to address this critical situation have been welcomed in these areas. Therefore, we encourage CMS to work with the Congress to re-establish the GPCI floor at 1.000.

PHYSICIAN SCARCITY AREAS

Just like the GPCI floor, the scarcity bonus payment is another important strategy to attract and retain practitioners in underserved areas. The AAOS believes that if the bonus payment is discontinued, it will exacerbate the access problems that many Medicare beneficiaries already experience in these areas. Again, we encourage CMS to work with the Congress to reinstate this patient protection initiative.

PHYSICIAN SELF-REFERRAL PROVISIONS

The AAOS appreciates the opportunity to review some of CMS' decision-making processes as it contemplates changes to the "Stark" self-referral regulations.

A. Diagnostic Tests/ "Anti-Markup Provisions":
The AAOS appreciates the issue that CMS is attempting to address through this proposal. Maintaining the fiscal and ethical integrity of the Medicare program is a goal we share with CMS.

The AAOS would like to thank CMS for its thoughtful and reasonable approach to addressing the problem of inappropriately profiting off of Medicare reimbursements by securing certain contract provisions. CMS' decision to focus on the billing of diagnostic tests by one physician or group where the diagnostic test is performed by someone other than a full-time employee is appropriate. In addition, CMS' approach of paying the lesser of the Medicare fee schedule amount, actual charges, or the charges of the physician performing the diagnostic test is inherently reasonable.

Regarding the "anti-markup" provision, the AAOS' main concern is how the data to determine the payment level would be calculated and captured. The AAOS requests that CMS ensure that the calculation of the payment level under the "anti-markup" provision place no new administrative burdens on the billing physician or group.

B. In-Office Ancillary Services Exception:
While CMS is not proposing to change the in-office ancillary exception (IOAE), the AAOS strongly challenges some of the characterizations articulated in this section of the proposed rule.

CMS refers to "hundreds of letters from physical therapists and occupational therapists that the in-office ancillary services exception encourages physicians to create physical and occupational therapy practices." CMS does not elaborate any further on the propriety or harm of this activity. We believe the question of whether or not this activity benefits or harms patients is at the heart of the matter.

As CMS knows, physical therapists (PTs) and occupational therapists (OTs) usually work either in free-standing PT or OT facilities, hospitals or medical practices. They are either independent contractors or employees. Some own their own facilities.

The exact number of orthopaedic and other medical practices that employ PTs and OTs is unknown. However, the advantages of this type of arrangement to physicians, PTs, OTs and, most importantly, patients are well understood.

When PTs and OTs work in a medical practice, it gives patients more places to choose from to get their services. It can also be a tremendous convenience for patients. For example, many patients that orthopaedists see have limited mobility and need ambulatory aids (e.g., crutches, walkers, wheelchairs). Some of these patients are transported to their orthopaedists' offices by ambulances, cabulances, and vans that are especially adapted for wheelchairs and stretchers. When these patients see their physicians, PTs or OTs at the same location, the physical burden of travel, as well as travel costs, are potentially lower than if the patients have to travel to a second site for their PT or OT services. In addition, some patients feel more comfortable knowing that their PTs or OTs and physicians are working together at the same location.

These types of arrangements give physicians the chance to interact more quickly and more frequently with PTs and OTs than they otherwise would be able to do if the PTs and OTs were located off-site. In addition, PTs and OTs get more choices about where to work. While many PTs and OTs may like working in hospitals or other facilities, others may prefer to work in a medical practice.

The AAOS requests that CMS elaborate on its concerns in this area, acknowledging that the number of letters received on a given subject is not always indicative of the gravity of an issue or the need for correction. The AAOS also requests that CMS engage in discussions with stakeholders on this issue given the obvious importance of physician expertise, patient needs, clinical quality, and the appropriate use of Medicare resources in these areas. Furthermore, the AAOS recommends that CMS analyze whatever data may exist in and out of the Medicare program to determine the cost-

effectiveness of PTs and OTs in medical practices in relation to the cost-effectiveness of PTs and OTs in other settings.

In addition to the PT/OT issue described above, CMS states that "services furnished today purportedly under the in-office ancillary services exception are often not as closely connected to the physician practice." CMS then goes on to cite concerns about pathology services. If CMS believes that there are specific instances in which the IOAE is being used inappropriately, it should pursue those cases individually or narrowly tailor changes to the exception to deal specifically with those types of cases. However, a drastic change to the exception would harm patient access to necessary care in an appropriate and convenient setting.

C. Alternative Criteria for Satisfying Certain Exceptions:
The AAOS commends CMS on its attempt to bring rationality to the strict enforcement of inadvertent form violations of the self-referral regulations. However, the AAOS also believes that CMS should amend the proposal so it is not so rigid in how it is enforced.

The proposed rule states that whether the criteria have been met will be determined "at the sole discretion" of CMS, and that decisions will not be "subject to further administrative or judicial review." Surely CMS can preserve its authority while simultaneously ensuring that those that are subjected to this rule and exception are able to access the benefits of it.

DME UPDATE

The AAOS believes that Class III devices, while innovative, may prove to be economically beneficial to payers in the long run by offsetting the costs of additional medical resources. Ackerman, Mafilios, and Polly[1] found that the use of bone morphogenetic protein (BMP) was counterbalanced by the reduction of costs associated with the prevention of pain and infections associated with the use of autogenous iliac bone graft. The use of BMP was estimated to be cost neutral when used in anterior lumbar fusion. Although not considered durable medical equipment, BMP used in conjunction with a spinal cage is classified by the Food and Drug Administration (FDA) as a Class III device.

The AAOS is concerned about adversely affecting patient access to the benefits of innovative devices if payments for Class III devices are not adequately updated. Medicare beneficiaries should have the use of innovative therapies to assist in their recovery process. Medically innovative therapies may be expensive when first introduced to the U.S. marketplace but often prove to be cost-effective in long-term disease management. Furthermore, innovative therapies may be the only options when treating difficult cases. For example, bone growth stimulators, which are Class III medical devices that CMS categorizes as durable medical equipment, are extremely

[1] Ackerman SJ, Mafilios MS, Polly DW. Economic evaluation of bone morphogenetic protein versus autogenous iliac crest bone graft in single-level anterior lumbar fusion: an evidence-based modeling approach. Spine 2002 Aug 15;27(16 Suppl 1):S94-9.

beneficial therapies used in the treatment of delayed unions and non-union fractures. Previously, many of these limbs with delayed or non-union fractures were amputated.

The AAOS urges CMS to support a reasonable annual payment update for durable medical equipment regardless of the FDA classification.

TRHCA—SECTION 101 (B): PQRI

A. Measure Development Process:
The AAOS appreciates the opportunity to comment on the 2008 Physician Quality Reporting Initiative (PQRI). The AAOS, through the American Medical Association's Physician Consortium for Performance Improvement (PCPI), assisted in the development of the measures used in the 2007 PQRI. The measures for orthopaedic surgeons are appropriate, and the AAOS supports their inclusion if the program continues in 2008.

However, the requirement that measures for the 2008 program be developed "through the use of a consensus-based process" provides too much latitude for differing interpretations. For instance, the consensus-based processes that the International Standards Organization (ISO) and the American Society for Testing and Materials, Int. (ASTM) use are vastly different. The ISO requires a two-thirds majority while the ASTM requires that all negative votes be resolved before the standard may be adopted. We therefore urge CMS to more narrowly define consensus organizations and establish that the PCPI is the only entity appropriate for the development of physician-level quality measures. Direct physician involvement in the development, testing, and implementation of quality measures is the only way to ensure measures are appropriate and clinically-relevant. Tasking the PCPI as the only group for developing physician measures significantly reduces the risk of duplicative or contradictory measures and ensures measure harmonization.

B. PQRI Measures:
As CMS seeks to make refinements, the AAOS would like to highlight a discrepancy between the Surgical Care Improvement Project (SCIP) VTE-1 (also referred to as the National Quality Forum Consensus Standard for Prevention and Care of Venous Thromboembolism) measure and the CMS PQRI "Measure #23, Perioperative Care: Venous Thromboembolism (VTE Prophylaxis)" which is an individual physician measure.

At this time, PQRI Measure #23 allows individual physicians to qualify for the PQRI payment bonus if they use one of the following prophylaxis treatments for DVT/VTE in all common orthopaedic procedures: Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux (Lovenox), or mechanical prophylaxis (i.e., pressure stockings, massage boots, etc.) for all major common orthopaedic inpatient surgical procedures (hip and knee replacement, hip fracture repair, etc.). However, SCIP-VTE-1 allows hospitals to receive a payment

bonus credit under the SCIP program if their operating physicians use certain chemoprophylaxis treatments for certain procedures only (i.e., LDUH is only permitted under SCIP-VTE-1 for hip fracture surgery, but not hip or knee replacement; mechanical prophylaxis is also not recognized under SCIP-VTE-1 for all orthopaedic patients and procedures, while it is for PQRI Measure #23). This discrepancy is understandably creating practice-standard conflicts between orthopaedists and hospital administrators.

The discrepancy should be addressed in the 2008 version of the PQRI program. More broadly, CMS should review all of its quality initiatives in relation to other programs to ensure that they are compatible and not in conflict with each other even though they operate separately from one another.

AAOS has recently released its own clinical practice guidelines for Pulmonary Embolism prophylaxis, which are in-line with the PQRI Measure #23. A summary of the AAOS clinical practice guideline is available at the following URL:
http://www.aaos.org/Research/guidelines/PE_summary.pdf

The AAOS believes that the quality initiatives implemented by CMS and many third party payors have the potential to benefit patients and reduce the costs of medicine. However, the AAOS believes that these quality initiatives- regardless of whether they are structured as pay-for-performance or pay-for-reporting- are not ready to be implemented as mandatory programs.

By all accounts, the health care community is in the infancy of quality assessment. The available evidence has not demonstrated that we are actually measuring parameters that represent increased quality. Certainly, we will need process measures to identify the source of difficulties but the ultimate measure of quality will be outcomes measures, and the physician community is just beginning to learn how to measure outcomes efficiently. Measuring outcomes requires that patients and/or physicians complete outcomes instruments. Subsequently, information must be entered into a database, most often manually. Until electronic patient records are widely adopted, this proves to be a burden both for both patients and physicians and is impractical.

Therefore, the AAOS strongly suggests that any quality reporting program remain voluntary until the time all stakeholders are certain that we are truly measuring quality and have developed a method to efficiently measure outcomes. The AAOS encourages CMS to be flexible in setting the parameters for the use of electronic measure reporting. Due consideration should be given to registries, electronic health records, and other means of electronic reporting.

Finally, the AAOS would like to provide comments on the inclusion of the podiatric measures. The AAOS has reviewed the proposed podiatric measures and feel that they are appropriate, and therefore, support their inclusion as applied to podiatrists only. While the proposed rule does not suggest a broader application, we do not believe they should be required of orthopaedic surgeons. The measures for proposed inclusion are currently under development by the American Podiatric Medical Association (APMA)

and will achieve National Quality Forum (NQF) endorsement or AQA Alliance adoption by November 15, 2007. The AAOS has reviewed drafts of the three measures developed by APMA for diabetic foot and ankle care: 1) neurological evaluation for peripheral neuropathy, 2) Ankle Brachial Index (ABI) measurement for peripheral arterial disease (PAD), and 3) evaluation of footwear for ulcer prevention.

Diabetes is the leading cause of lower extremity amputations, which are detrimental to a Medicare beneficiary's quality of life as well as expensive for the Medicare program. Despite widespread agreement among public health and medical experts that amputations could be prevented if patients with diabetes receives quality foot and ankle care, the number of amputations continues to rise.

The three quality measures developed by the APMA would encourage the evaluation of diabetic patients for possible peripheral neuropathy, measure the ABI of diabetic patients for possible PAD, and evaluate footwear of diabetic patients to prevent ulceration. The evaluations and measurement can identify diabetic patients who have a particularly high risk of lower extremity complications. The identification of patients who need appropriate diabetic foot care would help address a gap in care that has caused the number of amputations to increase. Thus, the AAOS believes these three quality measures should be included for reporting in the 2008 PQRI, and encourages CMS to facilitate approval of all three measures by the NQF or the AQA prior to November 15, 2007.

C. Data Submission Through Registries:

The breadth of the definition of a medical registry as "a file of documents containing uniform information about a defined population of individual persons or events, collected using an observational study design in a systematic way, in order to serve a predetermined scientific, clinical, or policy purpose" may encourage the collection of very narrow data to satisfy the quality reporting requirements without providing additional benefits to the providers contributing data to the initiative. Medical registries, such as the Society of Thoracic Surgeons national database cited in the proposed rule, have the potential to significantly contribute to the improvement of physician performance and patient outcomes when properly administered. The ability to capture data one time and submit it to multiple entities will be an attractive option to practitioners currently contributing to registries. Unfortunately, for physicians without the benefit of registry participation, the information must be redundantly reported to multiple agencies to satisfy various quality reporting, payment, and accreditation requirements. Data reported by these individuals may be of low quality or only satisfy minimum requirements. It is important to consider these issues when evaluating all five options to identify which, if any, present the best opportunity to collect high quality data in the least burdensome manner.

We encourage CMS to include registries that are not easily interfaced with the CMS data warehouse in addition to those that already possess this capability. We believe that understanding the resources that registries will need to link their systems with CMS is critical to the success of this proposal. Additionally, early release of this information

will enable other registries to begin planning for participation in this program well in advance of its widespread implementation, thereby increasing the potential number of participants and allowing smaller or less well-funded registries to better manage the associated costs.

We believe Options 1 through 4 provide the best alternatives for physicians to participate in PQRI via registries as well as allowing registries to manage and secure their proprietary information. Option 5 appears to be the least attractive option as it strips the registry of its ability to increase participation and compliance by negating its role as the conduit of information. By employing a "data dump" from the registry to CMS any early performance feedback provided by the registry computing reporting and performance rates is lost. The same information could be gathered and submitted from hospital billing and administrative data creating few incentives for registry participation. Option 5 will undermine compliance with existing registry efforts and diminish, rather than enhance, their role in the PQRI program.

If CMS selects more than one option for implementation, the AAOS recommends the agency be consistent with respect to the calculation of reporting and performance rates. Rates are calculated by CMS under Options 1, 2, 3, and 5 and by the reporting registries under Option 4. The AAOS recommends that rates for all options be calculated by the reporting registries and that CMS use the submitted data to validate the calculations. Local control of the submitted calculations and the added transparency of this method may increase compliance by increasing physician confidence in the process.

Finally, the AAOS understood, from previous communications with CMS, that the agency's data collection and storage capabilities are at capacity, precluding the collection of additional data elements. With a lack of new information technology (IT) infrastructure, we are concerned that the proposed options for the collection of PQRI data from registries will not be feasible on a national scale. We encourage CMS to provide additional information to the public with details on the agency's plan to collect and store PQRI data, including IT infrastructure capabilities.

IMPACT

A. Budget Neutrality Adjuster:

The AAOS recognizes that CMS is required by law to apply budget neutrality to the Physician Fee Schedule when RVU changes exceed $20 million in overall impact. However, the AAOS continues to believe the most appropriate place to apply a budget neutrality adjuster is the conversion factor rather than work RVUs for the following reasons:

1. Using a work budget neutrality adjuster unevenly distributes its impact on those services that have a higher portion of their total RVUs reflecting work. Using the

conversion factor evenly distributes the impact of the budget neutrality adjuster across all services.

2. Using a work budget neutrality adjuster confuses other payors that use the Medicare relative value scale and may lead them to lower their payment rates merely because Medicare has lowered the relative values of medical services and procedures. Using the conversion factor will not affect the payment rates of these other payors because their conversion factors are based on their own financial considerations.

3. Using a work budget neutrality adjuster could affect the relativity between and among procedures. Using the conversion factor helps maintain the integrity of the Medicare relative value scale.

B. Sustainable Growth Rate Formula:

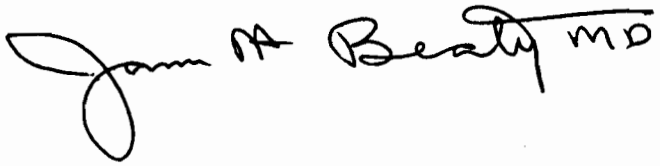
Although the U.S. Congress once again acted at the last minute to prevent the scheduled near 5.0 percent reduction in the 2007 conversion factor for the 2007 Physician Fee Schedule, the AAOS continues to believe the SGR formula is flawed and should be replaced by a fairer system that does not require Congressional intervention on an annual basis. In particular, CMS' failure to remove drugs from the SGR pool will continue to have an adverse impact on physicians.

After seven years of reimbursement cuts, freezes, or updates less than the rate of inflation, physicians are now faced with the largest payment reduction ever (- 9.9 percent). The costs associated with practicing medicine, such as increases in liability premiums, rising cost of medical equipment, and other factors, continue to increase. The proposed CY 2008 9.9 conversion factor decrease completely fails to recognize these actual increases in the costs of delivering care.

The AAOS is also disappointed that the Secretary of HHS and Administrator of CMS decided to apply the $1.35 billion from the Congressionally-appropriated Physician Assistance and Quality Initiative Fund to the PQRI bonus payments, rather than first addressing the flawed physician payment formula. In the proposed rule, CMS cites logistical issues in applying the fund to physician payment inequities. The AAOS believes that CMS, with reasonably little effort, could find a method for applying the $1.35 billion fund to physician payments. In addition, we believe this is a better use of tax payer and Medicare beneficiary money than applying it to the PQRI program in 2008 given the fact that CMS will not have had a chance to evaluate and audit the 2007 PQRI program to analyze whether it is an effective use of government resources and of benefit to the Medicare beneficiaries that CMS serves.

The AAOS appreciates the opportunity to comment on these important policy issues that affect our patients and our profession. We look forward to continuing our work together on behalf of Medicare beneficiaries and our nation's healthcare delivery systems.

Sincerely,



James H. Beaty, MD
President
American Association of Orthopaedic Surgeons

cc: Karen Hackett, FACHE, CAE, AAOS Chief Executive Officer
David Halsey, MD, Chair, AAOS Council on Advocacy
M. Bradford Henley, MD, Chair, AAOS Coding, Coverage & Reimbursement Committee
Robert Haralson, MD, AAOS Medical Director

Submitter : **Kathleen Baldwin** **Date: 08/30/2007**

Organization : **University of Illinois Athletic Training**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am curently an senior Athletic Training Student at the University of lllinois at Urbana-Champaign. I am currently working with the lllinois Football team and plan on attending gradutate school in order to furthur my knowledge ans degree in Athletie Training.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposcd 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 thesc proposed rulcs will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualificd to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experiencc, 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,

Kathleen Baldwin

Submitter : Dr. William Haller III **Date:** 08/30/2007

Organization : Gadsden Orthopaedic Assoc.

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attachment

CMS-1385-P-13040-Attach-1.PDF

#13040

Gadsden Orthopaedic Associates, P.C.

GADSDEN ORTHOPAEDICS
SPORTS MEDICINE

William N. Haller, Jr., M.D.
C. William Hartzog, M.D.
William N. Haller III, M.D.

Administrator:
Caryn W. Stark, CPA, CMPE
Office: 256.492.8590
Toll Free: 1.877.890.7031
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100 Medical Center Drive
Suite 101
Gadsden, Alabama 35903-1199
www.gadsdenortho.com

August 29, 2007

Via Electronic Submittal to CMS
Centers for Medicare & Medicaid Services
Dept of Health & Human Services
Attn: CMS-1385-P
P O Box 8018
Baltimore, MD 21244-8018

Re: CMS 1385-P
In Office Ancillary
Services Exception

Dear Sirs:

I am writing to provide my personal comment regarding the CMS decision making process related to the Stark self-referral regulations.

We currently have a three physician orthopedic practice, which includes ancillary services of in-house physical therapy and an in-house extremity MRI machine. While granted these departments are somewhat profitable, we have found that the main benefit of these departments is the convenience they offer to our patients as well as the ability for our physicians to provide a continuum of care.

We have found that with our physical therapy department patients tend to actually use fewer visits than when we refer patients out for physical therapy. Also, they tend to have a better experience as we are currently providing one on one physical therapy. In addition to that, we have no problem obtaining physical therapy documentation as it is included in our medical records. We are fortunate that our therapist has a very good relationship with all of our physicians and we feel that that has benefited our patients significantly.

We have found that once patients develop a comfort level with our office they prefer not to go out for physical therapy, but prefer to stay in our office for that treatment.

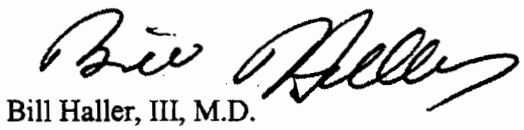
I do think that physical therapy as well as diagnostic imaging are essential parts of the practice of orthopedic surgery, and, therefore, separating those out as unrelated ancillary services is, in my opinion, inappropriate.

While I am sure that there are many medical practices that abuse ancillary services, I do not think that the solution is to legislate against them. Rather, those physicians who are using them inappropriately should be reprimanded and those privileges removed as opposed to punishing those of us that use them appropriately. I think that it is virtually impossible to legislate ethics particularly on a universal level.

Lastly, I will state that the argument against physician owned physical therapy is coming largely from physical therapist owned practices and, therefore, is purely financially driven. Competition tends to keep people honest as opposed to a monopoly system where consumers have no choices.

I certainly hope that this helps you in your consideration of this complex issue. If we can be of any further assistance, please do not hesitate to contact me.

Sincerely,



Bill Haller, III, M.D.

BH/kdk

Submitter : Dr. Evan Hellwig **Date:** 08/30/2007

Organization : Cedarville University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am an athletic trainer and a physical therapist with a PhD in sports medicine and I chair the Department of Athletic training at an NAIA institution. I believe I am well versed in the allied health care field and understand how the education and experiences of athletic trainers compare and contrast to other allied health professionals such as physical therapists.

I am very concerned about the staffing implications addressed in 1385-P. Athletic Trainers are very qualified to provide a variety of physical medicine and rehabiliation services which are unique and in addition to those provided by physical therapists.

I respectfully request that you withdraw the proposed changes realted to hospitals, rural clinics and any Medicare Part A or B hospital or rehabilitation facility.

Submitter : **Ms. Deborah Norris** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 30, 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,

Deborah G. Norris CRNA
69 Juniper Lane
Middlebury, VT 05753

Submitter : Mrs. Cindy Metcalf **Date:** 08/30/2007

Organization : Boca Raton Fire Rescue Services

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13043-Attach-1.DOC

CMS-1385-P-13043-Attach-2.TXT

#13043

City of Boca Raton

FIRE-RESCUE SERVICES DEPARTMENT • 6500 N CONGRESS AVE # 200• BOCA RATON, FLORIDA 334311-2808

PHONE: (561) 982-4000

FAX: (561) 982-450

August 30, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008.

Dear Ms. Norwalk:

Our organization provides emergency ambulance services to the communities which we serve. The proposed rule would have a severely negative direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. In addition, we believe this proposed rule will inappropriately provide incentives to seek signatures from patients who are in need of medical care and under mental duress. Additionally, this proposed rule would have a negative impact on wait times in the emergency room impacting our operations and the operations of emergency rooms throughout the country. We therefore urgently submit comments on ills of the proposed rule.

In summary, here are the points we would like you to consider:

- Beneficiaries under duress should not be required to sign anything;
- Exceptions where beneficiary is unable to sign already exist and should not be made more stringent for EMS;
- Authorization process is no longer relevant (no more paper claims, assignment now mandatory, HIPAA authorizes disclosures);
- Signature authorizations requirement should be waived for emergency encounters.

We understand that the proposed rule was inspired by the intention to relieve the administrative burden for EMS providers. However, the "relief" being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and the hospitals and would result in shifting the payment burden to the patient if they fail to comply with the signature requirements at the time of incident. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for emergency ambulance services.

Current Requirement

When the beneficiary is physically or mentally incapable of signing, the industry has been following the requirements listed in the CMS Internet Only Manual, Pub. 100-02, Chapter 10, Section 20.1.2 and Pub. 100-04, Chapter 1, Section 50.1.6(A) (3) (c). These sections allow for a representative of the ambulance provider or hospital to sign on behalf of the beneficiary when the patient is unable to sign, document that the beneficiary was unable to sign, the reason and that no one could sign for the beneficiary.

The proposed rule directly conflicts with the existing rule. It requires that the provider representative sign **contemporaneously** with the transport and **seek an additional signature** from the hospital in the event a patient is unable to sign.

BENEFICIARY UNDER DURESS SHOULD NOT BE REQUIRED TO SIGN ANYTHING

Emergency ambulance providers have no admission department and no registration desk. The same individuals responsible to providing medical care and transportation to the hospital are also responsible for fulfilling the administrative functions. All EMS encounters are emergency in nature and medically necessary ambulance transports in particular are stressful events on patients.

CMS has recognized this modified its rules for obtaining Advance Beneficiary Notice and Acknowledgement of HIPAA Privacy Notices, creating exceptions that do not require ambulance crews to interrupt their care to seek a signature from a patient under their care.

In fact, CMS has deemed that all emergency encounters put the patient under great duress. Under such duress, patients would sign anything in order to get the care they require. Therefore, any signature obtained in an emergency situation cannot be relied upon.

Yet the proposed rule is so burdensome on ambulance crews that they will have every incentive to obtain a patients signature even though the patient is under mental duress.

The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

EXCEPTIONS WHERE BENEFICIARY IS UNABLE TO SIGN ALREADY EXIST AND SHOULD NOT BE MADE MORE STRINGENT FOR EMS

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. The proposed exception essentially mirrors the existing requirements that the beneficiary is unable to sign and that no authorized person was available or willing to sign on their behalf, while adding additional documentation requirements. Therefore, we believe that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed sub-division (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, we do not object to the requirement that an ambulance provider obtain documentation of the date, time and destination of the transport. Nor do we object to the requirement that this item be maintained for 4 years from the date of service. However, we do not see any reason to include these in the Regulation, as they are already required and standard practice. The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. Our organization **strongly objects** to this new requirement as:

- Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.
- Hospital personnel will often refuse to sign <u>any</u> forms when receiving a patient.
- If the hospital refuses to sign the form, it will be the beneficiary that will be responsible for the claim.
- The ambulance provider or supplier would in every situation now have the additional burden in trying to communicate to the beneficiary or their family, at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.
- Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ER Admitting Record, etc.

We also strongly object to the requirement that ambulance providers or suppliers obtain this statement from a representative of the receiving facility *at the time of transport*. Since the proposed rule makes no allowances for the inevitable situations where the ambulance provider makes a good faith effort to comply, but is ultimately unable to obtain the statement, we believe this requirement imposes an excessive compliance burden on ambulance providers and on the receiving hospitals. Consider what this rule requires—the ambulance has just taken an emergency patient to the ER, often overcrowded with patients, and would have to ask the receiving hospital to take precious time away from patient care to sign or provide a form. Forms such as an admission record will become available at a later time, if CMS wants them for auditing purposes in addition to the trip transport that will already include date, time and receiving facility.

AUTHORIZATION PROCESS IS NO LONGER RELEVANT (NO MORE PAPER CLAIMS, ASSIGNMENT NOW MANDATORY, HIPAA AUTHORIZES DISCLOSURES)

Purpose of Beneficiary Signature

a. Assignment of Benefits –The first purpose of the beneficiary signature is to authorize the assignment of Medicare benefits to the health care provider or supplier. However, assignment of covered ambulance services has been mandatory since April 2002. Furthermore, 42 C.F.R. §424.55(c), adopted November 15, 2004 as part of the Final Rule on the Physician Fee Schedule (67 Fed. Reg. 6236), eliminated the requirement that beneficiaries assign claims to the health care provider or supplier in those situations where payment can only be made on an assignment-related basis. Therefore, the beneficiary's signature is no longer required to effect an assignment of benefits to the ambulance provider or supplier.

   CMS recognized this in the Internet Only Manual via Transmittal 643, by adding Section 30.3.2 to Pub. 100-04, Chapter 1. As a result, the beneficiary signature is no longer needed to assign benefits of covered ambulance services.

b. Authorization to Release Records – The second purpose of the beneficiary signature is to authorize the release of medical records to CMS and its contractors. However, the regulations implementing the HIPAA Privacy Rule, specifically 45 C.F.R. §164.506(c) (3), permit a covered entity (e.g. an ambulance provider or supplier) to use or disclose a patient's protected health information for the covered entity's payment purposes, without a patient's consent (i.e. his or her signature). Therefore, federal law already permits the disclosure of medical records to CMS or its contractors, regardless of whether or not the beneficiary's signature has been obtained.

Signatures Not Required for ABN's for Emergency Transports

The Third Clarification of Medicare Policy regarding the Implementation of the Ambulance Fee Schedule states that Advanced Beneficiary Notifications only be issued for non-emergency transports. The ABN's which require beneficiary signature "may not be used when a beneficiary is under great duress" which would include emergency transports. Would not the requesting of a Medicare Beneficiary's signature for any other reason during an emergency transport be less duress?

Signature Already on File

Almost every covered ambulance transport is to or from a facility, i.e. a hospital or a skilled nursing facility. In the case of emergency ambulance transports, the ultimate destination will always be a hospital. These facilities typically obtain the beneficiary's signature at the time of admission, authorizing the release of medical records for their services *or any related services*. The term "related services", when used by hospitals and SNFs, can mean more than only entities owned by or part of the facility. The term already includes physicians providing services at the facility. We believe that ambulance transport to a facility, for the purpose of receiving treatment or care at that facility, constitutes a "related service", since the ambulance transports the patient to or from that facility for treatment or admission. Therefore, we believe a valid signature will be on file with the facility. Additionally, for those transports provided to patients eligible for both Medicare and Medicaid, a valid signature is on file at the State Medicaid Office as a product of the beneficiary enrollment process.

Electronic Claims

It is also important to note that, as a result of section 3 of the Administrative Simplification Compliance Act and the implementing regulations at 42 C.F.R. §424.32, with very limited exceptions (e.g. providers or suppliers with less than 10 claims per month), ambulance suppliers must submit claims electronically. Thus, the beneficiary does not even sign a claim form. When submitting claims electronically, the choices for beneficiary signature are "Y" or "N". An "N" response could result in a denial, from some Carriers. That would require appeals to show that, while the signature has not been obtained, an alternative is accepted. As a result, many Carriers allow a "Y", even though the signature was not actually obtained, if one of the exceptions is met.

While this may be a claims processing issue, since you are now looking at the regulation, this would be a good time to add language indicating that the signature requirement will be deemed to be met if one of the exceptions to the requirement exists.

Program Integrity

It is important for CMS to realize that, for every transport of a Medicare beneficiary, the ambulance crew completes a trip report listing the condition of the patient, treatment,

origin/destination, etc. AND the origin and destination facilities complete their own records documenting the patient was sent or arrived via ambulance, with the date. Thus, the issue of the beneficiary signature should not be a program integrity issue.

SIGNATURE AUTHORIZATIONS REQUIREMENT SHOULD BE WAIVED FOR EMERGENCY ENCOUNTERS.

Conclusion

Based on the above comments, it is respectfully requested that CMS:

- Amend 42 C.F.R. §424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that "good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported".
- Amend 42 C.F.R. §424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
- Amend 42 C.F.R. §424.36(b) (5) to add "or ambulance provider or supplier" after "provider".

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

Thank you for your consideration of these comments.

Sincerely,

Cindy Metcalf, RN, EMT-P
Assistant Fire Chief
Emergency Medical Services
BOCA RATON FIRE RESCUE SERVICE

Submitter : Mr. Alan Maynard **Date:** 08/30/2007

Organization : University of Vermont

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Certified Athltic Trainers will be negatively affected by this legislation. We play an emerging and increasingly important role in health care. The biggest negative affect of this legislation will be seen with the athletic youth. In an era where we are trying to increase the level of health of our youngest americans, limiting the ability of Certified Athletic Trainers to work effectively in the prevention, treatment, and rehabilitation of this population certainly isn't the answer. Please consider eliminating CMS 1385-P and in doing so, bolster the health care system through inclusion and patient/phsyician choice.

Submitter : Dr. Jack Cronenwett **Date:** 08/30/2007

Organization : Vascular Study Group of Northern New England

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I previously tried to submit a comment with attachment, but it did not go through. Please see attachment. Previous attempt was Temporary Comment Number: 206685.

CMS-1385-P-13045-Attach-1.RTF

#13045

August 31, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS- I 385-P
P.O. Box 80 18
Baltimore, MD 2 1244-80 18

Re: CMS-1385-P TRHCA—SECTION 101(b): PQRI

Dear Ms. Norwalk:

I am writing on behalf of the Vascular Study Group of Northern New England (VSGNNE), a voluntary, cooperative group of clinicians, hospital administrators and research personnel from Maine, New Hampshire and Vermont, organized in 2002 to improve the care of patients with vascular disease. By collecting and exchanging information, the group strives to continuously improve the quality, safety, effectiveness, and cost of caring for patients with vascular disease.

During the past 4 years, 48 vascular surgeons from 9 hospitals in ME, NH and VT (25-615 beds) prospectively recorded patient, procedure and in-hospital patient outcome data. Results including 1-year follow-up data obtained at the physician office are analyzed at a central site are reported to each center at semiannual meetings where care processes and regional benchmarks are discussed. Mortality and compliance with procedure entry are validated by independent comparison with hospital administrative data. Our initial improvement efforts focused on optimizing preoperative medication usage.

As of December, 2006 a total of 6,143 operations were entered into the registry for carotid endarterectomy (CEA), lower extremity bypass (LEB) and abdominal aortic aneurysm repair (both open and endovascular (EVAR)).. In-hospital stroke or death following CEA was 1.0%, major amputation or death following LEB was 3.8% and mortality following elective OPEN and EVAR was 2.9% and 0.4%, respectively. Process improvement efforts initiated in 2004 increased preoperative beta-blocker administration from 72% to 91%; antiplatelet agents from 73% to 83%; and statins from 54% to 72% (all $P<001$). Procedure volume and discharge status validation with administrative data led to 99% of appropriate operations being reported to the registry. Mortality was accurately reported to the data registry for all patients.

Proposed Rule CMS-1385-P Section 101(b)—Physician Quality Reporting Initiative (PQRI) has particular importance for quality improvement efforts such as ours that have demonstrated the ability to accurately record details of patient care episodes in order to identify best practices and improve outcomes. In particular we appreciate the opportunity to comment on "Addressing a Mechanism for Submission of Data on Quality Measures Via a Medical Registry or Electronic Health Record."

First, we suggest that the VSGNNE is an ideal group to test the transmission of registry data to the CMS Clinical Data Warehouse as proposed for 2008 so that participating physicians could qualify for PQRI without having to submit duplicate data via the claims system. We have detailed patient, procedural and outcome data in our registry that are applicable to a variety of quality measures. Our registry is HIPAA and CHI compliant and technically capable of interfacing with the CMS clinical warehouse electronic data exchange interface. In addition, we represent a variety of physician practice types and hospitals, from academic to community practice. Further, we would like to test linkage of electronic hospital record data directly to this system, which would be possible from several hospitals in our group.

Second, we specifically suggest that preoperative beta-blocker usage for patients with vascular disease be adopted as an appropriate quality measure, since this has been already accepted for patients undergoing cardiac surgery, who represent the same patient population. Further, this measure has been validated by Level I evidence in patients undergoing the above operations, and this measure is appropriately recorded in our registry. As noted above, we have already demonstrated marked improvement in this quality process measure.

Finally, we suggest that physicians who participate in an appropriate data registry that reports requested results to CMS should qualify for PQRI benefits by virtue of their participation, assuming the database is validated against claims data to insure full reporting of all appropriate procedures, which is the case for VSGNNE.

In closing, we would underscore our belief that data registries, such as VSGNNE, provide an excellent opportunity to improve health care quality, and we fully support their usage in the PQRI initiative. We believe that our established registry would be ideal for pilot testing as planned by CMS for 2008.

Sincerely yours,

Jack L. Cronenwett, M.D.
Principal Investigator
Vascular Study Group of Northern New England
Dartmouth-Hitchcock Medical Center
Lebanon, NH 03756

Submitter : **Dr. Bruce Malmer** **Date: 08/30/2007**

Organization : **Dr. Bruce Malmer**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Edward Frankoski** **Date: 08/30/2007**

Organization : **Dr. Edward Frankoski**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Thank you for your attention to this comment.
I am writing you in regards to proposed cuts in reimbursement for Interventional Pain Physicians. These cuts appear draconian and will sinficantly impede on my ability to care for patients who rely on medicare. Costs of doing business have significantly increased. this is especially evident in South florida where malpractices costs have sky rocketed along with rent, housing and employeees.
Furthermore, Interventional Pain Physicians with the designation of -09, such as myself, have spent significantly more addition time in training than anesthsiologists. This needs to be taken into account when formulating reimbursement for particular procedures. Intereventional Pain Physicians bring to the table a highly specialized and innovative treatment option for for patients in chronic pain.
Thank you for your attention to this matter.
Edward J. Frankoski DO

Submitter : **Date: 08/30/2007**

Organization : **WCA SERVICES CORPORATION ALSTAR EMS**

Category : **Other Health Care Provider**

Issue Areas/Comments

Ambulance Services

Ambulance Services

August 30, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, Maryland 21244-8018

Re: CMS-1385-P: Geographical Price Cost Indices

Dear Mr. Kuhn:

This letter serves as our comments on the Geographical Price Cost Indices section of the Proposed Rule (CMS-1385-P). Our organization strongly opposes any reductions in Medicare reimbursement for ambulance service providers which would have an adverse impact on patient access to vital emergency and non-emergency ambulance care. The Proposed Rule would unfortunately cause that exact effect in areas where providers would receive lower reimbursement as a result of the updated Geographical Price Cost Index (GPC) figures.

While we recognize the statutory requirement for CMS to update the GPCI, any reductions in reimbursement would be in direct contradiction to the findings of the May 2007 Government Accountability Office (GAO) report entitled Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly (GAO-07-383) which determined that Medicare reimburses ambulance service providers on average 6% below their costs of providing services and 17% for providers in super rural areas. For those ambulance service providers who would receive lower reimbursement as a result of the changes to the GPCI, the Proposed Rule will further exacerbate the problems already caused by below-cost Medicare reimbursement.

The GAO recommended that CMS monitor the utilization of ambulance transports to ensure that negative Medicare reimbursement does not impact beneficiary access to ambulance services particularly in super rural areas. We believe that the Proposed Rule would have a considerable impact on beneficiary access in all areas adversely affected by the changes in the GPCI. We implore CMS to take this into consideration as it finalizes the Proposed Rule and alleviate any harmful impact these changes in the GPCI will have on providers while ensuring that those providers who would benefit from the changes receive the proposed increases which are desperately needed.

Thank you for your consideration of these comments

Sincerely,

Ronald P. Hasson Nicole Russo
Operations Manager Production & Operations
Billing Manager

Submitter : **Dr. Raymond Lupkas** **Date: 08/30/2007**

Organization : **Raymond R Lupkas, Jr., MD 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)

Dcar 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 addrcss this complicated issue.

Whcn thc RBRVS was institutcd, 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. Our Senior Citizens and Handicapped deserve this.

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 ensurc 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.

Sincercly,
Raymond R Lupkas, Jr. MD

Submitter : Mr. Joe Mccloskey **Date:** 08/30/2007

Organization : ADPI

Category : Health Care Industry

Issue Areas/Comments

Ambulance Services

Ambulance Services

see attachment

CMS-1385-P-13050-Attach-1.PDF

#13050

ADVANCED
DATA PROCESSING, INC.
EMS BILLING. COUNT ON US.

August 29, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008.

Dear Ms. Norwalk:

Our organization provides billing services for the ambulance providers in the communities which we serve. The proposed rule would have a direct negative impact on our operations and the ability to effectively provide emergency transport services to Medicare beneficiaries. We believe this proposed rule will inappropriately provide incentives to seek signatures from patients who are in need of medical care and under mental duress. Additionally, this proposed rule could have a negative impact on wait times in the emergency department, impacting ambulance operations and the operations of emergency departments throughout the country. We therefore submit the following comments in objection to the proposed rule.

In summary, here are the points we would like you to consider:

- Beneficiaries under duress should not be required to sign anything;
- Exceptions where beneficiary is unable to sign already exist and should not be made more stringent for EMS billing;
- Authorization process is no longer relevant (no more paper claims, assignment now mandatory, HIPAA authorizes disclosures);
- Signature authorizations requirement should be waived for emergency encounters.

We understand that the proposed rule was inspired by the intention to relieve the administrative burden for EMS providers. However, the "relief" being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services, hospitals and their billers, and would result in shifting the payment burden to the patient if they fail to comply with the signature requirements at the time of transport. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for emergency ambulance services.

6451 NORTH FEDERAL HIGHWAY, SUITE 1002, FT. LAUDERDALE, FL 33308
PHONE: 954-308-8700 FAX: 954-308-8725
WWW.EMSCLAIMS.COM

Current Requirement

When the beneficiary is physically or mentally incapable of signing, the industry has been following the requirements listed in the CMS Internet Only Manual, Pub. 100-02, Chapter 10, Section 20.1.2 and Pub. 100-04, Chapter 1, Section 50.1.6(A) (3) (c). These sections allow for a representative of the ambulance provider or hospital to sign on behalf of the beneficiary when the patient is unable to sign, document that the beneficiary was unable to sign, the reason and that no one could sign for the beneficiary.

The proposed rule directly conflicts with the existing rule. It requires that the provider representative sign **contemporaneously** with the transport and **seek an additional signature** from the hospital in the event a patient is unable to sign.

A BENEFICIARY UNDER DURESS SHOULD NOT BE REQUIRED TO SIGN ANYTHING IN ORDER TO QUALIFY FOR MEDICARE PAYMENT OF SERVICES

Emergency ambulance providers have no admission department and no registration desk. The same individuals responsible for providing medical care and transportation to the hospital are also responsible for fulfilling the administrative functions. All EMS encounters are emergency in nature and medically necessary ambulance transports in particular are stressful events on patients.

CMS has recognized this and modified its rules for obtaining Advance Beneficiary Notice and Acknowledgement of HIPAA Privacy Notices, creating exceptions that do not require ambulance crews to interrupt their service to seek a signature from a patient under their care.

In fact, CMS has deemed that all emergency encounters put the patient under great duress. Under such duress, patients would sign anything in order to get the care they require. Therefore, any signature obtained in an emergency situation cannot be relied upon.

Yet the proposed rule is so burdensome on ambulance crews that they will have every incentive to obtain a patients signature even though the patient is under mental duress. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

EXCEPTIONS WHERE BENEFICIARY IS UNABLE TO SIGN ALREADY EXIST AND SHOULD NOT BE MADE MORE STRINGENT FOR EMS

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. The proposed exception essentially mirrors the existing requirements that the beneficiary is unable to sign and that no authorized person was available or willing to sign on their behalf, while adding additional documentation requirements. Therefore, we believe

that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed sub-division (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, we do not object to the requirement that an ambulance provider obtain documentation of the date, time and destination of the transport. Nor do we object to the requirement that this item be maintained for 4 years from the date of service. However, we do not see any reason to include these in the Regulation, as they are already required and standard practice.

The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. Our organization **strongly objects** to this new requirement as:

- Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.
- Hospital personnel will often refuse to sign <u>any</u> forms when receiving a patient.
- If the hospital refuses to sign the form, it will be the beneficiary that will be responsible for the claim.
- The ambulance provider or supplier would in every situation now have the additional burden in trying to communicate to the beneficiary or their family, at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.
- Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ED Admitting Record, etc.

We also strongly object to the requirement that ambulance providers or suppliers obtain this statement from a representative of the receiving facility *at the time of transport.* Since the proposed rule makes no allowances for the inevitable situations where the ambulance provider makes a good faith effort to comply, but is ultimately unable to obtain the statement, we believe this requirement imposes an excessive compliance burden on ambulance providers and on the receiving hospitals. Consider what this rule requires—the ambulance has just taken an emergency patient to the ED, often overcrowded with patients, and would have to ask the receiving hospital to take precious time away from patient care to sign or provide a form. Forms such as an admission record will become available at a later time, if CMS wants them for auditing purposes in addition to the trip transport that will already include date, time and receiving facility.

THE AUTHORIZATION SIGNATURE PROCESS IS NO LONGER RELEVANT (NO MORE PAPER CLAIMS, ASSIGNMENT NOW MANDATORY, HIPAA AUTHORIZES DISCLOSURES)

Purpose of Beneficiary Signature

a. Assignment of Benefits –The first purpose of the beneficiary signature is to authorize the assignment of Medicare benefits to the health care provider or supplier. However, assignment of covered ambulance services has been mandatory since April 2002. Furthermore, 42 C.F.R. §424.55(c), adopted November 15, 2004 as part of the Final Rule on the Physician Fee Schedule (67 Fed. Reg. 6236), eliminated the requirement that beneficiaries assign claims to the health care provider or supplier in those situations where payment can only be made on an assignment-related basis. Therefore, the beneficiary's signature is no longer required to effect an assignment of benefits to the ambulance provider or supplier.

   CMS recognized this in the Internet Only Manual via Transmittal 643, by adding Section 30.3.2 to Pub. 100-04, Chapter 1. As a result, the beneficiary signature is no longer needed to assign benefits of covered ambulance services.

b. Authorization to Release Records – The second purpose of the beneficiary signature is to authorize the release of medical records to CMS and its contractors. However, the regulations implementing the HIPAA Privacy Rule, specifically 45 C.F.R. §164.506(c) (3), permit a covered entity (e.g. an ambulance provider or supplier) to use or disclose a patient's protected health information for the covered entity's payment purposes, without a patient's consent (i.e. his or her signature). Therefore, federal law already permits the disclosure of medical records to CMS or its contractors, regardless of whether or not the beneficiary's signature has been obtained.

Signatures Not Required for ABNs for Emergency Transports

The Third Clarification of Medicare Policy regarding the Implementation of the Ambulance Fee Schedule states that Advanced Beneficiary Notifications only be issued for non-emergency transports. The ABN's which require beneficiary signature "may not be used when a beneficiary is under great duress" which would include emergency transports. Would not the requesting of a Medicare Beneficiary's signature for any other reason during an emergency transport be less duress?

Signature Already on File

Almost every covered ambulance transport is to or from a facility, i.e. a hospital or a skilled nursing facility. In the case of emergency ambulance transports, the ultimate destination will always be a hospital. These facilities typically obtain the beneficiary's signature at the time of admission, authorizing the release of medical records for their services *or any related services.*

The term "related services," when used by hospitals and SNFs, can mean more than only entities owned by or part of the facility. The term already includes physicians providing services at the facility. We believe that ambulance transport to a facility, for the purpose of receiving treatment or care at that facility, constitutes a "related service", since the ambulance transports the patient to or from that facility for treatment or admission. Therefore, we believe a valid signature will be on file with the facility. Additionally, for those transports provided to patients eligible for both Medicare and Medicaid, a valid signature is on file at the State Medicaid Office as a product of the beneficiary enrollment process.

Electronic Claims

It is also important to note that, as a result of section 3 of the Administrative Simplification Compliance Act and the implementing regulations at 42 C.F.R. §424.32, with very limited exceptions (e.g. providers or suppliers with less than 10 claims per month), ambulance suppliers must submit claims electronically. Thus, the beneficiary does not even sign a claim form. When submitting claims electronically, the choices for beneficiary signature are "Y" or "N". An "N" response could result in a denial, from some Carriers. That would require appeals to show that, while the signature has not been obtained, an alternative is accepted. As a result, many Carriers allow a "Y", even though the signature was not actually obtained, if one of the exceptions is met.

While this may be a claims processing issue, because amendments to the regulation are now proposed, it would be appropriate to add language indicating that the signature requirement will be deemed to be met if one of the exceptions to the requirement exists.

Program Integrity

It is important for CMS to realize that, for every transport of a Medicare beneficiary, the ambulance crew completes a trip report listing the condition of the patient, treatment, origin/destination, etc. AND the origin and destination facilities complete their own records documenting the patient was sent or arrived via ambulance, with the date. These records are always available for audit or claims processing purposes, and are corroborated in the facility records for the patient admission. Thus, the issue of the beneficiary signature should not be a program integrity issue.

SIGNATURE AUTHORIZATIONS REQUIREMENT SHOULD BE WAIVED FOR EMERGENCY ENCOUNTERS.

Conclusion

Based on the above comments, it is respectfully requested that CMS:

- Amend 42 C.F.R. §424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that "good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for

them OR the signature is on file at the facility to or from which the beneficiary is transported."

- Amend 42 C.F.R. §424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
- Amend 42 C.F.R. §424.36(b) (5) to add "or ambulance provider or supplier" after "provider."

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

Thank you for your consideration of these comments.

Sincerely,

Joseph McCloskey
Compliance Officer

Submitter : **Mr. Brinkman Murray** **Date: 08/30/2007**

Organization : **Marietta College**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13051-Attach-1.DOC

#13051

To Whom This May Concern:

My name is Brinkman Murray. I am a senior athletic training student at Marietta College. I will be completing my last rotations this coming spring and plan to graduate in May 2008.

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.

Being an athletic training student, I aspire to be able to utilize my abilities in numerous settings, including athletic fields, hospitals, and rehabilitation clinics. Considering Marietta College has recently been accredited by CAATE for the following seven years and I pass the national certification exam, I will be recognized as capable to provide quality health care to my patients. Despite being regarded as qualified by State law and hospital medical professionals, the proposed policies seem to disregard those standards.

With the evident shortage of qualified employees in therapy positions exists, the CMS would be doing the general public a great disservice by eliminating services to the citizens it is supposed to watch over. Creating a bigger shortage in the workforce would only damage already cost-efficient healthcare organizations and professionals, which also hurts the proper and timely care given to patients in need of it. I politely urge you to withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Brinkman Murray, ATS

Submitter : **Dr. Andrew Pierwola** **Date: 08/30/2007**

Organization : **University of Pennsylvania Anesthesiology/CritCare**

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,
Andrew J. Pierwola, M.D.
University of Pennsylvania Department of Anesthesiology and Critical Care

Submitter : **Miss. Stephanie McNamara** **Date: 08/30/2007**

Organization : **Athletic Training**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See attached document

CMS-1385-P-13053-Attach-1.DOC

#13053

August 29, 2007

Dear Sir or Madam:

Hello, my name is Stephanie McNamara and I am currently an Athletic Training Fellow at Emory Sports Medic are a Sports Medicine Physician based clinic in Atlanta, Georgia. We have six (6) orthopaedic sports medicine, trained physicians and five (5) full time athletic trainers working in the clinic as orthopaedic athletic trainers/ph extenders, directly with our physicians and patients. We also have an athletic training fellowship with four (4) A each year. I completed my undergraduate degree at University of Indianapolis in Indiana and my graduate studi University. I have been a Certified Athletic Trainer (ATC) for two and a half years now.

Currently, I am working in a physician setting at Emory University and Hospital and since coming here have ob Orthopaedic Technologist Certification (OTC through the NBCOT). All of our clinical ATC's and ATC Fellow obtained their OTC for multi-credentialing purposes. In our practice, our physicians feel that ATC's are the idea liaison in the clinic setting to see patients. Who better to see musculoskeletal patients than a musculoskeletal sp Certified Athletic Trainers have the education and knowledge to perform all skills necessary, and are some of th qualified to use their skills in physical medicine, patient evaluation, and rehabilitation.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing p 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 usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality heal patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know as physical therapy. My education, clinical experience, and national certification exam ensure that my patients health care. State law and hospital medical professionals have deemed me qualified to perform these services a 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 for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to fu their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilita 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 st encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hos clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Stephanie McNamara EdM, ATC/L, CSCS, OTC

Athletic Training Fellow

Submitter : **Dr. William Whitehead** **Date: 08/30/2007**

Organization : **University of Texas Medical Branch**

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.

Submitter : **Dr. James Willis** **Date: 08/30/2007**

Organization : **Willis Chiropractic Clinic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

"MEI"
Centers for Medicare and Medicaid Services
Dept. of HHS
Attn: CMS-1385-P
P. O. Box 8018
Baltimore, MD 21244-8018

Re: Techical Corrections

Dear Sirs:

The proposed rule dated July 12th, published in the Federal Register, contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in stong opposition to this proposal.

While subluxation does not need to be detected by an X-ray study, in some cases the patient will clinically will require an X-ray to identify a subluxation or to rule out any "red flags" or to also determine need for further diagnostic testing, i.e., MRI, or referral to appropriate specialist.
By limiting a D.C. to refer for X-rays, the patient costs go up as the patient will have to be referred back to their provider to obtain X-ray request. For some patients on fixed incomes and limited resources, this may result in financial hardships or the patient abandoning treatment by the D.C. Also, delaying needed studies may result in life-threatening conditions not being detected early enough.

I urge you to table this proposal. X-rays if needed, are necessary to treatment plans of Medicare patients.

Sincerely,

James T. Willis D.C.
Thomasville, GA 31792

Submitter : **Mr. Edgar Morrison** **Date: 08/30/2007**

Organization : **Jackson Walker L.L.P.**

Category : **Attorney/Law Firm**

Issue Areas/Comments

IDTF Issues

IDTF Issues

See Attachment.

CMS-1385-P-13056-Attach-1.DOC

#13056.

Comment on Physician Fee Schedule

IDTF Issues

COMMENT: One of the proposed rule changes is that an IDTF: "Does not share space, equipment, or staff or sublease its operations to another individual or organization." The meaning essentially is that the IDTF facility must be used exclusively by that IDTF. However, another requirement of the Program Integrity Manual is that a medical group that bills for diagnostic services must also register as an IDTF if it receives a significant amount of outside referrals. Thus, a cardiology group that performs coronary CT's for its patients, and also accepts a substantial number of referrals from other physicians for their patients, eventually must register and obtain an IDTF designation for the non-practice referrals. That would require the medical group and its wholly owned IDTF to share equipment, space, staff, etc., which would be contrary to the proposed rule. If this proposed rule is made final, it should exempt a medical group that wholly owns the IDTF from the "shared space" prohibition.

Jed Morrison

Edgar C. Morrison, Jr.
Jackson Walker L.L.P.
112 E. Pecan, Suite 2400
San Antonio, TX 78205
(210) 978-7780
JMorrison@jw.com

Submitter : Mr. James Pratt **Date:** 08/30/2007

Organization : Athletic Training

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attached document

#13059

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Miss. Payton Haynes** **Date: 08/30/2007**

Organization : **Athletic Training**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See attached document

#13061

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Mrs. Mary Beth Blake **Date:** 08/30/2007

Organization : Polsinelli Shalton Flanigan Suelthaus PC

Category : Attorney/Law Firm

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See Attachment

CMS-1385-P-13065-Attach-1.PDF

#13065

Polsinelli

Shalton | Flanigan | Suelthaus PC

700 West 47th Street, Suite 1000 | Kansas City, MO 64112-1802
(816) 753-1000 | Facsimile: (816) 753-1536 | www.polsinelli.com

Mary Beth Blake
(816) 360-4284
mblake@polsinelli.com

August 30, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244

RE: Medicare Physician Fee Schedule Proposed Rule

To Whom It May Concern:

As counsel to a large urology practice in the Midwest, we wish to submit the following comments regarding the Medicare Physician Fee Schedule Proposed Rule ("MPFS Proposed Rule") published in the July 12, 2007 *Federal Register*. Some of the proposed changes would have a serious impact on the way urology clinics practice medicine and will not lead to the best medical practices. The two issues most likely to impact urology practices such as the one we represent are (i) the request for comments regarding possible limitations on the in-office ancillary services exception; and (ii) the proposed changes to the rules regarding purchased diagnostic tests.

Description of Urology Practice

The urology practice that our firm represents (the "Practice") serves multiple states in the Midwest and has an office ("Clinic") near the border between two states. It serves approximately 8,400 Medicare and Medicare Advantage beneficiaries per year and specializes in the provision of urological surgery and medical services, such as the diagnosis and treatment of prostate cancer. The Practice provides a full array of urological care to men, women and children of all ages. With respect to diagnostic services, the urologists purchased their own out-of-state lab[1] in 2003. Before that time, the Practice sent biopsies to several different out-of-state labs. The urologists obtain tissue samples from their patients at the Clinic and send the samples to its own lab unless the patient's insurance requires use of another lab. The Practice contracts with a management company that provides technical staff for its lab and with a pathologist who performs the professional review of the tissue samples. With respect to treatment, the urologists

[1] The Practice owns the lab equipment but leases space in a building that is also used by other labs. However, the Practice's space is used solely by the Practice for diagnostic testing for its patients and is not used by any other lab.

provide radiation therapy in the Clinic. The Practice bills for the technical and professional components of both diagnostic and therapeutic services.

In-Office Ancillary Services Exception

With respect to the Stark in-office ancillary services exception, we do not believe the exception should be limited in any way. First, there is no legitimate reason to limit the scope of the exception. We understand that CMS is concerned about the extension of the in-office ancillary services exception leading to a "proliferation of in-office laboratories" and a "migration of sophisticated and expensive imaging or other equipment to physician offices." However, it appears that this concern stems largely from situations in which physicians perform and bill for specialized ancillary services through the use of independent contractor relationships, rather than referring a patient to a specialist. Although the OIG has cited similar concerns, it has limited its focus to a narrower subset of contractual relationships. Specifically, the OIG has noted its concerns about arrangements in which an owner of one line of business contracts out substantially the entire operation of a related line of business to a competitor and receives in return the profits of the business as remuneration for its referrals.[2]

We do not believe that CMS should be in the business of addressing issues related to competition. Indeed, the primary purpose of the Stark law is to prohibit overutilization and fraud. In the absence of evidence of such overutilization or fraud, it would be difficult to justify limiting the in-office ancillary services exception merely because certain specialist physicians are losing business opportunities due to the competitive nature of physician practice. There is no substantive evidence of overutilization. Since the Practice opened its own lab, the percentage of patients that have undergone prostate biopsies had not increased. In 2002 the Practice had 61,259 patient visits and performed biopsies on 1,160 patients (1.9%). In 2006, the most recent year for which we have data, the Practice had 86,195 patient visits and performed biopsies on 1,414 patients (1.6%). Thus the Practice did not increase its utilization when it purchased and began using its own lab.

Second, there are benefits to not changing the scope of the in-office ancillary services exception. It is important to patient care for urologists to have the ability to provide pathology services in their own offices. The current flexibility of the Stark in-office ancillary services exception allows physician groups to provide better oversight of the care provided to their patients and better continuity of care in a convenient manner that does not require multiple visits by patients to multiple locations.

For example, with respect radiation therapy services, the Practice has the equipment located in the Clinic and is thus able to have direct control of the technology, allowing the Practice to offer a unique state of the art service to its patients as well as to communicate daily with the patients and radiation therapy colleagues. In addition, the Practice assures compliance with its internal quality assurance program. With respect to diagnostic services, although the Practice's lab is located in a different state, the diagnostic samples are obtained during the patient's Clinic visit and are then sent to the lab for analysis without sending the patient to a separate location. By utilizing its own lab, the Practice is better able to control consistency and quality in the processing and reading of patient biopsies. It also vastly improves communication

[2] Special Advisory Bulletin, April, 2003; OIG Opinion 04-17 (December 17, 2004).

between the urologist and the pathologist. When patients can obtain diagnostic testing and therapeutic procedures (e.g., radiation oncology) in one location, it results in better overall care of the patients. However, unlike certain tests and treatments that require the presence of the patient, lab work can be done, and has for years been performed by large companies, away from the office where the patient is seen in another city or state.

The following is one of many examples of the improved quality that results from the Practice's use of its own lab. One of the Practice's urologists ordered a biopsy of a patient's prostate gland. The patient's insurance plan obligated the Practice to send the tissue sample to another lab for examination. As a result, the urologist who ordered the biopsy was forced to rely on the review of a pathologist with whom he was not acquainted and whose competency he had no means to assess. That pathologist concluded that the patient had high grade prostatic intraepithelial neoplasia. This is a precancerous condition with a 25% to 50% likelihood of developing into prostate cancer. Fortunately, the urologist questioned the pathology report and obtained a second opinion from a urological pathologist of his choosing (who was not the Practice's pathologist). The second report showed no hint of a precancerous condition in the specimen. As a result of the second opinion, the urologist was able to avoid mistakenly giving the patient incorrect and potentially very upsetting news. This has happened with more than one patient. When the treating physician has questions about reports from the Practice's lab, the ordering physician and the Practice's pathologist communicate directly so the concern is addressed promptly.

Anti-Markup Provision (Purchased Diagnostic Test Rule)

In addition to the issues involving the Stark in-office ancillary services exception, we are concerned about the proposed change to the purchased diagnostic test rules that would impose an anti-markup provision on both the TC and PC of diagnostic tests performed by "outside suppliers" (defined as any supplier that is not a full-time employee of the billing physician or physician group). We understand that the anti-markup provisions are intended to prohibit profiting on tests not performed by the billing Medicare program participant. They should not, however, be used to penalize a program participant who provides and bills for services provided on a less than full time basis.

Even a large urology group such as the one we represent does not have the volume of patients who need a prostate biopsy to support full-time laboratory personnel. Limiting reimbursement for the professional component of diagnostic tests performed by outside suppliers could create an incentive to hire full-time staff and then overutilize pathology services in an attempt to keep such personnel working full time. Use of outside suppliers can often be a cost-effective and efficient way of providing certain diagnostic testing services. Physicians who select quality outside suppliers and implement appropriate quality review procedures should not be penalized for doing so.

Sincerely,

Mary Beth Blake

Mary Beth Blake

Submitter : Dr. Timothy Allari **Date:** 08/30/2007

Organization : Santa Cruz County Medical Society

Category : Health Care Professional or Association

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

See Attachment for details.

#13073

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Dr. Timothy Allari **Date:** 08/30/2007

Organization : Santa Cruz County Medical Society

Category : Health Care Professional or Association

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

Resending - initial attachment not accepted by website.

CMS-1385-P-13077-Attach-1.DOC

13077

August 30, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: "GPCIs"

I am writing on behalf of the Santa Cruz County Medical Society [SCCMS] in response to the proposed rules (72 FR 38140) regarding Medicare physician payment localities and GPCIs. Our medical society is in support of Option 3 (72FR 38141).

In 1997, HCFA applied a 5 percent threshold to existing localities to consolidate them into comparable cost areas creating our current national physician fee schedule structure (61 FR 59494). The intent of current Medicare law is to reimburse providers according to the cost of providing services, make adjustments for geographic differences in those costs, and distribute payments accordingly. In 1997, based on Santa Cruz County Geographic Adjustment Factors [GAFs], Santa Cruz County should have been placed in its own payment locality. Instead of applying the 5% iterative rule using county costs as the unit of comparison, HCFA averaged the cost of providing care between Santa Cruz County and San Benito County. Due to this oversight, Santa Cruz County was placed in Locality 99.

In 1996, HCFA chose between multiple options presented by Health Economics Research, Inc. Option 1i, 5-percent threshold, was chosen. Under this option, payment localities from 1996 were used as the building blocks for creating revised payment localities. Presumably, this was the rationale for treating Santa Cruz County and San Benito County as a combined unit, rather than examining their county-specific GAFs. However, in the same final rules (61 FR 59494), when examining subcounty localities, HCFA stated, "We proposed to use counties as the basic locality structure...Using counties as the basic locality unit provides a national uniform physician fee structure." It is problematic that CMS decided to utilize larger units than counties when considering Santa Cruz and San Benito counties but CMS utilized county-specific costs in most other circumstances. This seems as if it were either an arbitrary decision or an oversight on the part of HCFA.

As CMS is well aware, physicians in Santa Cruz County are reimbursed at the lowest levels in the State of California, yet borders Santa Clara County, which is reimbursed at the highest level in the entire nation.

Since 1997, demographics and consequently the cost of providing care have changed significantly within payment localities. In particular, Locality 99 has widely divergent practice costs. At the same time that costs have diverged within Locality 99, the State of California has received increasing reimbursement. As the State has received increased reimbursement, the inclusion of counties with higher GAFs within Locality 99 has resulted in greater relative differences between the cost of providing care and reimbursement in these higher cost counties. Each year that State reimbursement increases without a resolution of payment disparities, the problem becomes magnified.

CMS (72 FR 38140) indicates that "... we are also concerned about the redistributive effects of locality changes since changes must be applied in a budget neutral manner." However, as noted above, failing to act in a timely manner has only acted to worsen the impact of these redistributions. Given the magnitude of the discrepancy between the cost of providing care and the reimbursement for care, each year of inactivity only leads to more difficult choices. We commend CMS for recognizing that it "is ultimately responsible for establishing fee schedule areas (70 FR 45784)." We would strongly recommend that CMS act this year to correct payment discrepancies. If CMS does not act administratively it is clear that legislative action will occur.

Perhaps the most important issue when evaluating the proposed options is to consider their applicability on a national scale and their internal consistency and applicability on an ongoing basis for periodic updates. The primary reason why CMS has refrained from revising the Physician Fee Schedule [PFS] is the concern about the response to redistributive impacts in a budget neutral setting. As noted above, delaying redistribution only magnifies the difficulty of revising the PFS. Performing updates on a periodic basis minimizes disruption to the physicians of the nation while addressing the need to make adjustments for geographic differences in the cost of providing care.

SCCMS strongly supports the United States Government Accountability Office [GAO] report from June 2007. It states, "GAO recommends that CMS (1) examine and revise the payment localities using an approach that is uniformly applied to all states and based on the most current data and (2) update the payment localities on a periodic basis."

RE: Option 1: if this were revised to reapply the final rules adopted in 1996, this option might be the most palatable to our medical society. In 1996, HCFA chose Option 1i, 5-percent threshold (61 FR 59494). In 1997, HCFA used an iterative method to apply the 5% threshold. The decision by CMS to propose a non-iterative application of a 5% threshold in Option 1 in the current proposed rules seems designed to limit the number of payment localities. If an iterative method were used, this would seem to be an internally consistent method to revise the current PFS and it would provide a reasonable framework for periodic revisions in the future.

RE: Option 2: this option does not seem to be consistent with the manner in which the PFS was created in 1996. The primary concern with this approach is that although the cost structures in these counties seem similar at this time, there is no strong reason to suppose that these counties will have similar cost structures in the future. Therefore, it may be problematic to revise this new locality in the future. Would a county be extracted from this locality if its cost structure varied from the other counties? Would it be any more or less reasonable to revise the current locality structure by placing existing single county localities within another payment locality if their cost structures were similar? This option does not address this issue. Although CMS currently has stated it would not offer periodic updates, this is likely to be mandated in the future for the reasons stated above. Choosing an option which does not provide a reasonable framework for future revisions would be unwise. Although it is certainly reasonable to remove the counties with the largest payment discrepancies, it would be problematic to apply this method to other states. It seems unlikely that counties in other states which have payment discrepancies could easily be placed together in new localities. Even if their cost structures were similar at this time, it is fairly unpredictable how demographics and cost structures may change in the future.

RE: Option 3: as proposed, this option has the strongest support from the physicians of Santa Cruz County. By revising the current payment localities rather than focus only on Locality 99, this is a method which could be applied universally across the nation. This option would be consistent with the intent of Medicare to reimburse physicians based on the cost of providing

care. Completely revising the payment localities in California is the most objective method to accomplish this goal. Both Option 1 and Option 2 are faulty methods because they rely on existing payment localities. The convention of relying on existing localities has created worsening payment inaccuracies within the state of California. In some cases, counties with lower cost structures which have been previously granted their own payment localities are being reimbursed at higher rates than higher cost counties which are currently in Locality 99. By utilizing existing payment localities to revise the PFS, rather than revising all payment localities, CMS implies that a county previously granted 'own-locality' status is somehow more important or more valuable than counties which have remained within Locality 99. It is unreasonable to treat counties differently based purely on whether or not they have been historically placed in or excluded from Locality 99. The reimbursements should be based on the cost structure of the counties, not primarily on the basis of historical locality designations.

The GAO report [June 2007] highlighted several advantages to the county-based GAF ranges method of restructuring the payment localities. Of the 5 approaches evaluated, using county-based GAF ranges would reduce the average payment difference the most. As stated, "The number of counties that could potentially experience difficulty attracting and retaining physicians as a result of relative underpayments would also decrease." As expected, in addition to improving average payment accuracy, using the county-based GAF ranges would reduce the number of counties which are under- and over-paid. From a national perspective, Option 3 in the proposed rules is the best option.

From a local perspective, Option 3, as presented in the GAO report [Appendix II] would significantly reduce inter-county friction and impetus to change practice location. For example, according to the GAO report, both Santa Clara and Santa Cruz would be in Locality 2, and Monterey and San Benito would be in Locality 3. This minimization in payment differences makes sense and would reduce local tensions. CMS has proposed in Option 3 (72 FR 38142) that San Benito would be in Locality 5, but if CMS were to use the methodology in the GAO report, San Benito would be in Locality 3. Again, from a local perspective, the GAO revision methodology would improve the entire area's ability to attract and retain physicians.

In summary, the SCCMS strongly supports Option 3 in the proposed rules, particularly if CMS were to use the methodology used in the GAO report.

Cordially,

Timothy W. Allari, MD
Chairman, Legislative Committee
Santa Cruz County Medical Society

Submitter : Dr. Timothy Allari **Date:** 08/30/2007

Organization : Santa Cruz County Medical Society

Category : Health Care Professional or Association

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

Resubmitting in different file format to assure receipt.

CMS-1385-P-13082-Attach-1.TXT

#13082

August 30, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: "GPCIs"

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SCCMS strongly supports the United States Government Accountability Office [GAO] report from June 2007. It states, "GAO recommends that CMS (1) examine and revise the payment localities using an approach that is uniformly applied to all states and based on the most current data and (2) update the payment localities on a periodic basis."

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In summary, the SCCMS strongly supports Option 3 in the proposed rules, particularly if CMS were to use the methodology used in the GAO report.

Cordially,

Timothy W. Allari, MD
Chairman, Legislative Committee
Santa Cruz County Medical Society

Submitter : Donna Rice **Date:** 08/30/2007

Organization : American Association of Diabetes Educators

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13083-Attach-1.DOC

#13083

AADE American Association of Diabetes Educators

August 30, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave. SW, Room 314G
Washington, DC 20201

Re: CMS-1385

Dear Sir:

On behalf of the American Association of Diabetes Educators (AADE), we would like to take this opportunity to comment on the notice of proposed rulemaking: *"Medicare Program, Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and other Part B Payment Policies for Calendar Year 2008"*. Diabetes is a serious and growing health threat in the U.S., with the percentage of Americans with diabetes more than doubling since 1980. Today, almost 21 million Americans have diabetes, and 2,200 people are diagnosed with diabetes each day.

AADE is a multidisciplinary professional membership dedicated to advancing the practice of diabetes self-management training and care as integral components of health care for persons with diabetes, and lifestyle management for prevention of diabetes. AADE currently has 105 local chapters and 19 specialty practice groups, and represents more than 12,000 members, including nurses, dietitians, pharmacists, physicians, social workers, exercise physiologists and other members of the diabetes teaching team.

Diabetes Self Management Training (DSMT), provided according to a physician's plan of care by a Diabetes Educator or other specially trained health professional, is a vital tool to help control the disease and prevent serious and costly health complications of diabetes. DSMT provides critical training to help individuals with diabetes learn how to monitor their blood glucose levels, manage a healthy eating plan, engage in an appropriate exercise regimen, and take other steps needed to stay healthy.

DSMT was statutorily mandated by Congress as a Medicare benefit in 1997. Since that time, however, federal policies and reimbursement mechanisms have failed to keep pace with the overwhelming need to support strong DSMT programs in a variety of settings. As a result there are still outstanding issues of concern regarding CMS payment policies for providers of DSMT that should be addressed.

First, DSMT is currently reimbursed under the Level II Healthcare Common Procedure Coding System (HCPCS), generally used to identify products, services and procedures not included in the Level I CPT-4 codes maintained by the American Medical Association (AMA). Because DSMT has no associated physician work values,

reimbursement will likely continue to decrease for these services, due to scheduled decreases in practice expense valuations. DSMT should more properly be reimbursed as a Level I CPT-4 code, with work values assigned that reflect the appropriate nature of this service.

Second, the benefit itself is limited in scope and hampers beneficiary access to needed care. Certified Diabetes Educators (CDEs) are not currently recognized as Medicare providers of DSMT services. In addition, current accreditation requirements for Medicare DSMT programs are burdensome and expensive, with the result that too many hospital DSMT programs are closing, and too few small providers can afford the time and expense needed to meet the myriad of requirements imposed on large facilities by virtue of the current program requirements for certification.

When taken together, these policies serve as barriers to widespread adoption of DMST, arguably the most essential component of a successful diabetes management program. We respectfully urge CMS to address these gaps by working with DSMT providers to develop more appropriate coding valuations for DSMT, and to support the development of distinct small practice setting accreditation requirements that would promote the development of DSMT in non-hospital settings and provide better access to care for people with diabetes. We urge CMS to support legislation that will recognize CDEs as Medicare providers, and to expand the DSMT benefit to reach those individuals who are at high risk of developing diabetes.

Thank you for the opportunity to comment on this Notice, and we appreciate your consideration. AADE looks forward to working with CMS to address these important DSMT issues.

Respectfully submitted,

Donna Rice

Donna Rice, MBA, BSN, RN, CDE
President
American Association of Diabetes Educators

CC: Martha L. Rinker

Submitter : Dawn Hopkins **Date:** 08/30/2007

Organization : Society of Interventional Radiology

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please, see attachment

CMS-1385-P-13084-Attach-1.PDF

CMS-1385-P-13084-Attach-2.PDF

CMS-1385-P-13084-Attach-3.PDF

#13084

SOCIETY OF INTERVENTIONAL RADIOLOGY
Enhanced care through advanced technology™

Society of Interventional Radiology
3975 Fair Ridge Drive, Suite 400 North
Fairfax, VA 22033
(703) 691-1805

August 30, 2007

Herb Kuhn
Acting Director
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via CMS Web site, http://www.cms.hhs.gov/eRulemaking, with hardcopy sent via FedEx

RE: "Medicare Program: Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 [CMS-1385-P]"

Dear Mr. Kuhn:

The Society of Interventional Radiology (SIR) is a physician association with over 4,000 members that represents the majority of practicing vascular and interventional radiologists in the United States. SIR having reviewed the "Medicare Program: Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 [CMS-1385-P]" offers the following general and specific comments:

CMS Support for RUC-PERC Process
SIR commends the Centers for Medicare & Medicaid Services (CMS) for the sincere and extraordinary effort of your staff in supporting the RUC process and in particular the RUC-PERC process, which requires diligence, impeccable attention to detail, and an intense level of scrutiny. CMS staff does an exceptional job in ensuring that the data pertaining to practice expense inputs is as accurate and up-to-date as reasonably possible.

Creation of Non-Facility RVU Rates for Peripheral Stent Services
SIR commends CMS for supporting the creation of non-facility RVU rates for codes 37205, 37206 and 75960. However, it appears that the update to the non-facility RVU rate for code 75960 was inadvertently not included in the proposed rule. Per correspondence with CMS staff, this was a result of failing to update the 2007 "C"- carrier price status for this code to an active code. SIR eagerly awaits confirmation of the correction of this minor oversight.

The creation of non-facility RVU rates for peripheral stent services is timely and appropriate. Per Medicare 2005 utilization data, these services are most typically being provided in the outpatient setting (50.21%, including 48.15% hospital outpatient and 2.06% office setting - Source: 2005 Medicare utilization data, American Medical Association/Specialty Society RUC Database 2007)

and SIR asserts that since 2005, undoubtedly the outpatient/office utilization rate has even further increased above the available statistics rate.

There are several studies that clearly establish that peripheral stent services are safely performed with short observation stays as is typical in the non-facility environment. Kruse and Cragg (JVIR 2000) concluded, "many interventional vascular procedures [including stent placement] can be performed safely on an outpatient basis with relatively short observation times [four hours or less]. Early discharge from the SSU did not result in an increased readmission rate to the hospital because of delayed complications." Additionally, Akopian and Katz (J Vasc Surg 2006) found significant cost savings associated with interventional vascular procedures with short observation times with no compromise in safety. Copies of both these articles have been attached for your reference.

CMS' Request for Additional Information Regarding Practice Expense Data
CMS has requested specific information regarding practice expense data for codes 37205/37206 and 36481. Please find SIR's compliance with this request, as follows:

Codes 37205 and 37206
CMS has requested confirmation of the price of the "vascular stent deployment system, a description of the kits contents and the typical quantity needed". A copy of the price listing supporting the $1645 price and a brochure describing the device as supplied by the manufacturer, Cordis (both, of which, have already been submitted to CMS staff) have been attached for your reference.

SIR members currently performing these services in the freestanding/non-facility setting do find that typically 1-2 stents are used in these procedures, supporting SIR's initial recommendation to the RUC-PERC of 1.5 stents. However, RUC-PERC advisors found that non-facility practice expense costs should cover all typical scenarios, hence the RUC-PERC recommendation of 2 stents. Regretfully, as these devices are quite expensive and there is not currently sufficient reimbursement to cover the costs of providing these services in the non-facility setting, the utilization rate of these services in the non-facility is currently relatively low; limiting the availability of published data to challenge CMS' decision to only include 1 stent. It is hoped that CMS is cognizant that this decision is being made based on the information contained in "a published clinical research study". Akopian and Katz (J Vasc Surg 2006) findings regarding the typical number of peripheral stents placed, supports the experience of SIR members with 46 single stent (53%) and 40 multiple stents (47%) placed during 86 stent procedures. SIR asserts that the findings of one study examined by CMS, that can be contradicted by the Akopian and Katz study, should not override the recommendation of the RUC-PERC, which brings the experience of many providers, and strongly urges CMS to reconsider including the practice expense (PE) cost of 2 stents, or at minimum the believed to be "average" of 1.5 stents, in the non-facility PE value for code 37205.

Code 36481
SIR, having reviewed the entire listing of the current three different types of practice inputs (equipment, clinical staff, and medical supplies) for code 36481 (*Percutaneous portal vein catheterization by any method*), as detailed in the "2008 PFS Proposed Rule (CMS 1385-P): Direct Practice Expense Values Used To Create Resource-Based Practice Expense Relative

Value Units" data files, finds that the list of practice expense (PE) inputs for this code appears to be that for a plasma pheresis procedure and does not reflect the PE inputs that would be typical for percutaneous portal vein catheterization. For percutaneous portal vein catheterization, one would anticipate the inclusion of angiographic equipment, catheters to access the portal vein and the inclusion of Radiologic Technologist/Angio Technician staff time. SIR recommends that CMS refer code 36481 to the RUC-PERC process for the development of accurate and appropriate PE inputs for the facility and non-facility settings.

In the interim, SIR recommends that CMS consider cross-walking the PE inputs for code 36481 to a code with similar established non-facility PE inputs. Regretfully, what is believed to be the most similar service to portal vein catheterization, TIPS revision (code 37183 - *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation*) does not currently have non-facility PE inputs developed. Therefore, until such time as PE inputs for code 36481 can be addressed through the RUC-PERC process, SIR recommends using the non-facility PE inputs for the closest existing code with non-facility PE inputs developed, which is code 36012, (*Selective catheter placement, venous system; second order, or more selective, branch*). While code 36481 is believed to be more resource intensive than code 36012, this code does offer the closet estimate of PE inputs at this time. In addition to referring code 36481 to the RUC-PERC process for the development of PE inputs, SIR recommends that CMS also consider referring the related TIPS revision code 37183 for PE input development.

Proposed Annual Pricing of High Cost Disposable Medical Supplies
SIR is aware that the RUC has recommended that "High cost disposable medical supplies (priced at or above $200) should either be reported separately with J codes or individually identified within the payment bundle and then re-priced on an annual basis." Regretfully, obtaining pricing information from device manufacturers can be time consuming and administratively burdensome. It is believed that this recommendation would result in an undue administration burden on specialties such as interventional radiology that provide device-intensive services. Therefore, SIR recommends that CMS consider instituting a minimum utilization level in conjunction with device price, as the trigger for annual re-pricing of disposables.

Equipment Utilization Assumptions
SIR supports CMS' proposal to retain the current 50% equipment utilization assumption and concurs with CMS' statement, "*We do not believe we have sufficient empirical evidence to justify an alternative proposal [to the 50% utilization assumption].*" Additionally, an increase in the utilization rate assumption is not supported by MedPAC survey data. In fact, MedPAC issued the following warning regarding any attempts to rely on the methodologically flawed survey data they recently commissioned:

"This survey is a first step…It was not nationally representative and it was not designed to determine equipment use rates. Its intent was to assess the feasibility of getting use rate data from the survey….. *I do want to caution that this survey is not representative [of] anything."* (p. 237 and 242 of April 19, 2006 MedPAC meeting transcript).

SIR appreciates the opportunity to provide comment to CMS regarding the valuation of interventional radiology services under the Medicare Physician Fee Schedule. If SIR can be of any assistance as CMS continues to consider and review the 2008 Medicare Physician Fee Schedule, please do not hesitate to contact Dawn Hopkins, Director of Reimbursement & Health Policy at (800) 488-7284, ext. 588, Hopkins@SIRweb.org,

Sincerely,

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Safety of Short Stay Observation after Peripheral Vascular Intervention[1]

Janice R. Kruse, RD
Andrew H. Cragg, MD

Index terms: Angiography, complications • Angioplasty, complications

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Abbreviation: SSU = short stay unit

PURPOSE: To determine whether short observation periods (less than or equal to 4 hours) are safe in outpatients undergoing arterial peripheral vascular interventions.

MATERIALS AND METHODS: A retrospective review of 203 patient medical records from the Interventional Vascular Department for 239 lower extremity or abdominal procedures (161 men and 78 women) during a 5-year period was completed. The average patient age was 62.2 years (range, 32–83 years). Thirty-six patients had more than one procedure. Indication, intervention, coagulation status, complication rate, and hospitalizations within 7 days after discharge from the short stay unit (SSU) were reviewed and the outcome was measured. Patients were grouped according to the length of their observation period (≤4 hours or >4 hours) for statistical analysis.

RESULTS: In 85% of the procedures (204 procedures), claudication was the primary indication for intervention. Angioplasty (203 procedures) was also commonly performed. Ninety procedures (38%) required stent placement, and other interventional procedures performed were pulse-spray thrombolysis (eight procedures), atherectomy (two procedures), and stent-graft placement (one procedure). None of the patients required hospitalization as a result of their radiologic intervention within 7 days after discharge from the SSU. Specifically, there were no major "at home" complications in patients discharged after an observation period of ≤4 hours. Two patients were admitted for outpatient procedures and were subsequently hospitalized as a result of a complication from the procedure. The complication rate (including minor complications) was 8% (seven of 87) in the ≤4 hour observation period group compared with 24.3% (37 of 152) in the >4 hour group ($P < .01$). This difference was due to a greater number of minor hematomas in the >4 hour group.

CONCLUSION: Based on the authors' findings, many interventional vascular procedures can be performed safely on an outpatient basis with relatively short observation times. Early discharge from the SSU did not result in an increased readmission rate to the hospital because of delayed complications.

COMPLICATIONS related to vascular interventional procedures have been well documented for the hospitalized patient (1,2). However, partially because of changes in the healthcare market, outpatient angiography and intervention have become more common in the last 5 years. As a result, short stay units (SSU) have been created as cost-effective patient care units for monitoring outpatient's vital signs (and other variables) prior to discharge. Traditionally, patients have been monitored in the SSU for a minimum of 4 hours and up to 23 hours after the procedure (1,3–5).

For the past 5 years, our facility

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has performed angiography and other interventional procedures, such as angioplasty, stent placement, thrombolysis, and atherectomy, as outpatient procedures. In the past several years, a trend toward shorter observation periods has developed. Observation periods of 2–4 hours are now common. The actual length of stay is individually determined by the treating physician, taking into account the patient's overall medical status. Patients are discharged to their home under the supervision of an adult companion for the next 24 hours.

We were interested in assessing the safety of discharging patients in less than 4 hours after their interventional procedure. We were also interested in determining if we provided the appropriate level of monitoring and care (and, if necessary, hospitalization) required by the patient.

MATERIALS AND METHODS

We retrospectively reviewed the medical records of 203 consecutive patients who were admitted on an outpatient basis to our SSU for observation after peripheral lower extremity or abdominal vascular intervention from February 1992 to February 1997. Inpatients or patients admitted directly to the hospital from the interventional suite were not included in the study. Patients who underwent procedures not performed in the lower extremity or abdomen were also excluded.

Prior to the procedure, all patients and their medical histories were evaluated by a physician for the appropriateness of undergoing angiography and an interventional procedure performed on an outpatient basis. Another factor leading to outpatient rather than inpatient observation was physician practice. Some physicians had a preference for longer observation periods and inpatient observations. Diagnostic angiography and the associated intervention were performed in the same procedure. Interventions performed included angioplasty, stent placement, thrombolysis, stent-graft placement, and atherectomy of the aortoiliac or infrainguinal arteries. No arterial closure devices were used in this population and puncture site bleeding was controlled with use of manual compression. Patients were not treated as outpatients if they had any of the following: poorly controlled insulin-dependent diabetes, uncontrolled hypertension, electrolyte imbalances, severe renal insufficiency, symptomatic cardiopulmonary failure, or coagulopathies. The decision to treat a patient as an outpatient was based on general criteria for a group of clinical patients rather than precise laboratory or clinical parameters.

Data collection included (i) indication for the procedure, (ii) comorbidity of the patient, (iii) intervention performed, (iv) sheath size, (v) length of procedure, (vi) length of recovery time, (vii) complications, and (viii) the location where the complications were discovered (in the hospital or outside of the hospital). Major complications were defined as those that required the patient to be hospitalized. Minor complications were defined as those noted in the medical record not requiring hospitalization. In the case of minor hematomas, no distinction was made between the size of the hematoma. A hematoma that required a transfusion or admission as part of the treatment was classified as a major complication.

The patients were admitted to the SSU of the hospital as outpatients 1 hour prior to angiography to obtain laboratory blood analysis and undergo clinical examination performed by an interventional radiologist. After the interventional procedure, the patient was returned to the SSU. The patient's vital signs and puncture site(s) were monitored every 15 minutes for 1 hour, and then hourly while the patient was in the SSU. Patients were positioned with the upper torso at a 45° angle in a patient recliner and were allowed to move from side to side. The routine length of stay in the SSU was 2–6 hours. Prior to discharge, a SSU nurse examined the patient's puncture site(s), checked the vital signs, and made sure the patient was alert, oriented, able to ambulate, and tolerated oral fluids. If these criteria were judged by the nurse to be abnormal or not met, the physician was consulted and the patient was required to stay in the SSU for further observation. Patients also received instructions on activity restrictions, fluid intake, and emergency care should bleeding or other complications arise. Normal activity was restricted until the following day and strenuous physical activity was restricted for 72 hours. Pressure over the puncture site was also recommended during coughing, laughing, or sneezing. Fluids were also encouraged during the 24-hour period after the procedure. Preprocedure medications were resumed after the discharge. The patients were required to have someone transport them home and to be under the supervision of an adult for 24 hours.

A nurse telephoned the patients the next morning from the SSU. The nurse assessed the status of each patient with a short telephone interview and answered additional questions for the patients. Patients were reminded to call the SSU should future complications develop. Information on rehospitalization was obtained by reviewing the medical record. Most of the patients had health insurance and, as a result, would be required to seek emergency care at the same facility that provided treatment.

During the approximate 5-year period, 203 patients underwent 239 procedures (161 men, 78 women). The average patient age was 62.2 years (range, 32–83 years). In the study group, 36% of patients spent 4 hours or less in the SSU. Sixty-four percent spent more than 4 hours (**Fig 1**). Thirty-six patients underwent more than one procedure during this 5-year period.

Subanalysis of the data was performed by grouping the patients according to the recovery time (≤4 hours or >4 hours) spent by the patient in the SSU, as documented in the patient's medical record. The use of heparin during the procedure was not used as criteria for a longer

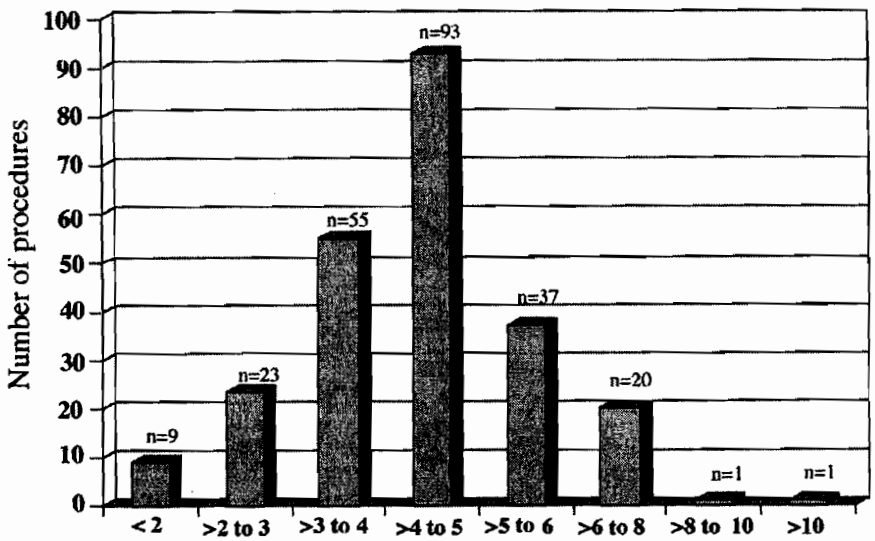

Figure 1. Length of recovery, in hours.

observation period. The complication rate was calculated and the chi-squared test was performed on related variables. Statistical significance was specified as $P \leq .05$.

RESULTS

The primary indication for the intervention was claudication in 204 (85%) of the procedures. Angioplasty was performed in 203 (85%) of the procedures.

Stents were placed in 90 (38%) of the procedures. Other interventional procedures performed were atherectomy (n = 2), stent-graft (n = 1), and pulse-spray thrombolysis (n = 8). The interventions were almost equally performed in the iliac and femoralpopliteal region, 42% and 55%, respectively. Eleven percent of the procedures were performed while the patient was taking an anticoagulant, such as warfarin. The use of heparin during the procedure was also equally split, with 48% of the patients receiving heparin while 52% did not receive heparin.

The majority of sheaths used in all procedures were 6-F (68%), whereas some procedures required a 7-F sheath (8%). In 20% of the procedures, the sheath size was not able to be determined. A 6-F sheath was used in approximately 70% in both observation period groups. The femoral puncture site was used almost exclusively (89%) in all procedures. Femoral access was used in 84% of the procedures in the short observation period group versus 93% in the long observation period group. However, bilateral access was more common in the >4 hour group versus the ≤4 hour group (27% vs. 14%). Many of the procedures lasted approximately 1–2 hours (70%), although in some cases the procedure lasted less than 1 hour (23%). Both observation groups had equal (79%) distribution of the procedure length at 1–2 hours. Claudication as the indication for intervention was also equally distributed (approximately 85%) in each group. Lastly, the presence of heart disease was twice as likely in the >4 hour observation group (28%) versus the ≤4 hour group (13%).

However, there was not a statistically significant relationship between groups for certain variables, such as indication for the procedure, type or location of the intervention, or the patient age greater than 75 years.

In our analysis, there appeared to be two principal reasons for observation periods that were longer than 4 hours. These were physician preference and the need for additional monitoring because of a minor complication or medical condition.

None of the patients who had outpatient procedures required hospitalization as a result of their radiologic intervention within 7 days after discharge. Specifically, no patients who were discharged after the short observation period required readmission for a complication.

The overall major complication rate was the same for both recovery period groups (0%). Minor complications (primarily minor hematomas) were more common in the ≤4 hour group ($P < .003$). **(Table 1)**.

Five patients (six procedures) were admitted to the hospital for other reasons within 7 days after their interventional radiology procedure. The admissions were for nonemergent surgeries, such as bypass surgery (n = 3), endartarectomy (n = 2), and an amputation of a toe (n = 1).

• Complications

There were two patients who were not discharged but admitted directly from the SSU to the hospi-

Table 1
Complication Rates for Length of Recovery Times

Variable	≤4 hrs	>4 hrs	P value
Major complications (required readmission to hospital)	0%	0%	NS
Minor complications	8.0% (7/87)	24.3% (37/152)	.003

Note.—NS = not statistically significant.

tal as a result of major complications due to the interventional procedure. The complications were diagnosed in the SSU. One patient who had a stent placed in the common and external iliac arteries developed a moderate hematoma with a small amount of external bleeding and pain in the groin area. The patient was hospitalized as a precautionary measure for overnight observation and did not receive a blood transfusion. The remaining patient, who had an angioplasty in the superficial femoral artery, was hospitalized for 48 hours for medical management of hypertension after symptoms of nausea, vomiting, and vertigo worsened in the SSU. Both patients were discharged from the hospital without any further complications. There were no deaths in this study within 30 days after discharge.

Puncture site hematomas were the most prevalent minor complication and were seen in 15% (n = 37) of the cases, accounting for 84% of the complications. Any evidence of extravascular bleeding was recorded as a hematoma. This included skin induration 1 cm or greater. In all but one case, patients were discharged without further complications. None of these patients received transfusions as part of their treatment.

Heparinization was also more common in the >4 hour group (P < .001) **(Table 2)**. Among those patients who received heparin, the rate of minor complications was not different between shorter and longer observation periods (χ^2 = 3.16). However, among the patients who did not receive heparin, there were fewer complications for those in the short observation period group than those in the long observation period group (P < .01) **(Table 3)**.

Table 2
Variables for Length of Recovery Times

Variable	≤4 hours	>4 hours	P value
Indication for procedure			
Claudication	82.8% (72/87)	86.8% (132/152)	NS
All other indications	17.2% (15/87)	13.2% (20/152)	
Intervention			
Angioplasty	84.0% (73/87)	85.5% (130/152)	NS
Stents	32.2% (28/87)	40.8% (62/152)	NS
Procedure location			
Iliac	34.5% (30/87)	46.7% (71/152)	NS
Femoral-popliteal	54.0% (47/87)	55.9% (85/152)	
Heparin use during the procedure			
Received heparin	32.2% (28/87)	57.2% (87/152)	.001
Age of patient			
≤75 y	92.0% (80/87)	85.6% (130/152)	NS
>75 y	8.0% (7/87)	14.5% (22/152)	

Note.—NS = Not statistically significant.

• DISCUSSION

The complication rate associated with angiography has been defined for the hospitalized patient (3). In the past few years, a small number of articles have been published on the complication rates of outpatient angiography and angioplasty.

Recently, Payne et al (3) documented a 4% complication rate for 168 outpatient angioplasties after a minimum observation period of 4 hours. The complication rate included patients requiring hospitalization as a result of the angioplasty. Struk et al (4) showed there was no greater risk of complication in outpatients who received angioplasty and a 6-hour recovery period as compared to hospitalized patients. They documented a complication rate of 5% for 141 outpatient procedures. Hematomas comprised most of the complications requiring hospitalization. Rogers et al (5) also described outpatient angioplasty with a recovery period of 4–6 hours. In this series of 149 angioplasties, one patient required hospitalization as a result of the angioplasty procedure.

Heparin was more common in the longer observation period group. The reasons for differences in the heparinization during the procedure were not readily identifiable in our study, but were likely due to physician practice and individual patient requirements. The fact that heparinized patients tended to stay longer after the procedure likely reflected physician judgment that longer observation was needed.

In our experience, the hospitalization rate of 0% within 7 days after discharge from the outpatient radiology procedure substantiates the safety of performing interventional vascular procedures on an outpatient basis, and discharging these patients with a recovery time of ≤4 hours. Our minor complication rate of 8% for the group that had a recovery time of ≤4 hours is similar to published reports for less complicated vascular intervention (1,4,5). It is important to note that our analysis group included many patients with complex intervention, such as stent placement and thrombolysis.

The rate of minor hematomas was relatively high in both groups in this analysis. This was, in part, a

Table 3
Heparin Use

Variable	≤4 hours	>4 hours	P value
Heparin Use–Minor complications	17.8% (5/28)	25.3% (22/87)	NS
No Heparin Use–Minor complications	3.4% (2/59)	23.1% (15/65)	.01

reflection of the close monitoring of patients by the SSU nurses. Any area of induration >1 cm was recorded as a hematoma. Importantly, none of the patients with minor hematomas required further care or resulted in postdischarge sequelae. Our analysis also found a significant relationship between the occurrence of a minor complication and prolonged observation. We believe this reflected appropriate judgment on the part of the SSU nurses and physicians.

The limitations to our analysis include its retrospective design and the fact that patients were selected for early discharge, in part on the basis of clinical judgment. Nonetheless, the patient populations appeared similar with respect to age, comorbidity, indication for intervention, and procedure length.

Our data suggest that selected patients can be safely sent home soon after extensive percutaneous revascularization procedures. Our principal concern about "at home" recovery from endovascular interventions, such as iliac stent placement, was the possibility of a catastrophic hemorrhagic complication at the treatment site. Our analysis does not exclude this possibility, but it does suggest that in properly selected patients, it should be rare.

There are many advantages to shorter recovery times for patients undergoing interventional procedures. Shorter stays may decrease the shortage of beds in the SSU caused by the increasing popularity of outpatient procedures. The shorter stay would also be cost-effective because these patients are charged an hourly fee for the monitoring. In addition, shorter recovery times may also allow later scheduling of cases, thus increasing interventional laboratory efficiency. Puncture closure devices may further shorten recovery times by potentially lowering the minor complication rate observed in our analysis.

In conclusion, the increased number of interventions performed on an outpatient basis, and shorter observation periods will require proper identification of patients requiring a higher level of care after interventional procedures.

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Peripheral angioplasty with same-day discharge in patients with intermittent claudication

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Background: **As the number of endovascular interventions increase and resources become scarce, surgeons need to be aware of cost-effective and efficient practice options. Many surgeons routinely admit their patients for overnight observation after uneventful endovascular interventions. Although this may be appropriate for patients with tissue loss and rest pain, we believe that peripheral angioplasty in patients with claudication can be safely performed as an outpatient procedure with significant cost savings.**

Methods: **All patients with intermittent claudication undergoing peripheral angioplasty by a single vascular surgeon were enrolled prospectively in a same-day discharge protocol. Involved arteries and use of stent and closure device were recorded. Time to mobilization and time to discharge were determined. Patients were observed in an observation unit by a registered nurse, and were examined by the surgeon at the time of ambulation and before discharge. Patients were admitted to the hospital if complications arose during the predetermined observation period. Periprocedural complications and reasons for admission were noted. Patients were evaluated at 1 week, 6 weeks, and 3 to 6 months after the intervention.**

Results: **During 27 months, 112 interventions were performed in 97 patients. The superficial femoral artery was the most frequent site of intervention (47%). Multiple sites had angioplasty in 27 (24%) procedures. Nine (8%) procedures resulted in admission. One patient was admitted for a major puncture site hematoma requiring blood transfusion, two patients for observation of a minor hematoma at the puncture site, one for chest pain, and one for observation of transient bradycardia. The mean time to mobilization was 1.4 ± 1.3 hours, and the mean time to discharge was 2.8 ± 1.2 hours. The average postprocedural cost for patients undergoing same-day discharge was $320 per patient, which contrasts with $1800 for routine overnight observation. No deaths or unplanned admissions to the hospital occurred ≤30 days of intervention.**

Conclusions: **Same-day discharge after peripheral angioplasty is safe and cost-effective. Need for admission is evident within 2 hours. Routine admission after peripheral angioplasty for patients with claudication is unnecessary and should no longer be the standard of care. (J Vasc Surg 2006;44:115-8.)**

After the introduction of the coaxial catheter[1] in the 1960s and the subsequent creation of the balloon angioplasty catheter[2] a decade later, percutaneous transluminal angioplasty (PTA) became an acceptable form of treatment for patients with occlusive arterial disease. Over the last two decades, PTA has seen tremendous growth as a treatment option for peripheral vascular disease. With an ever-increasing population of elderly,[3] the prevalence of peripheral vascular disease and vascular interventions is expected to rise. Because catheter based procedures are now being performed with minimal complications, the appropriateness of routine hospitalization after these procedures should be brought into question.

The Society of Interventional Radiology Standards of Practice Committee guidelines[4] in 2003 called for overnight observation after PTA on the basis of the limited number of studies that addressed this issue. Although diagnostic angiography is routinely performed as a same-day procedure, outpatient PTA has been limited to a few centers. Our preliminary observation suggested that many patients having percutaneous interventions for intermittent claudication did not require hospital admission. In an attempt to determine the safety, efficacy, and cost benefits of outpatient PTA, we prospectively enrolled 112 patients in a study protocol of same-day discharge to test this hypothesis. This report focuses on the feasibility of same-day discharge from the short-term complication rates and cost analysis in this series of patients.

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Competition of interest: none.

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MATERIAL AND METHODS

Between January 1, 2003, and March 31, 2005, all patients admitted for elective percutaneous interventions were prospectively enrolled in a same-day discharge protocol. Interventions were performed by or under the supervision of one vascular surgeon (S. G. K.). Data were collected according to the guidelines set forth by the Society for Vascular Surgery and the International Society for Cardiovascular Surgery,[5] stratified by Transatlantic Intersocietal Consensus (TASC) classification,[6] and analyzed on an intent-to-treat basis. When multiple segments underwent intervention at one setting, the highest TASC classification lesion was recorded. Patient demographics, presence of comorbidities, history of smoking, use of anticoagulants, stent placement, location of disease, use of closure device, and prior vascular interventions were recorded. The protocol was approved by the institutional review board, and patients gave written informed consent.

All patients were ambulating without assistance before the intervention and had adequate home support. None were from nursing homes, although16 were from assisted living facilities. The payer mix for this population of patients was 43% Medicare, 37% managed care, and 20% private pay. None of the payers require admission or discharge after endovascular interventions.

Patients did not undergo prescreening, and all interventions were planned within the same-day protocol. No patients were admitted the night before the intervention. Before the procedure, patients routinely underwent duplex evaluation of their lower extremities for planning purposes only. The preoperative duplex result did not change the decision to enroll the patients in the same-day protocol.

All patients were begun on clopidogrel (75 mg daily) beginning 4 days before the intervention. Patients able to tolerate aspirin were also given 325 mg daily. Warfarin was discontinued 72 hours before the procedure, and procedures were postponed if the international normalized ratio was >2.0.

Vascular access was obtained through a transfemoral approach using the micropuncture technique. Diagnostic arteriography was performed immediately before the intervention. All patients were systemically anticoagulated with heparin (5000 U). Stents were routinely placed after iliac angioplasty per surgeon preference and initially in infrainguinal vessels if flow-limiting dissection or incomplete angioplasty (residual stenosis >30%) was noted. Beginning in January 2004, stents were routinely placed after superficial femoral artery and popliteal artery angioplasty as part of an ongoing protocol studying the results of primary stenting of the infrainguinal vessels. For occlusions >5 cm, subintimal angioplasty techniques were used in almost all of the patients. For occlusions <5 cm, both transluminal and subintimal techniques were used.

Placement of the Angio-Seal Vascular Closure Device (St. Jude Medical, Inc., St. Paul, Minn) was attempted after all procedures if the puncture site was in the common femoral artery and if there was <40% stenosis ≤1 cm of the puncture site.[7,8] Feasibility of closure device deployment was angiographically determined. When a closure device was not successfully deployed, the physician performed manual groin compression at the groin access site for 10 minutes, re-evaluated for bleeding or hematoma, and pressure was reapplied if there was bleeding or an expanding hematoma. Heparin was not reversed at the conclusion of the procedure.

Patients were ambulated in 1 hour after having successful placement of a closure device and considered for discharge in 2 hours if their post-procedure course was uncomplicated. If manual compression was used, patients were ambulated after 4 hours and considered for discharge shortly thereafter.

Patients were observed in a four-bed observation unit staffed by one registered nurse. Time to ambulation and time to discharge were determined at the end of the procedure and adhered to if there were no complications. All procedures were started between 8 AM and 3 PM and completed between 9 AM and 5 PM. There were no payer requirements that would alter the decision to admit or discharge.

Table I. Comorbidities of study patients

Comorbidity	*N (%)*
Hypertension	88 (78.6)
Tobacco use	61 (54.5)
Hypercholesterolemia	57 (50.9)
Coronary disease	50 (44.6)
Diabetes mellitus	31 (27.7)
Arrhythmias	9 (8.0)
Renal disease*	5 (4.5)

*Defined as serum creatinine >2.0 mg/dL.

Patients underwent duplex evaluation at 6 weeks and every 3 months for the first year, and every 6 months thereafter. Patients were seen in the office at 1 week, 6 weeks, and every 3 months for the first year, and every 6 months thereafter. Additional phone calls were not routinely made, and patients were only seen outside of this follow-up schedule if problems arose.

Cost analysis data were collected from the hospital's business office. Cost analysis was performed on actual costs rather than patient charges. Hospital cost for a 1-hour stay in the observation unit is $115, and an overnight stay in an inpatient surgical bed is $1800. The average cost for patients being discharged was calculated by multiplying the average length of stay by $115. Data are provided as counts or means ± standard deviation. Analysis was performed using SAS (SAS Inc, Cary, NC).

RESULTS

During the 27-month study period, 112 consecutive procedures were performed in 97 patients. Twenty-eight additional interventions, which are not included in this analysis, were performed in other patients for tissue loss or rest pain. The mean age for the group was 74 ± 9 years. There were 49 men and 48 women. In 45 procedures (40%), the patient had undergone a prior vascular intervention.

The most common comorbidity was hypertension (79%), followed by tobacco use (55%) (Table I). In 70 procedures (63%) the patients had Rutherford category 3 (severe) claudication. In 42 procedures (38%) the patients had Rutherford category 2 (moderate) claudication. Interventions were not performed on patients with category 1 (mild) claudication. There were 87 interventions performed on TASC category A and B lesions, and 25 were performed on TASC C and D lesions.

The most common site of intervention was the superficial femoral artery (SFA) in 53 procedures (Table II). Angioplasty was performed on a single segment during 80 procedures (71%) and on multiple segments during 27 procedures (24%). Five patients (5%) failed treatment because the lesion could not be traversed. These patients are included in the analysis on an intent-to-treat basis.

Table II. Location of intervention

Location	*N (%)*
Common Iliac	20 (17.9)
External Iliac	18 (16.1)
Common femoral	4 (3.6)
Superficial femoral	53 (47.3)
Popliteal	41 (36.6)

Stents were deployed in 86 procedures (77%). A single stent was used in 46 procedures (41%), and multiple stents were placed in 40 procedures (36%). Of these, 75 stents were self-expanding, and the rest were balloon-expandable. A 6F sheath was used to perform 104 procedures (93%), seven procedures were performed through a 7F sheath, and one through an 8F sheath.

A closure device was attempted after 99 procedures (88%) and was successful in 92 attempts (93% success rate). Overall, a closure device was successfully placed at the conclusion of 82% of proeedures; in the rest, hemostasis was obtained by manual groin compression.

The average length of the procedure was 72 ± 31 minutes (range, 17 to 175 minutes), with an average time to mobilization of 1.4 ± 1.3 hours and average time to discharge of 2.8 ± 1.2 hours. Same-day discharge was achieved after 103 procedures. Nine patients (8%) were admitted for overnight observation. Four patients were admitted for lack of support mechanisms at home. One patient was admitted for chest pain but was found not to have had a myocardial infarction, and one patient was admitted for observation of transient bradycardia, which spontaneously resolved. One patient had a major puncture site hematoma requiring blood transfusion, and two patients had minor hematomas. Of the three patients with hematomas, two had what was assumed to be successful deployment of a closure device, whereas in one patient, deployment of a closure device was not attempted. After procedures in which a closure device was successfully deployed, patients were discharged to home on the same day 95% of the time, while 80% of patients undergoing manual groin compression underwent same day discharge.

Eight of the admissions had TASC A or B lesions, and one patient had a TASC C lesion. Eight of the nine admissions had a length of stay of 1 day, and the patient with chest pain stayed 4 days. In patients discharged the same day, there were no deaths or unplanned readmissions ≤30 days of the procedure. The average postprocedural cost for patients discharged the same day was $320 per patient, which contrasts with $1800 for routine overnight observation.

There were three treatment failures, at 13 days, 17 days, and 27 days. These patients were successfully treated with open elective surgical intervention.

DISCUSSION

The last decade has witnessed striking technologic advances that have radically altered the manner in which care has been delivered to patients with arterial occlusive disease. With the development of catheter-based techniques to treat patients with intermittent claudication, it becomes the responsibility of the operator to perform these procedures in a safe, fiscally responsible, and cost-effective manner. In the past, it has been considered the standard of care to admit these patients to the hospital postprocedure for overnight observation in hopes of recognizing complications in a timely fashion. In our experience, complications have been infrequent and occurred in the early postprocedure period. This led us to attempt to modify our practice guidelines by routinely discharging patients on the day of their procedure. The results of this study confirm that peripheral angioplasty in patients with intermittent claudication can be performed in a cost-effective manner without compromising clinical outcomes.

Several studies[9-14] have addressed the topic of outpatient angioplasty. Although successful, most of their patients were prescreened or preselected for inclusion in the study. In addition, most of these procedures were performed on single arterial segments, and stents were rarely used. In contrast, we assumed that all patients with claudication undergoing PTA had an equal probability of being discharged, and thereby avoided selection bias by including patients having extensive procedures on multiple arterial segments in our study protocol. Still, we were able to discharge 92% of our patients on the day of their intervention. The safety of this approach is evidenced by the fact no patients died or had unplanned readmissions to the hospital ≤30 days of their procedure.

Although all of the patients in our series had claudication, we and others[15-18] have extended percutaneous interventions to those patients with limb threat, with gratifying results. We have found that selected patients with limb threat as their indication for intervention can be discharged on the day of the procedure. The site of intervention, length of the arterial segment treated, or the number of stents placed did not affect the chance of admission. Many complications of peripheral angioplasty are related to puncture site complications.[19,20] Interestingly, almost half of our admissions were unrelated to medical problems and were due to a lack of adequate social support at home. Perhaps with better planning and foresight on our part, some of these admissions could have been prevented.

Traditionally, patients undergoing peripheral angioplasty have been admitted to the hospital for overnight observation. However, preservation of health care resources has become increasingly important. In our area and in many parts of the country, hospitals are running at their maximum capacity, and bed space is at a premium. Limiting unnecessary admissions and optimal utilization of available resources would help to alleviate this problem. In addition, same-day discharge after PTA can result in significant cost savings. In our institution, our patients are observed in an observation unit rather than a recovery room, allowing for a substantial reduction in hospital cost. Our average postprocedural cost for patients undergoing same day discharge was $320 compared with the $1800 institu-

tional cost incurred for overnight admission to an unmonitored medical-surgical bed.

CONCLUSION

Same day discharge after peripheral angioplasty in patients with intermittent claudication is safe, cost-effective, and does not adversely affect patient outcomes. Determination of the need for admission can usually be made ≤2 hours after the procedure. Attention to the social needs of the patient and avoidance of puncture site complications should minimize hospital admission. Although we preferentially use closure devices, we were able to successfully discharge to home on the same day 80% of patients undergoing manual compression. Those who do not use closure devices should not be dissuaded from attempting same-day discharge. We conclude that routine admission after peripheral percutaneous intervention in patients with claudication is unnecessary and should no longer be considered the standard of care.

AUTHOR CONTRIBUTIONS

Analysis and interpretation: SGK, GA
Data collection: GA
Writing the article: SGK, GA
Critical revision of the article: SGK, GA
Final approval of the article: SGK, GA
Statistical analysis: GA
Obtained funding: Not applicable
Overall responsibility: SGK

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Submitted Jan 3, 2006; accepted Mar 20, 2006.

8-31-2007

RE: CMS - 1385 - P

The American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) welcomes the opportunity to comment on the proposed changes in the physician fee schedule outlined in the July 12, 2007 ***Federal Register***. Our comments focus solely on proposed changes related to the provision of cardiac rehabilitation services.

The AACVPR is the leading professional health care association focusing on cardiac and pulmonary rehabilitation. It is estimated that there are currently over 2600 cardiac rehabilitation programs in the United States. AACVPR members number approximately 3000 and the association is comprised of all professionals who serve in the field of cardiac and pulmonary rehabilitation. Members include: cardiovascular physicians, exercise physiologists, cardiopulmonary physical therapists, pulmonary physicians, nurses, dieticians, respiratory therapists and others.

Cardiac rehabilitation is comprised of a multi-disciplinary approach considered the standard of care for patients with coronary artery disease-related conditions. The U.S. Public Health Service definition states that, *"Cardiac rehabilitation services are comprehensive, long-term programs involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling...designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk of sudden death or reinfarction, control cardiac symptoms, stabilize or reverse the atherosclerotic process, and enhance the psychosocial and vocational status of selected patients."*[1] In fact, CMS cites this well-accepted definition in the recent Decision Memo for Cardiac Rehabilitation Programs (NCD 20:10).

The clinical evidence for a net health benefit from cardiac rehabilitation (CR) in patients with heart disease is conclusive, with meta-analyses of clinical trials consistently demonstrating a 25-30% reduction in total and cardiovascular mortality for CR participants compared to non-participants.[2,3] Participation in medically supervised CR programs has also been shown to reduce cardiovascular risk factors, including sedentary lifestyle and low physical fitness, obesity, dyslipidemia, endothelial dysfunction, hypercoagulability, abnormal sympathetic tone, and inflammation, in a variety of populations including men, women, and the elderly. Additionally, health-related Quality of Life (QOL) in patients participating in CR, including the elderly, is significantly improved.[2-23] Effectiveness analyses such as those by Witt et al. document that the benefits of CR extend beyond the clinical trial setting and that CR as practiced in the community results in substantial improvements in morbidity and mortality among CR participants in the current era of thrombolysis, revascularization and widespread use of pharmacological treatments known to improve prognosis among patients with coronary heart disease.[24]

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Cardiac rehabilitation is a multifactorial process

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Establishment of new Level II HCPCS codes (G codes) to replace current CPT codes:

According to the proposal, the primary reason for assigning a status indicator of "I" and shifting to the G code approach is to "clarify coding and payment" for these services. Structurally, CMS proposes to move away from the current term of "sessions" and change to more time sensitive terminology of "hours." On the one hand, we surmise that CMS is unaware that the long standing standard of care is for cardiac rehabilitation sessions of one hour duration. Ironically, CMS tacitly acknowledges this as it recognizes that one hour of service was assumed in establishing the current RVUs. Therefore, we do not believe that CMS will gain any additional information by shifting from sessions to hours, as the actual billing units of cardiac rehabilitation likely will remain virtually the same.

However, if CMS is determined to shift from the concept of sessions to hours, we strongly urge important clarification of this new, time sensitive code.

1. We assume that programs will be required to document in the medical record the specific time frame billed. Will it be within the 45 - 74 minute time frame, or within a 31 - 89 minute time frame? In other words, please clarify your use of the term hour, as we know that other time sensitive codes used by Medicare traditionally include time parameters.

2. Because the current NCD puts a primary limit of up to "36 sessions," it would be important to make sure that any change outlined in the ***Federal Register*** final rule is not contrary to policies outlined in the NCD.

Secondly, we believe use of the term "MD services" within the *Addendum B RVU payment table* must be deleted. The vast majority of services identified in the physician fee schedule are physician services but do not include the phrase "MD services" in the actual code descriptor within the RVU table. We are very concerned that Medicare contractors might construe the inclusion of that term in the RVU tables as a tacit requirement that all components of the service be provided by the physician rather than the traditional "incident to" model that has long been in place.

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Submitter : **Date: 08/30/2007**

Organization : **AACVPR**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1385-P-13086-Attach-1.DOC

13086

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE AND MEDICAID SERIVICES
FFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

lea.. note: We did not receive the attachment that was cited in his comment. We are not able to receive attachments that have been repared in excel or zip files. Also, the commenter must click the ellow "Attach File" button to forward the attachment.

lease direct your questions or comments to 1 800 743-3951..

Submitter : Dawn Hopkins **Date:** 08/30/2007

Organization : Society of Interventional Radiology

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

-additional attachments in support of submission of comments previously uploaded this day, via this site by the Society of Interventional Radiology

CMS-1385-P-13091-Attach-1.PDF

CMS-1385-P-13091-Attach-2.PDF

#13091

LIST OF ACTIVE CATALOGS
Endo
7/23/2007

Catalog Number	Catalog Description	Package Quantity	Package Unit of Measure	List Price	Product Group
C10020SL	SMART CONTROL, ILIAC 10X20	1	EA	1485	Stents Sx
C10020ML	SMART CONTROL, ILIAC 10X20ML	1	EA	1485	Stents Sx
C10030SL	SMART CONTROL, ILIAC 10X30	1	EA	1645	Stents Sx
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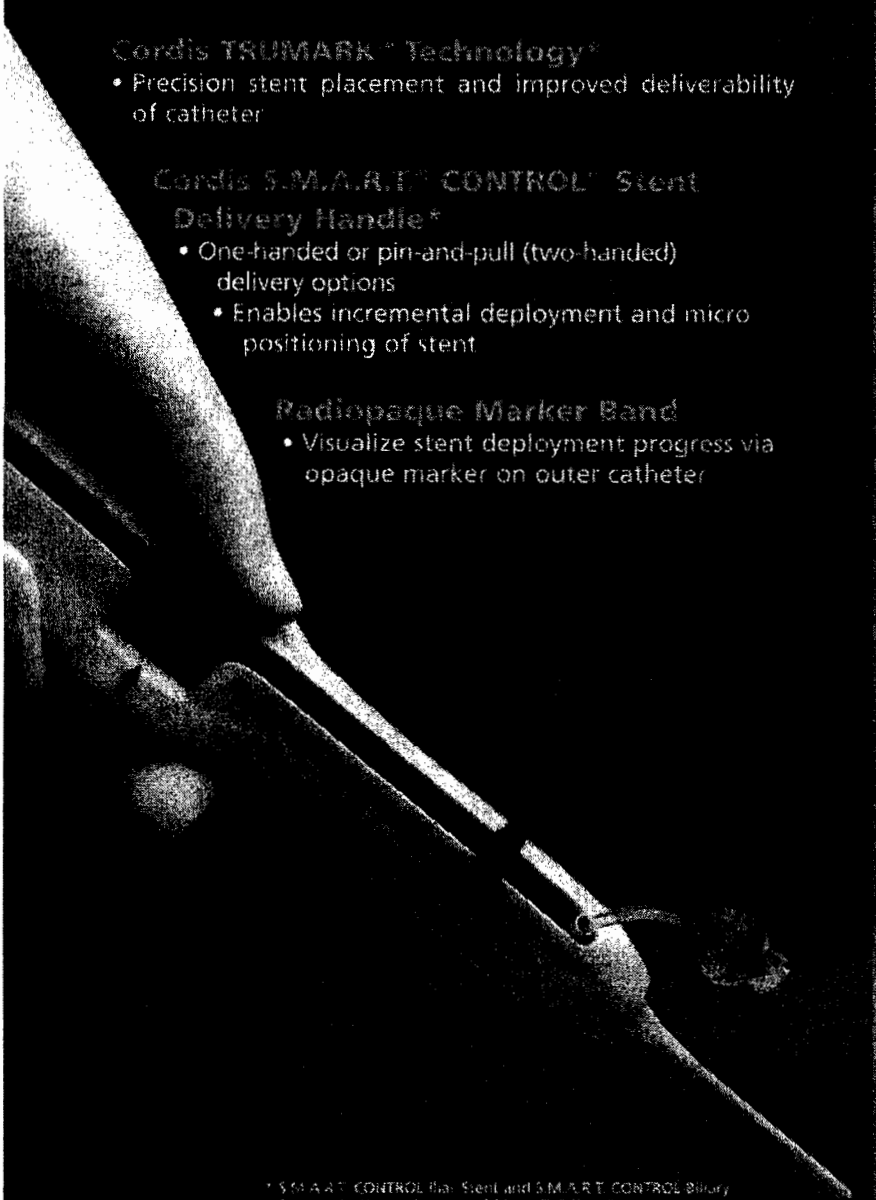

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Submitter : Mrs. Linda Velding **Date:** 08/30/2007

Organization : Northern Physical Therapy Services

Category : Occupational Therapist

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-13101-Attach-1.DOC

#13101

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS - 1385 - P
P.O. Box 8018
Baltimore, MD 21244-8018

Physician Self-Referral Issues

Dear Mr. Weems,

I am a Certified Occupational Therapist Assistant who currently works in private outpatient physical and occupational therapy clinics. I have 15 years of experience where I have worked in hospitals and private outpatient therapy clinics. I graduated with my Associates degree in 1992 from Grand Rapids Community College and continued my education at Grand Valley State University.

I am writing to you regarding the July 12 proposed 2008 physician fee schedule rule, particularly the issue of physician-owned therapy services and "in-office ancillary services" exception. Physicians who own a therapy practice are going to be making profits from that practice leaving the potential for abuse and fraud. I have seen this through my years of practicing Occupational Therapy. The biggest problem I have encountered time and time again is physicians who told their patients that they needed to go to therapy at their clinics. I even had a patient who asked to come to our practice because it was 5 minutes from their home and was told that we did not offer Occupational Therapy services. Luckily the patient followed up with our clinic and found this not to be true; that we did offer Occupational therapy, with very qualified therapists. If he would not have investigated further and listened to his physician, he would have been driving over 30 miles one way to therapy. I know for a fact that we sent our marketing materials to that practice and met with the physicians. They should have been aware of the services we provided. I often wonder how many patients that live in the rural areas, where our 5 clinics are located, don't know they have a choice and drive several miles to/from therapy with high gas prices, bad weather and highway construction. On a personal note, I would not want my 75 year old mother to have to travel miles for therapy when she could go to highly qualified therapists close to home.

I have had patients tell me that their physician's told them they would receive better care and the physician would be there to monitor their care. Our outpatient clinic is very proactive regarding continuing education. We meet monthly for a study group, we are sent to conferences and they host courses. There also is a monthly meeting with an orthopedic surgeon to go over different topics. We are encouraged to continue our education. We also keep the physicians up to date with their patient's progress through meetings, telephone conversations and monthly progress notes.

Over utilization of therapy services is a very high possibility in a physician-owned practice. The only way to prevent this from happening is to eliminate the therapy as a designated health service under the in-office ancillary services exception.

Thank you for considering my comments with regards to physician-owned therapy clinics. I appreciate your time and effort to correct this situation and prevent further abuse.

Respectfully,

A concerned COTA

CMS-1385-P-13107 **Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies; Revisions to Payment Policies for Ambulance Services for CY 2008;**

Submitter : **Date & Time:** **08/30/2007**

Organization :

Category : **Drug Industry**

Issue Areas/Comments

ASP Issues

ASP Issues

In the proposed rule, CMS asserts that it is appropriate to implement a specified method for treating bundled price concession in the calculation of average sales price (ASP). Specifically, CMS is proposing that the manufacturer must allocate the total value of all price concessions proportionally according to the dollar value of the units of each drug sold under a bundled arrangement.

ION urges CMS to ensure that the methodology adopted by CMS to calculate bundled price concessions allows for an accurate representation of the price paid by physicians . We recognize CMS□ desire to implement a consistent methodology across manufacturers□ ASP calculations. However, it is also important that CMS not adopt any one specific methodology that may be inflexible and prevent beneficial arrangements. If CMS decides to adopt a specific methodology that manufacturers must use for the treatment of bundled price concessions, CMS should ensure that the methodology will accurately reflect the prices paid by physicians, and most importantly, ensure beneficiary access to innovative drugs.

CAP Issues

CAP Issues

The proposed rule details changes to the Competitive Acquisition Program (CAP) that will enhance the attractiveness of the program to physicians as well as vendors. ION is encouraged to see CMS re-examining ways to enhance the CAP program. As a member of the Specialty Biotech Distributors Association (SBDA), ION echoes the position set forth by the SBDA in its recently submitted comments regarding the 2008 Fee Schedule, pertaining specifically to changes targeted toward physicians relating to proposed new exigent circumstances under which physicians may terminate CAP participation, as well as new rules that would permit physicians to transport drugs among office locations.

Specifically, CMS is proposing to establish an additional exigent circumstance to permit physicians to opt out of CAP outside of the annual election process. Under this proposal, CMS would establish a process through which physicians could request to end their CAP physician election agreement if they are able to prove that continuing their participation would place a significant burden on them. ION believes such a change will encourage greater physician participation in CAP because physicians will have additional options to terminate their participation if it becomes burdensome.
CMS is also contemplating a positive modification to the current rules governing transport of CAP drugs. Currently, a significant drawback in terms of physician participation in CAP is the restriction on a physician□s ability to transport CAP drugs to office locations beyond the site of delivery. In the proposed rule, CMS indicates that it is considering narrowing this restriction where permitted under State law and other applicable

laws and regulations. ION supports easing the parameters of the transportation restriction, while also being mindful of the importance of ensuring that the integrity of the product is not compromised.

ION encourages CMS to make the aforementioned changes as well as other proposed changes detailed in the rule that will increase the likely success of CAP. However, we suggest that the agency refrain from making these changes during the performance of the current CAP contract. Bidders and other parties relied on the language in the enabling statute and implementing rules in assessing the viability to participate in CAP under its current structure. ION believes it would be inequitable for CMS to adopt substantial revisions to the program midstream that would harm those who relied on the original language and governing rules. Therefore, CMS should only implement the proposed changes if other interested entities are provided an opportunity to participate in CAP under the same rules.

Drug Compendia

Drug Compendia

CMS is proposing to implement a new process to add new compendia to the statutorily recognized list or remove current compendia from the list. Under the new process, CMS would annually post a notice on the CMS Web site offering an opportunity to request changes in the list of recognized compendia. The request would need to demonstrate how the specific compendium complies or does not comply with the desirable characteristics identified by the Medicare Evidence Development and Coverage Advisory Committee (MedCAC).

ION commends CMS for proposing an open process for determining changes to the compendia list. This process will present stakeholders an opportunity to provide important feedback on particular compendia, which CMS can then incorporate into assessing any potential changes to the compendia list. ION also encourages CMS to swiftly clarify and identify acceptable compendia, including a determination by CMS whether DrugPoints is a □successor□ publication or a □substitute□ publication to USP-DI.

Impact

Impact

CMS projects a negative update of -9.9 percent for 2008 due to the application of the Sustainable Growth Rate (SGR) formula. Oncologists, along with all physicians, continue to face unprecedented financial and administrative pressure. This negative update is compounded by additional payment reductions confronting oncologists, such as payment reductions for certain imaging services. ION urges CMS to pursue all policy changes that would provide relief from the flawed physician payment update formula. One such step that CMS could adopt is to apply the $1.35 billion Physician Assistance and Quality Initiatives Fund to the CY 2008 conversion factor update. The fund will help lower the cost of Congressional action needed to reduce the projected 9.9 percent cut.

TRHCA-Section 110: Anemia
Quality Indicators

TRHCA-Section 110: Anemia Quality Indicators

The Tax Relief and Health Care Act of 2006 (TRHCA) requires that, effective January 1, 2008, physicians requesting payment for anti-anemia drugs furnished to treat anemia resulting from the treatment of cancer must report the beneficiary□s hemoglobin or hematocrit level. As CMS examines implementation of this requirement, ION urges the agency to minimize any additional burdens this new reporting requirement will impose on physician practices. Physicians face unprecedented regulatory requirements and burdens as a result of substantial Medicare changes in recent years. CMS should ensure that the process for reporting hemoglobin or hematocrit levels is integrated as much as possible into the standard

claims submission process that physicians follow when treating patients. We urge CMS to consider delaying this requirement until the administrative burden is understood and can be better addressed in the future as we progress toward electronic health records.

CMS-1385-P-13107-Attach-1.DOC

CMS-1385-P-13107-Attach-1.DOC

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CMS-1385-P-13107-Attach-1.DOC

CMS-1385-P-13107-Attach-1.DOC

#13107.

ION
AmerisourceBergen Specialty Group

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August 27, 2007

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B payment Policies for CY 2008

Dear Acting Deputy Administrator Kuhn:

International Oncology Network (ION), a registered name of International Physician Networks, LLC, is pleased to submit the following comments regarding "Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B payment Policies for CY 2008" published in the July 12, 2007 *Federal Register.* ION recognizes the difficult task CMS faces in addressing a myriad of payment policies in the proposed rule and we commend the agency for its effort. However, ION does have a few specific concerns regarding proposed policy changes included in the rule that potentially impact its physician members. As detailed below, we urge CMS to consider these concerns before it makes any final determinations.

Overview of International Oncology Network

ION, a wholly owned subsidiary of AmerisourceBergen Corporation, is the leading physician specialty group purchasing organization with membership of over 10,000 community-based medical specialists. ION members range from solo practitioners to some of the country's largest and most renowned private practices -- all committed to improving the quality of patient care in their own communities. ION's physician membership is comprised of medical specialists who perform a significant volume of drug administration services, including oncologists/ hematologists; urologists, rheumatologists; and gastroenterologists.

ION serves as a Group Purchasing Organization (GPO) for its members in an effort to ensure that they receive the pharmaceutical products necessary for high-quality patient care at the lowest possible costs. It believes that these group purchasing arrangements

are critical in ensuring that medical specialists operate their practices at optimum efficiency, and that patients continue to have access to the highest quality of care in community settings. In addition to negotiating and administering group purchasing arrangements, ION provides a variety of related practice management and clinical educational services to its members in an effort to enhance the efficiency of their practices and the quality of care received by their patients. These services include facilitating participation in clinical trials, developing timely clinical and scientific education programs, and providing information related to various practice management support services. By bringing clinical research, educational symposia, information systems, and other innovative services to the local oncology community, ION provides tools to physicians that can help maintain a level of expertise so needed in the rapidly changing medical environment.

ION provides a variety of services on behalf of its vendors in return for administrative fees that are paid pursuant to the applicable safe harbor regulations governing health care group purchasing arrangements. Although the exact nature of the work ION performs varies for each vendor, generally, ION provides the following services to pharmaceutical companies in exchange for its GPO administrative fees:

- Negotiating and administering the purchasing agreement on behalf of its physician members;
- Informing its members of the vendors' services and programs related to particular products;
- Distributing educational material to its members on behalf of the vendors;
- Assisting the vendors with data collection efforts related to its members' utilization of products and services;
- Providing vendors with logistical and administrative support related to conducting Advisory Boards, and providing other assistance related to gathering feedback from its members related to vendors' products and services; and
- Publishing both clinical and marketing materials in ION publications on a regular basis.

ION, and other physician-based GPOs, serve a valuable and beneficial role in ensuring quality healthcare by providing significant assistance and services to community-based practitioners, and the vendors who provide them necessary products and services.

Bundled Price Concessions/ASP Issues

In the proposed rule, CMS asserts that it is appropriate to implement a specified method for treating bundled price concession in the calculation of average sales price (ASP). Specifically, CMS is proposing that the manufacturer must allocate the total value of all price concessions proportionally according to the dollar value of the units of each drug sold under a bundled arrangement.

ION urges CMS to ensure that the methodology adopted by CMS to calculate bundled price concessions allows for an accurate representation of the price paid by physicians . We recognize CMS' desire to implement a consistent methodology across manufacturers' ASP calculations. However, it is also important that CMS not adopt any one specific methodology that may be inflexible and prevent beneficial arrangements. If CMS decides to adopt a specific methodology that manufacturers must use for the treatment of bundled price concessions, CMS should ensure that the methodology will accurately reflect the prices paid by physicians, and most importantly, ensure beneficiary access to innovative drugs.

TRHCA—Section 110: Anemia Quality Indicators

The Tax Relief and Health Care Act of 2006 (TRHCA) requires that, effective January 1, 2008, physicians requesting payment for anti-anemia drugs furnished to treat anemia resulting from the treatment of cancer must report the beneficiary's hemoglobin or hematocrit level. As CMS examines implementation of this requirement, ION urges the agency to minimize any additional burdens this new reporting requirement will impose on physician practices. Physicians face unprecedented regulatory requirements and burdens as a result of substantial Medicare changes in recent years. CMS should ensure that the process for reporting hemoglobin or hematocrit levels is integrated as much as possible into the standard claims submission process that physicians follow when treating patients. We urge CMS to consider delaying this requirement until the administrative burden is understood and can be better addressed in the future as we progress toward electronic health records.

Drug Compendia

CMS is proposing to implement a new process to add new compendia to the statutorily recognized list or remove current compendia from the list. Under the new process, CMS would annually post a notice on the CMS Web site offering an opportunity to request changes in the list of recognized compendia. The request would need to demonstrate how the specific compendium complies or does not comply with the desirable characteristics identified by the Medicare Evidence Development and Coverage Advisory Committee (MedCAC).

ION commends CMS for proposing an open process for determining changes to the compendia list. This process will present stakeholders an opportunity to provide important feedback on particular compendia, which CMS can then incorporate into assessing any potential changes to the compendia list. ION also encourages CMS to swiftly clarify and identify acceptable compendia, including a determination by CMS whether DrugPoints is a "successor" publication or a "substitute" publication to USP-DI.

CAP Issues

The proposed rule details changes to the Competitive Acquisition Program (CAP) that will enhance the attractiveness of the program to physicians as well as vendors. ION is

encouraged to see CMS re-examining ways to enhance the CAP program. As a member of the Specialty Biotech Distributors Association (SBDA), ION echoes the position set forth by the SBDA in its recently submitted comments regarding the 2008 Fee Schedule, pertaining specifically to changes targeted toward physicians relating to proposed new exigent circumstances under which physicians may terminate CAP participation, as well as new rules that would permit physicians to transport drugs among office locations.

Specifically, CMS is proposing to establish an additional exigent circumstance to permit physicians to opt out of CAP outside of the annual election process. Under this proposal, CMS would establish a process through which physicians could request to end their CAP physician election agreement if they are able to prove that continuing their participation would place a significant burden on them. ION believes such a change will encourage greater physician participation in CAP because physicians will have additional options to terminate their participation if it becomes burdensome.

CMS is also contemplating a positive modification to the current rules governing transport of CAP drugs. Currently, a significant drawback in terms of physician participation in CAP is the restriction on a physician's ability to transport CAP drugs to office locations beyond the site of delivery. In the proposed rule, CMS indicates that it is considering narrowing this restriction where permitted under State law and other applicable laws and regulations. ION supports easing the parameters of the transportation restriction, while also being mindful of the importance of ensuring that the integrity of the product is not compromised.

ION encourages CMS to make the aforementioned changes as well as other proposed changes detailed in the rule that will increase the likely success of CAP. However, we suggest that the agency refrain from making these changes during the performance of the current CAP contract. Bidders and other parties relied on the language in the enabling statute and implementing rules in assessing the viability to participate in CAP under its current structure. ION believes it would be inequitable for CMS to adopt substantial revisions to the program midstream that would harm those who relied on the original language and governing rules. Therefore, CMS should only implement the proposed changes if other interested entities are provided an opportunity to participate in CAP under the same rules.

Physician Fee Schedule Update

CMS projects a negative update of -9.9 percent for 2008 due to the application of the Sustainable Growth Rate (SGR) formula. Oncologists, along with all physicians, continue to face unprecedented financial and administrative pressure. This negative update is compounded by additional payment reductions confronting oncologists, such as payment reductions for certain imaging services. ION urges CMS to pursue all policy changes that would provide relief from the flawed physician payment update formula. One such step that CMS could adopt is to apply the $1.35 billion Physician Assistance

and Quality Initiatives Fund to the CY 2008 conversion factor update. The fund will help lower the cost of Congressional action needed to reduce the projected 9.9 percent cut.

Conclusion

ION appreciates the opportunity to comment on these important issues. We hope that CMS addresses our concerns and incorporates changes as warranted. ION looks forward to working with CMS on these and other critical issues to ensure that oncologists throughout the country can provide the most effective and efficient care to their patients. If you should have any questions regarding these comments, please contact Aaron Krupp, JD at (202) 775-1329.

Sincerely,

Mike Martin
President, ION

Submitter : Suzanne Goodrich **Date:** 08/30/2007

Organization : City of Orange Fire Department

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13108-Attach-1.PDF

#13108

CITY OF ORANGE

FIRE DEPARTMENT PHONE: (714) 288-2500 • FAX: (714) 744-6035 www.cityoforange.org

August 30, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions.

Dear Ms. Norwalk:

The City of Orange Fire Department provides emergency ambulance services to the community in which we serve. The proposed rule would have a direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. We therefore greatly appreciate this opportunity to submit comments on the proposed rule.

BENEFICIARY SIGNATURE

The City of Orange Fire Department commends CMS for recognizing that providers and suppliers of emergency ambulance transportation face significant hardships in seeking to comply with the beneficiary signature requirements. Ambulance services are atypical among Medicare covered services to the extent that, for a large percentage of encounters, the beneficiary is not in a condition to sign a claims authorization during the entire time the supplier is treating and/or transporting the beneficiary. Many beneficiaries are in physical distress, unconscious, or of diminished mental capacity due to age or illness. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

We believe strongly, however, that the relief being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and on the hospitals. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for ambulance services.

Current Requirement

When the beneficiary is physically or mentally incapable of signing, the industry has been following the requirements listed in the CMS Internet Only Manual, Pub. 100-02, Chapter 10, Section 20.1.2 and Pub. 100-04, Chapter 1, Section 50.1.6(A)(3)(c). These sections require the ambulance provider or supplier to document that the beneficiary was unable to sign, the reason and that no one could sign for the beneficiary.

Summary of New Exception Contained in Proposed Rule

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. If "provider" in this context was intended to mean a facility or entity that bills a Part A Intermediary, the language should be changed to also include "ambulance supplier". The proposed exception essentially mirrors the existing requirements that the beneficiary be unable to sign and that no authorized person was available or willing to sign on their behalf, while adding additional documentation requirements. Therefore, we believe that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed sub-division (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, we do not object to the requirements that an ambulance provider obtain (1) a contemporaneous statement by the ambulance employee or (2) documentation of the date, time and destination of the transport. Nor do we object to the requirement that these items be maintained for 4 years from the date of service. However, we do not see any reason to include these in the Regulation, as they are already required and standard practice.

The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. Our organization **strongly objects** to this new requirement as:

- Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.
- Hospital personnel will often refuse to sign <u>any</u> forms when receiving a patient.
- If the hospital refuses to sign the form, it will be the beneficiary that will be responsible for the claim.
- The ambulance provider or supplier would in every situation now have the additional burden in trying to communicate to the beneficiary or their family, at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.
- Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ER Admitting Record, etc.

b. Authorization to Release Records – The second purpose of the beneficiary signature is to authorize the release of medical records to CMS and its contractors. However, the regulations implementing the HIPAA Privacy Rule, specifically 45 C.F.R. §164.506(c)(3), permit a covered entity (e.g. an ambulance provider or supplier) to use or disclose a patient's protected health information for the covered entity's payment purposes, without a patient's consent (i.e. his or her signature). Therefore, federal law already permits the disclosure of medical records to CMS or its contractors, regardless of whether or not the beneficiary's signature has been obtained.

Signature Already on File

In the case of emergency ambulance transports, the ultimate destination will always be a hospital. These facilities typically obtain the beneficiary's signature at the time of admission, authorizing the release of medical records for their services *or any related services*. The term "related services", when used by hospitals and SNFs, can mean more than only entities owned by or part of the facility. We believe that ambulance transport to a facility, for the purpose of receiving treatment or care at that facility, constitutes a "related service", since the ambulance transports the patient to or from that facility for treatment or admission. Therefore, we believe a valid signature will be on file with the facility. Additionally, for those transports provided to patients eligible for both Medicare and Medicaid, a valid signature is on file at the State Medicaid Office as a product of the beneficiary enrollment process.

Electronic Claims

It is also important to note that, as a result of section 3 of the Administrative Simplification Compliance Act and the implementing regulations at 42 C.F.R. §424.32, with very limited exceptions (e.g. providers or suppliers with less than 10 claims per month), ambulance suppliers must submit claims electronically. Thus, the beneficiary does not even sign a claim form. When submitting claims electronically, the choices for beneficiary signature are "Y" or "N". An "N" response could result in a denial, from some Carriers. That would require appeals to show that, while the signature has not been obtained, an alternative is accepted. As a result, many Carriers allow a "Y", even though the signature was not actually obtained, if one of the exceptions is met.

While this may be a claims processing issue, since you are now looking at the regulation, this would be a good time to add language indicating that the signature requirement will be deemed to be met if one of the exceptions to the requirement exists.

Program Integrity

It is important for CMS to realize that, for every transport of a Medicare beneficiary, the ambulance crew completes a trip report listing the condition of the patient, treatment, origin/destination, etc. AND the origin and destination facilities complete their own records documenting the patient was sent or arrived via ambulance, with the date. Thus, the issue of the beneficiary signature should not be a program integrity issue.

Conclusion

Based on the above comments, it is respectfully requested that CMS:

- Amend 42 C.F.R. §424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that "good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported".
- Amend 42 C.F.R. §424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
- Amend 42 C.F.R. §424.36(b) (5) to add "or ambulance provider or supplier" after "provider".

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

AMBULANCE SERVICES – AMBULANCE INFLATION FACTOR

The City of Orange Fire Department has no objection to revising 42 C.F.R §414.620 to eliminate the requirement that annual updates to the Ambulance Inflation Factor be published in the Federal Register, and to thereafter provide for the release of the Ambulance Inflation Factor via CMS instruction and the CMS website.

Thank you for your consideration of these comments.

Sincerely,

Suzanne Goodrich

Suzanne Goodrich, RN, MSN
EMS Manager
City of Orange Fire Department

Submitter : Mr. Robert Chapple **Date:** 08/30/2007

Organization : Carolina Pain Specialists, LLC

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13112-Attach-1.DOC

#13112

CPS

Iva T. Chapple, M. D.

Carolina Pain Specialists, LLC

August 30, 2007

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, "Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008" (the "Proposed Rule") published in the *Federal Register* on July 12, 2007. As requested, I have limited my comments to the issue identifiers in the Proposed Rule.

There are approximately 7,000 physicians practicing interventional pain management in the United States. I am included in this statistic. As you may know, physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that, effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the "all physicians" crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians' ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries' access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list

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Re: CMS-1385-P

interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as "interventional pain physicians" for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. **CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.**

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to "all physicians" for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. Interventional pain is an inter-disciplinary practice that draws on various medical specialties of anesthesiology, neurology, medicine & rehabilitation, and psychiatry to diagnose and manage acute and chronic pain. Many interventional pain physicians received their medical training as anesthesiologists and, accordingly, clinically view themselves as anesthesiologists. While this may be appropriate from a clinically training perspective, their Medicare designation does not accurately reflect their actual physician practice and associated costs and expenses of providing interventional pain services.

This disconnect between the Medicare specialty and their practice expenses is made worse by the fact that anesthesiologists have the lowest practice expense of any specialty. Most anesthesiologists are hospital based and do not generally maintain an office for the purposes of rendering patient care. Interventional pain physicians are office based physicians who not only furnish evaluation and management (E/M) services but also perform a wide variety of interventional procedures such as nerve blocks, epidurals, intradiscal therapies, implant stimulators and infusion pumps, and therefore have practice expenses that are similar to other physicians who perform both E/M services and surgical procedures in their offices.

Re: CMS-1385-P

Furthermore, the utilization rates for interventional pain and pain management specialties are so low that they are excluded from Medicare rate-setting or have very minimal affect compared to the high utilization rates of anesthesiologists. CMS utilization files for calendar year 2007 overwhelming report anesthesiologists compared to interventional pain physicians and pain management physicians as being the primary specialty performing interventional pain procedures. The following table illustrates that anesthesiologists are reported as the primary specialty providing interventional pain services compared to interventional pain physicians

CPT Code	**Anesthesiologists - 05 (Non-Facility)**	**Interventional Pain Management Physicians - 09 (Non-Facility)**
64483 (Inj foramen epidural l/s)	59%	18%
64520 (N block, lumbar/thoracic)	68%	15%
64479 (Inj foramen epidural c/t)	58%	21%
62311 (Inject spine l/s (cd))	78%	8%

The high utilization rates of anesthesiologists (and their extremely low practice expenses) drive the payment rate for the interventional pain procedures, which does not accurately reflect the resource utilization associated with these services. This results in payment rates that are contrary to the intent of the Medicare system—physician payment reflects resources used in furnishing items and services to Medicare beneficiaries.

I urge CMS to make a modification to its practice expense methodology as it pertains to interventional pain services such that its methodology treats physicians who list anesthesiology as their primary specialty and list interventional pain as their secondary specialty designation as interventional pain physicians for rate-setting. This pool of physicians should be cross-walked to "all physicians" for practice expenses. This will result in a payment for interventional pain services that is more aligned with the resources and costs expended to provide these services to a complex patient population.

I urge CMS not to delay implementing our proposed recommendation to see if the updated practice expenses information from the Physician Practice Information Survey ("Physician Practice Survey") will alleviate the payment disparity. While I believe the Physician Practice Survey is critical to ensuring that physician services are appropriately paid, I do not believe that updated practice expense data will completely resolve the current underpayment for interventional pain services. The accurate practice expense information for interventional pain physicians will continue to be diluted by the high utilization rates and associated low practice expenses of anesthesiologists.

Re: CMS-1385-P

II. CMS Should Develop a National Policy on Compounded Medications Used in Spinal Drug Delivery Systems

We urge CMS to take immediate steps to develop a national policy as we fear that many physicians who are facing financial hardship will stop accepting new Medicare beneficiaries who need complex, compounded medications to alleviate their acute and chronic pain. Compounded drugs used by interventional pain physicians are substantially different from compounded inhalation drugs. Interventional pain physicians frequently use compounded medications to manage acute and chronic pain when a prescription for a customized compounded medication is required for a particular patient or when the prescription requires a medication in a form that is not commercially available. Physicians who use compounded medications order the medication from a compounding pharmacy. These medications typically require one or more drugs to be mixed or reconstituted by a compounding pharmacist outside of the physician office in concentrations that are not commercially available (*e.g.*, concentrations that are higher than what is commercially available or multi-drug therapy that is not commercially available).

The compounding pharmacy bills the physician a charge for the compounded fee and the physician is responsible for paying the pharmacy. The pharmacy charge includes the acquisition cost for the drug ingredients, compounding fees, and shipping and handling costs for delivery to the physician office. A significant cost to the physician is the compounding fees, not the cost of drug ingredient. The pharmacy compounding fees cover re-packaging costs, overhead costs associated with compliance with stringent statutes and regulations, and wages and salaries for specially trained and licensed compounding pharmacists bourn by the compounding pharmacies. The physician administers the compounded medication to the patient during an office visit and seeks payment for the compounded medication from his/her carrier. In many instances, the payment does not even cover the total out of pocket expenses incurred by the physician (*e.g.*, the pharmacy fee charged to the physician).

There is no uniform national payment policy for compounded drugs. Rather, carriers have discretion on how to pay for compounded drugs. This has lead to a variety of payment methodologies and inconsistent payment for the same combination of medications administered in different states. A physician located in Texas who provides a compounded medication consisting of 20 mg of Morphine, 6 of mg Bupivicaine and 4 of mg Baclofen may receive a payment of $200 while a physician located in Washington may be paid a fraction of that amount for the exact same compounded medication. In many instances, the payment to the physician fails to adequately cover the cost of the drug, such as the pharmacy compounded fees and shipping and handling. Furthermore, the claim submission and coding requirements vary significantly across the country and many physician experience long delays in payment.

We urge CMS to adopt a national compounded drug policy for drugs used in spinal delivery systems by interventional pain physicians. Medicare has the authority to develop a separate

payment methodology for compounded drugs. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA") mandated CMS to pay providers 106% of the manufacturer's Average Sales Price ("ASP") for those drugs that are separately payable under Part B. The language makes clear that this pricing methodology applies only to the sale prices of manufacturers. Pharmacies that compound drugs are not manufacturers, and Congress never contemplated the application of ASP to specific drug compounds created by pharmacies. Accordingly, CMS has the discretion to develop a national payment policy.

We believe that an appropriate national payment policy must take into account all the pharmacy costs for which the physicians are charged: the cost of the drug ingredient, the compounding fee costs, and the shipping and handling costs. We stand ready to meet with CMS and its staff to discuss implementing a national payment policy.

III. CMS Should Incorporate the Updated Practice Expenses Data from Physician Practice Survey in Future Rule-Making

I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

IV CMS Should Work Collaboratively with Congress to Fix the SGR Formula so that Patient Access will be preserved.

The sustainable growth rate ("SGR") formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

Because of the flawed formula, physicians and other practitioners disproportionately bear the cost of providing health care to Medicare beneficiaries. Accordingly, many physicians face clear financial hardship and will have to make painful choices as to whether they should continue to practice medicine and/or care for Medicare beneficiaries.

CMS should work collaboratively with Congress to create a formula that bases updates on the true cost of providing healthcare services to Medicare beneficiaries.

Re: CMS-1385-P

Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

Iva T. Chapple, MD
421 Hulon Lane
West Columbia, SC 29169

Submitter : Steven Hartzell **Date:** 08/30/2007

Organization : Physical Therapy Board of California

Category : State Government

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

See Attachment

CMS-1385-P-13113-Attach-1.DOC

#13113

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

Physical Therapy Board of California
1418 Howe Avenue, Suite 16, Sacramento, California 95825
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August 27, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box8018
Baltimore, MD 21244-1850

Submitted by email

Re: CMS-1385-P

Therapy Standards and Requirements

Dear Sir or Madam:

The Physical Therapy Board of California (PTBC) submits the following comments, and recommended changes, on the proposed rules changing the definition of "physical therapist" and "physical therapist assistant" in Section 484, Title 42 of the Code of Federal Regulations. The proposed rules are part of the 2008 Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 2008, found in Volume 72 of the Federal Register, published on July 12, 2007.

The PTBC is opposed to the continuation of existing, or establishment of any new regulatory requirements relative to reimbursement of care provided to Medicare patients except for licensure, or other standards, established by a state in which they are practicing. California, as well as the licensing authorities throughout the US, have established licensure standards for physical therapy professionals based on the level of competency required to protect the public.

The existing and proposed regulations usurp the states' function of licensing physical therapists and other professionals. CMS respects states' rights and state licensure for other health care professions, and it should do so with physical therapy professionals. For example, CMS' regulations define a physician as a "doctor of medicine ... legally authorized to practice medicine and surgery by the State in which such function or action is performed." 42 C.F.R. § 484.4 (2006). Likewise, a registered nurse is defined as "[a] graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing."42 C.F.R. § 484.4. Establishing requirements that are different than what the states require for licensing physical therapist and physical therapist assistants would be inconsistent with not only the rights of the states, but also CMS' own standards. Transforming the state licensure function into a federal function is inappropriate. There is no justification for this action, and CMS should prevent it by modifying the current rule to recognize licensure by a state.

In the preamble to the proposed regulations, CMS states it is seeking uniformity. The fact of the matter is that uniformity and consistency of physical therapy professionals has been established by the states.

The states, largely through the efforts of the Federation of State Boards of Physical Therapy (FSBPT), whose membership consists of all the state licensing authorities, have worked diligently over the last 20 years to develop licensing standards that are consistent and, in most cases, provide for portability of a license among states. No federal regulation of standards is required.

The establishment of the American Physical Therapy Association (APTA), as the approving authority for education, equivalency determination, and examination, instead of the states, is problematic for numerous reasons. The first of which is CMS should not empower an advocacy group, like the APTA, to establish the qualifications for professionals to provide healthcare services to patients. The APTA's mission is to advocate and promote the profession they represent. As a regulatory body, our mission is to protect the public. The FSBPT, the organization to which we look for the establishment of consistent standards for licensure across the US, was created to eliminate, protect against and prevent the inherent conflict of interest that the APTA previously had over the examination and credentialing processes. The APTA itself, recognized this conflict of interest problem when the examinations in use at that time were sold to the FSBPT many years ago. CMS must not allow this conflict of interest to revert to what existed twenty years ago by becoming rule.

An additional, and equally troubling issue is we are not aware of any standards developed by APTA for the evaluation of those educated outside of the US, or the development and administration of examinations to determine competency in physical therapy. If they do not exist, the standards have not been developed with any input from the regulators or consumers in California. This is opposit to the efforts by the states, which are controlled by open meeting laws, individually and collectively through the FSBPT to develop tools for the evaluation of education received outside of the US, and establishment of psychometrically sound examinations.

The proposed regulations ignore almost twenty years that the FSBPT has spent enhancing the examinations that were purchased from the APTA. This work has included seeking accreditation of the examination processes utilized by the FSBPT. It is unlikely that the State of California could justify abandoning the work that has been done to ensure a fair evaluation of education, or changing to an examination that did not have a proven record, and was not developed by the active participation of the state regulatory authorities who are responsible for consumer protection.

The proposed regulations could be especially disruptive to the ongoing care of Medicare and Medicaid beneficiaries who would be impacted if different evaluation and examination standards, other than those already established by the states for licensure, were recognized for Medicare reimbursement. The confusion would likely be replaced by an interruption of medically necessary care since many physical therapists may not be able to meet additional standards if APTA did not recognize the standards that currently exist, and have been protecting consumers.

An example of possible disruption of service is the republication and interpretation of the existing definition of physical therapist assistant that occurred first for outpatient services, and then for inpatient care. The republications resulted in many physical therapist assistants being reassigned and then losing their employment. The disruption was not just to providers, but also to patients, especially in rural areas

of California. From our understanding the republication was largely deemed necessary based on misinformation regarding the standard used by the State of California for licensure of a physical therapist assistant based on education and training which has been determined to be equivalent to the education received by attending an approved educational program. All of which was caused based on information received by CMS from organizations and/or individuals whose primary mission is something besides consumer protection.

Reviewing the wrong information that CMS acted on, and the actual requirements, demonstrates the states have established standards that ensure licensees are qualified to perform patient care no matter who is paying for the care. CMS advised the PTBC that the basis for republication was that individuals who had certifications, such as athletic training, could achieve licensure by merely submitting an application based on experience working as an unlicensed physical therapy aide. The PTBC was not contacted by CMS prior to the republication to determine the accuracy of the information received. Had CMS done so, they would have known that the standards are in statute and regulation. Specifically an applicant must complete 45 units of education from an accredited college, 30 of which must be specific to physical therapy, and a minimum of 36 months full time experience as a physical therapy aide performing patient related tasks under the supervision of a physical therapist. In order to ensure that applicants have experience with individuals with acute medical conditions, 18 months of the experience must be in an acute care inpatient facility. This compares to a total of 60 units, which includes clinical experience, required to complete an accredited physical therapist assistant educational program. Additional pathways recognized by the state are education provided by the United Sates Military, that is considered by them sufficient to care for our soldiers, or graduation from a physical therapist educational program located outside of the US. In addition to the education and experience requirements, all applicants must pass the same national written examination in order to demonstrate competency.

The PTBC requests that the language in the proposal that is indicated by strikethrough and red (~~stikethrough and red~~) be deleted:

§484.4 Personnel Qualifications
Physical therapist. A person who is licensed by the State in which practicing ~~and meets one of the following requirements:~~
~~CMS-1385-P 581~~
~~(1) Requirements for individuals beginning their practice on or after January 1, 2008. Meets all practice requirements set forth by the State in which the physical therapy services are furnished and meets one of the following educational/training requirements on or after January 1, 2008:~~
~~(i) (A) Graduated after successful completion of a college or university physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy~~

~~Education (CAPTE); and~~
~~(B) Passed the National Examination approved by the American Physical Therapy Association.~~
~~(ii) If educated outside the United States or trained by the United States military--~~
~~(A) Graduated after successful completion of an education program that, by a credentials evaluation process approved by the American Physical Therapy Association, is determined to be comparable with respect to physical therapist entry level education in the United States; and~~
~~(B) Passed the National Examination approved by the American Physical Therapy Association.~~
~~(2) Requirements for individuals beginning their practice after December 31, 1977 and before January 1, 2008. Has graduated from a physical therapy~~
~~CMS-1385-P-582~~
~~curriculum approved by one of the following after December 31, 1977 and before January 1, 2008:~~
~~(i) The American Physical Therapy Association.~~
~~(ii) The Committee on Allied Health Education and Accreditation of the American Medical Association.~~
~~(iii) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association.~~
~~(3) Requirements for individuals beginning their practice on or after January 1, 1966 and on or before December 31, 1977. Had 2 years of appropriate experience as a physical therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service on or before December 31, 1977.~~
~~(4) Requirements for individuals beginning their practice before January 1, 1966. Meets one of the following requirements before January 1, 1966:~~
~~(i) Was admitted to membership by the American Physical Therapy Association.~~
~~(ii) Was admitted to registration by the American Registry of Physical Therapist.~~
~~CMS-1385-P-583~~
~~(iii) Graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education.~~
~~(iv) Was licensed or registered prior to~~

~~January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy.~~
~~(5) Requirements for individuals trained outside of the United States before January 1, 2008. If trained outside the United States before January 1, 2008 meets the following requirements:~~
~~(i) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.~~
~~(ii) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.~~
Physical therapist assistant. A person who ~~meets one of the following requirements:~~
~~(1) Requirements for individuals beginning their practice on or after January 1, 2008. A person who~~
~~CMS-1385-P 584~~
provides certain physical therapy services under the supervision of a qualified physical therapist and is licensed, registered, certified or otherwise recognized as a physical therapist assistant, if applicable, by the State in which practicing, ~~continues to meet all practice requirements set forth by the State in which physical therapy services are furnished, and meets one of the following educational/training requirements:~~
~~(i) Graduated after successful completion of a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association.~~
~~(ii) If educated outside the United States or trained in the United States military, graduated after successful completion of an education program that by a credentials evaluation process approved by the American Physical Therapy Association, is determined to be comparable with respect to physical therapist assistant entry level education in the United States.~~
~~(2) Requirements for individuals beginning their practice before January 1, 2008. Is licensed as a physical therapist assistant, if applicable, by the State in which~~

~~practicing, meets either of the following requirements:~~
~~CMS-1385-P 585~~
~~(i) Has graduated from a 2-year college-level program approved by the American Physical Therapy Association.~~
~~(ii) Has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapist assistant after December 31, 1977.~~

We appreciate the opportunity to comment on the proposed rules regarding physical therapist and physical therapist assistant qualification requirements.

Respectfully yours,

Steven K. Hartzell
Executive Officer

Submitter : **Mr. Michael Weinper** **Date: 08/30/2007**

Organization : **PTPN**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

We have commented on various sections. Please see attached.

CMS-1385-P-13114-Attach-1.DOC

#13114

PTPN
Setting The Standards in Rehabilitation

WITH NETWORKS IN:
Arizona • California • Colorado • Florida • Louisiana • Maine
Maryland • Massachusetts • Michigan • Mississippi • Missouri • New Hampshire • New Jersey
New York • Ohio • Oklahoma • Pennsylvania • Rhode Island • Tennessee • Texas • Vermont • West Virginia

August 30, 2007

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
P.O. Box 8018
Baltimore, MD 21244

Re: CMS-1385-P

Dear Mr. Kuhn:

On behalf of PTPN, the oldest and largest nationwide multi-disciplinary network of independent private practices providing physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services, thank you for the opportunity to comment on the proposed rule pertaining toe the Medicare Physician Fee Schedule (PFS) as published in the *Federal Register* / Vol. 72, No. 133 / Thursday, July 12, 2007.

As the nation's first and largest network of rehabilitation therapists in private practice, PTPN has led the rehabilitation industry in pioneering national contracting and quality assurance programs since 1985. The network has more than 1,300 provider offices in 23 states. PTPN contracts with most major managed care organizations including insurers, workers' compensation companies, PPOs, HMOs, medical groups, and IPAs. Only offices that are owned and operated by rehabilitation therapists can be members of the network. PTPN therapists are highly qualified, subjected to stringent credentialing and membership standards, and their performance is continually monitored to maintain efficiency and effectiveness of services provided.

"PHYSICIAN SELF-REFERRAL PROVISIONS"
Medicare rules currently prohibit the markup of the technical component of certain diagnostic tests that are performed by outside suppliers and billed to Medicare by a different individual or entity (§ 414.50). In addition, Medicare program instructions restrict who may bill for the professional component (the interpretation) of diagnostic tests (CMS Pub. 100–04, Chapter 1, 30.2.9.1).

In the CY 2007 PFS proposed rule (71 FR 48982), CMS expressed concern that allowing physician group practices or other suppliers to purchase or otherwise contract for the provision of diagnostic testing services and to then realize a profit when billing Medicare may lead to patient and program abuse in the form of over-utilization of services and result in higher costs to the Medicare program (71 FR 49054).

PTPN agrees that allowing practices to contract for services that they order and realize a profit from same is a formula for over-utilization and program abuse. In fact, PTPN would extrapolate the scenario further and suggest that Medicare should hold the same concern for over-utilization and program abuse when physicians are allowed to profit from ordering physical and occupational therapy services when holding a financial interest in such services. Indeed, numerous studies have provided evidence of increased and over-utilization when a physician refers a patient for therapy to a therapy service in which he or she has a monetary interest.

We agree with the condition Medicare is considering applying to the purchased interpretation rules and suggest that the concern should be broadly applied not only to tests but also to therapeutic services the physician orders. In other words, we recommend that therapy services, in addition to tests, "must be ordered by a physician who is financially independent of the person or entity performing" the therapy.

The agency is soliciting comments as to whether changes are necessary and, if so, what changes should be made to the in-office ancillary services exception. PTPN believes changes are necessary and would recommend that physical therapy and occupational therapy provided on an "incident to" basis should not qualify for the in-office ancillary exception. Physical and occupational therapy services should adhere to the same standards and requirements regardless of the setting in which they are delivered. The Government Accountability Office (GAO) has in two separate studies, detected considerable abuse when PT and OT services were furnished in physicians' offices.

Additionally, the Agency is soliciting comments on whether CMS should prohibit time-based or unit-of-service-based payments to an entity lessor by a physician lessee. For the same general and specific reasons stated above, PTPN believes this practice should be prohibited. PTPN concurs with the opinion expressed by the Medicare Payment Advisory Commission (MedPAC) in reference to a similar provision in the same section of the proposed rule and believes it is applicable here: that "prohibiting these arrangements should help ensure that referrals are based on clinical, rather than financial, considerations. It would also help ensure that competition among health care facilities is based on quality and cost, rather than financial arrangements with entities owned by physicians who refer patients to the facility."

"THERAPY STANDARDS AND REQUIREMENTS"

The Agency proposes to update the personnel qualifications in § 484.4 for PTs, PTAs, OTs, and OTAs. CMS also proposes to revise the qualifications for SLPs to remove a reference to audiologists in the definition for speech-language pathologists because a speech-language pathologist would not have a Certificate of Clinical Competence in audiology, as implied by the regulation, unless that person was dually qualified as an audiologist. Otherwise, the agency is not proposing to update the qualifications for SLPs because CMS believes the qualifications in § 484.4 are currently appropriate and address the issues of continuing education and internationally trained SLPs. CMS is proposing these changes for the following several reasons: (1) the current regulations at § 484.4 contain outdated terminology relating to several of the relevant professional organizations;

(2) the standards that now exist in the fields of physical therapy and occupational therapy have changed since a substantial portion of these qualification requirements were developed; (3) some of the current qualification requirements do not address individuals who have been trained outside of the United States, or refer to outdated requirements; and (4) these revisions would have the benefit of establishing consistent standards across provider/supplier lines.

As we interpret this proposed provision, CMS desires to grandfather in therapists prior to January 1, 2008, and grandfather in anyone who is licensed or certified by their state, but might not meet all the educational requirements due to the state requirements, or lack of state requirements, at the time that they became licensed. If our interpretation is correct we have no objection to this provision. Likewise, we support the agency's proposal to require the same standards for foreign trained therapists as those trained in the United States. PTPN is also supportive of the proposal to apply the same personnel qualifications to all settings.

Personnel Qualifications with Respect to Physical Therapist Assistants
Currently Medicare does not recognize Physical Therapist Assistants (PTAs), in private practice, if the PTA did not attend a formal education program but has become licensed in their state. Some states will license PTAs based on their work experience in PT and having the proper number of college credits. We feel that state licensed PTAs should be recognized by Medicare in the private practice setting as the Medicare program currently recognizes any licensed PTAs in hospitals and home health settings.

Outpatient Therapy Certification Requirements
PTPN applauds CMS for proposing the modification of the physician recertification requirement to 90 days and believe this should be the same requirement for all settings. The signature of a physician or NPP in the medical record indicating approval of the plan of care for outpatient therapy services certifies the initial need for therapy services furnished under Part B. For other covered medical and health services furnished by providers and suppliers of outpatient services, certification is required only once, either at the beginning or at the end of a series of visits. Recertification is not required for most health services. In 1988, the Agency added a 30-day recertification requirement for outpatient therapy services to the regulation at § 424.24. This requires that a physician certifies a plan of care for 30 days, regardless of the appropriate length of treatment. To continue treatment past 30 days, the physician is required to recertify the plan. PTPN supports the Agency's belief that requiring recertification at 30-day intervals may not always provide sufficient flexibility to provide the correct amount of therapy for the patient's needs. In some cases, it may impact utilization by encouraging reevaluations at intervals based on certification timing, rather than on necessity.

Since the Agency's analyses have indicated that the 30-day recertification requirement has not had the anticipated impact on utilization of services and does not serve to limit therapy services payments, the evidence suggests that the interval of the recertification requirement does not affect professional decisions regarding the duration of treatment.

We agree with the Agency's proposal that the physician (or NPP, as appropriate) would continue to review and certify the initial plan of care as soon as possible, but that the certification would apply for an episode length based on the patient's needs, not to exceed 90 days and would be recertified every 90 days thereafter. We, therefore, urge CMS to amend § 424.24 to require recertification every 90 days after beginning treatment; and to revise § 424.24 to remove reference to a certification "statement" and to require that the continuing need for therapy services be documented in the medical record such as in the plan of treatment.

"TRHCA—SECTION 201: THERAPY CAPS"

Section 1833(g)(1) of the Act applies an annual per beneficiary combined cap beginning January 1, 1999, on outpatient physical therapy and speech-language pathology services, and a similar separate cap on outpatient occupational therapy services. These caps apply to expenses incurred for the respective therapy services under Medicare Part B, with the exception of outpatient hospital services. The caps were implemented from January 1, 1999 through December 31, 1999, from September 1, 2003 through December 7, 2003, and beginning January 1, 2006 (with an exception process). In CY 2000 through CY 2002, and from December 8, 2003 through December 31, 2005, the Congress placed moratoria on implementation of the caps. Section 1833(g)(2) of the Act provides that, for CY 1999 through CY 2001, the caps were $1500, and for the calendar years after 2001, the caps are equal to the preceding year's cap increased by the percentage increase in the Medicare Economic Index (MEI) (except that if an increase for a year is not a multiple of $10, it is rounded to the nearest multiple of $10).

Section 5107(a) of the DRA required the Secretary to develop an exceptions process for the therapy caps effective for expenses incurred during CY 2006. Details of the CY 2006 exceptions process were published in a manual change on February 13, 2006 (CR4364 consists of Transmittal 855, Transmittal 47, and Transmittal 140). Section 201 of the MIEA-TRHCA extended the exceptions process to apply for expenses incurred through December 31, 2007. Therapy cap exception policies for 2007 were specified in Change Request 5478 which consists of three transmittals with current numbers of—

- . Transmittal 1145CP, Pub. 100-04;
- . Transmittal 63BP, Pub. 100-02; and
- . Transmittal 181PI, Pub. 100-08.

CMS indicates in the proposed rule that the extension of the exceptions process to the therapy caps will end on December 31, 2007. PTPN acknowledges the statutory limitations on the exceptions process but believes the process has worked well to enable those patients who need therapy to receive such care in a cost-effective manner. Moreover, PTPN is proud to report that all its network clinics and practices will be collecting and reporting clinical outcomes (functional status) data by the end of 2007. Not only will these data be beneficial in documenting the amount of improvement a patient achieves in response to treatment, but will serve valuable purposes in assisting therapists in their clinical decision-making. PTPN urges CMS to move rapidly toward the use of clinical outcomes data in determining the amount of care needed by a specific beneficiary

and is willing to collaborate with the Agency in collecting and analyzing data that could lead to the replacement of the therapy caps altogether or the replacement of the exceptions process with one that is predicated on the supplier's cooperation in collecting and submitting clinical outcomes (functional status) data.

Irrespective of the Agency's inability to extend the therapy cap exceptions process, PTPN recommends that CMS retain and reissue the documentation guidance and requirements contained in Transmittal 63BP, Pub. 100-02 as they are very helpful in clarifying acceptable and required documentation behavior.

"TRHCA—SECTION 101(b): PQRI"

"Nonphysician Measures Currently Under Development"
CMS proposes to include measures in the final 2008 PQRI quality measures selected from those listed in Table 18 that are currently under development by Quality Insights of Pennsylvania (under the Medicare Quality Improvement Organization (QIO) contract for the State of Pennsylvania) and that achieve NQF endorsement or AQA adoption by November 15, 2007. The proposed rule indicates that comments on the implications of including any given measure are welcome.

The Agency proposes to select from among these measures based upon: Development completion in a sufficiently timely manner that implementation for 2008 would be practical; their importance in relation to quality goals; their meaningfulness as measures of quality; their utility in the PQRI program such as through augmenting the scope of services provided by eligible professionals to which PQRI measures apply; the degree to which they meet the needs of the Medicare program and their functionality in terms of ability to be collected and calculated in the PQRI program.

PTPN is familiar with some of the measures that have been developed by Quality Insights of Pennsylvania as some of them, but not all, have been the subject of a call for public comment. Of the four measures listed, PTPN is unaware that "Screening for Cognitive Impairment" has been vetted to the public. Moreover, the other three measures, which are all process measures, are not supported by the literature as having a considerable and predictable impact on the results (outcome) of care.

"Pain Assessment Prior to Initiation of Patient Therapy"
Specifically, "Pain Assessment Prior to Initiation of Patient Therapy" is a therapist level process measure reported on the initial visit. While pain can be an important element influencing a therapeutic intervention, the successful one-time reporting of the measure satisfies the criteria have described by the QIO for the measure's proposed use.

The more significant and revealing use of a pain indicator would be an assessment of the degree, if any, to which the reported pain affects the patient's function. Therefore, it is PTPN's recommendation that, if this process measure is to be used, that it be modified, converted to, or combined with an outcomes measure such as a functional status indicator. Employing such a modified or combined measure would make the collection of these data

more important, meaningful and useful. Moreover, the use of a functional outcomes measure or a clinical data registry that accomplishes same, would accelerate the collection and use of more valuable data that would have profound positive implications for the patient, the provider and the health reimbursement system.

The two articles cited by the QIO as support for this measure [Bloch (2004) and Schunk (2000)] emphasize the importance of pain as an element of **function and outcomes measurement**. These findings and conclusions support our comments above. Starke (2005) is an article that appeared in a magazine which is not a peer-reviewed publication. Likewise, the Barr article (which was retrieved from a website) does not meet criteria for a scientific article that has been published in a refereed journal.

"Patient Co-development of Treatment Plan / Plan of Care"
The second and third measures listed in Table 18 can be combined, for purposes of this discussion, into "Patient Co-development of Treatment Plan / Plan of Care." Collaborative intervention, especially in the rehabilitation therapies, is an important element and one that is consistent with the highly respected "Chronic Care Model" as described by Ed Wagner. Significant evidence which has appeared in peer-reviewed journals supports the value of informed patients taking an active involvement in their care. However, no significant evidence is cited supportive of the concept that physical therapy, occupational therapy or speech-language pathology patients participating in the development of a treatment plan have better outcomes.

One could hypothesize that a patient who participates in establishing the **goals** of the intervention (and to a lesser extent, the plan of care itself), might achieve more meaningful improvement (effectiveness) in a shorter period of time (efficiency). However, such data (i.e., indication of patient participation) would only be meaningful and successful in proving such a theory (or "addressing a perceived gap in care or practice") if a measure of functional improvement, functional outcomes or functional status accompanied the "patient involvement in care planning" measure.

The citations listed by the QIO as support for this measure are not relevant. Most (Geller, 2003, Resnicow, 2002, Rollnick, 1995, Ruback, 2005, Amrhein, 2003) relate to cognitive therapy, behavioral health issues including drug abuse, eating disorders and other addictive conditions. The article describing "patient-centered physical therapy" (Graham, 2002) does not define "patient-centered care" as including patient participation in the development of plan of care. The article does, however, address and support the importance of identifying the patient's perception of the functional limitation resulting from the physical condition.

There is a much stronger, more scientific, more specific and more effective (as well as more meaningful) indicator that is supported by this article than the patient's participation in the development of a plan of care. That more meaningful element is functional status-related and, when measured, not only reveals the patient's perception of the limitation but also serves as a guide for intervention and, at the conclusion of care, provides accurate evidence of the results (outcome) of care. Therefore, measuring functional status and/or

participation in a clinical data registry which does so, would be a more useful and meaningful measure. PTPN recommends that these (above) measures listed in Table 18 **not** be adopted by CMS without modification or adaptation.

"TRHCA—SECTION 101(d): PAQI"

Section 1848(1) of the Act, as added by section 101(d) of the MIEA-TRHCA requires the Secretary to establish a Physician Assistance and Quality Initiative Fund (PAQI) which shall be available for physician payment and quality improvement initiatives, which may include application of an adjustment to the update of the PFS CF. The provision makes available $1.35 billion to the Fund for services furnished during 2008. Specifically, the provision directs the Secretary to provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire $1.35 billion for payment for physicians' services furnished during CY 2008. The provision also requires that if expenditures from the Fund are applied to, or otherwise affect, a conversion factor for a year, the conversion factor for a subsequent year shall be computed as if the adjustment to the conversion factor had never occurred.

As the legislation indicates, this Fund can be used to either buy down the negative update to the fee schedule or for quality improvement initiatives. CMS believes it is essential that Medicare continue to encourage improvement in the efficiency and quality of health care delivered to Medicare beneficiaries. The Agency is proposing that the $1.35 billion be used to fund bonus payments to be made during 2009 for physician reporting of measures during 2008 as opposed to an application to an adjustment for a payment update to the Medicare Physician Fee Schedule. PTPN agrees with and supports this decision with the understanding that when CMS refers to "bonus payments to physicians" it means eligible professionals including physicians and suppliers.

CMS also proposes that the physician quality initiative for 2008 be structured and implemented in the same manner as the 2007 PQRI with regard to the professionals eligible to participate in the program, reporting quality measures via claims submission, and the standards for satisfactory reporting. PTPN is generally supportive of this proposal with two exceptions: one was noted above with respect to the additional "process" measures being developed by the Quality Insights QIO of Pennsylvania; and the other is PTPN's strong recommendation that CMS move rapidly, that is, by 2008, to become able to utilize functional status (outcomes) measures as one (additional) basis for paying bonuses to eligible rehabilitation therapists under the PQRI.

PTPN again thanks the Centers for Medicare and Medicaid Services for the opportunity to submit these views and urges the Agency to seriously consider our recommendations. We are committed to working with you as you proceed.

Sincerely,

Michael Weinper

Michael Weinper, MPH, PT
President/CEO

Submitter : Mr. Daniel Smith **Date: 08/30/2007**

Organization : American Cancer Society Cancer Action Network

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13118-Attach-1.PDF

CMS-1385-P-13118-Attach-2.PDF

#13118

August 30, 2007

Herb B. Kuhn
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

RE: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008; Proposed Rule

Dear Mr. Kuhn:

On behalf of the American Cancer Society Cancer Action Network (ACS CAN) and its many volunteers and supporters, we respectfully submit the following comments for your consideration regarding the Centers for Medicare & Medicaid Services' (CMS') revision to payment policies under the Physician Fee Schedule (PFS) for Calendar Year (CY) 2008, CMS-1385-P, as published in the Federal Register on July 12, 2007. ACS CAN is the sister advocacy organization of the American Cancer Society, which is the nation's largest community-based voluntary health organization dedicated to eliminating cancer as a major health problem.

As you may know, cancer is a disease that disproportionately affects the elderly—according to the American Cancer Society's 2007 Facts & Figures, more than 60 percent of all new cancer diagnoses occur in the elderly population. As the nationwide voluntary health organization committed to eliminating cancer as a major health problem, ACS CAN has a particular interest in ensuring that our nation's seniors have access to high quality cancer prevention, early detection, and treatment tools through the Medicare program. Given the importance of outpatient services to cancer patients, ACS CAN appreciates the opportunity to provide you with comments on the PFS and looks forward to working with CMS to strengthen the Medicare program.

Summary

The American Cancer Society Cancer Action Network is dismayed that CMS has chosen not to include tobacco, colorectal cancer and breast cancer screenings in the 2008 Physician Quality Reporting Initiative (PQRI). With twenty cents of every Medicare dollar spent on cancer (according to the Medical Expenditure Panel Survey 1996-2001),

CMS cannot afford to not include these scientifically proven preventive measures. Cancer screenings are critical to preventing cancer and/or detecting cancer in its earliest, most curable stage.

ACS CAN is also very concerned about the potential detrimental effect of the proposed reductions in payment proposed in this regulation. Of particular concern is the availability and ease of access to services for cancer patients if providers feel they can no longer afford to perform mammography or colorectal cancer screenings.

ACS CAN is pleased by the inclusion of a process by which CMS will accept and consider suggestions for the addition and deletion of compendia to the list of recognized compendia under Medicare. Nonetheless, ACS does not believe that adoption of additional compendia should be delayed until September 2008. .

Proposed Physician Fee Schedule Changes

Provisions

ACS CAN is committed to ensuring that Medicare beneficiaries have access to necessary cancer screenings and quality care. ACS CAN is concerned that the 9.9% reduction in payments to physicians, combined with the adjustments in the relative value units and the conversion factor could diminish Medicare beneficiaries' access to quality care. Specifically, we are concerned that the proposed payment reductions may limit or delay access to preventive services and diagnostic procedures critical to their receiving optimal care. We ask that CMS carefully monitor and evaluate the effects on access of any final changes.

We are particularly troubled by the cuts to imaging services under Medicare. For example, while the payments for all imaging services are being reduced, screening mammograms (CPT/HCPCS 77057) are being cut by approximately $7 and digital screening mammograms (CPT/HCPCS G0202) are being reduced by even deeper cuts of up to $13. Similarly, the combined impact of these proposed reductions indicates that Radiology will see a 10 percent reduction in reimbursement. ACS CAN is concerned that reimbursement for mammography services may be insufficient to cover the costs for many providers and that further disincentives through reductions in payments will increase delays or reduce access to breast cancer screening for women by encouraging sites to do fewer procedures and train fewer skilled mammographers.

Of particular concern to ACS CAN is the significant reduction in reimbursement for colorectal cancer screening (CPT/HCPC G0105 & CPT/HCPC G0121) of $38 in the non-facility setting and $18 in the facility setting. These cuts potentially could have serious consequences on beneficiary health, despite CMS' recent positive efforts to increase screening by eliminating the deductible for these tests. While eliminating the deductible may encourage beneficiaries to avail themselves of these lifesaving screenings, the reduced payment can decrease access as fewer providers are willing to offer them.

In addition, ACS CAN is concerned with the effects that these reductions will have on such important services as the "Welcome to Medicare" visit (initial preventive exam, CPT/HCPCS G0344) which currently has a very low utilization rate of about four percent. The "Welcome to Medicare Visit" is being cut by roughly $10 in the both the physician office and hospital settings. The Society has expressed concerns in the past that the payment for the Welcome to Medicare Visit may be insufficient to compensate physicians for the services provided. The proposed payment may not adequately compensate physicians for their time, and result in visits that fail to include all of the appropriate education, counseling, and referrals. The Society urges you to reconsider the proposed reductions in payment for this benefit and other life-saving cancer screenings, and raise them to levels that will not act as disincentives for providers and make them unavailable to patients.

DRA Proposals

Payment for subsequent surgical procedures performed during the same operative session by same physician

ACS CAN is concerned with the impact of the proposed multiple procedure payment reduction for Mohs Micrographic Surgery (MMS) (CPT codes 17311 through 17315). MMS surgery codes have been exempt from the multiple procedure payment reduction rules since the inception of the Physician Fee Schedule. MMS is one of the many surgical procedures where a significant portion of the work (in this case, the pathology portion) must be repeated when two or more procedures are performed during the same surgery. The Society is concerned that applying the multiple surgery reduction rule to Mohs codes would reduce reimbursement to a level less than the cost of providing the service. Providers may refuse to perform more than one Mohs procedure on any patient in a single day, leading to inconvenience for many patients and their families, and possibly dangerous delays in treatment. Furthermore, this policy indicates that when a Mohs surgery is reimbursed at a rate less than a reconstructive procedure on the same

day, the first Mohs code will be subject to the multiple surgery reduction rule, which may require patients to have their Mohs surgery and their reconstruction done on separate days, unnecessarily increasing health care costs. Given the high rates of new skin cancer diagnoses, the Society is very concerned about the potential detrimental effects on patient access to this life-saving treatment that the proposed policy represents.

Compendia for Determination of Medically Accepted Indications for Off Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen

ACS CAN is pleased that CMS has designed a process to consider requests for the addition or deletion of compendium to the list of recognized compendia. As you know, off-label use of cancer chemotherapy drugs and biologics has been part of the standard care for patients with cancer for many years. In a rapidly changing area such as cancer care, FDA approved cancer chemotherapy drugs and biologics for specific uses do not accurately reflect current state-of-the art treatment options for cancer patients in the United States.

Currently, only two recognized compendia are available to the Medicare program to determine medically-appropriate chemotherapy and biologic treatments for cancer. ACS CAN believes it is important that a mechanism exist to provide other authoritative expert reference sources to support off-label uses of drugs and biologics in the treatment of cancer. The development of drugs and biologics for the treatment of cancer is one of the most rapidly evolving areas of medicine; ACS CAN believes that the present two recognized compendia are not keeping up-to-date with regulatory approval as well as published scientific, clinical evidence.

ACS CAN is concerned however, that the implementation schedule outlined in the proposed rule is unnecessarily lengthy. It would appear that the earliest that CMS intends to act to revise the list of compendia utilized for coverage determination of drugs and biological products for anticancer chemotherapy treatment is September 2008. Given that an extensive review by the Medicare Coverage Advisory Committee (MedCAC) of six compendia has already been undertaken,

Section 101(b) --Physician Quality Reporting Initiative (PQRI)

ACS CAN is dismayed that CMS has not included vital primary care prevention measures in its proposed expanded list of measures to be included in the 2008 Physician Quality Reporting Initiative (PQRI). ACS CAN has worked closely with CMS staff to facilitate inclusion of three critical measures: breast cancer screening, colorectal cancer

screening and tobacco use. These quality measures are taken directly from the recommended starter set of clinical measures for physician performance approved at the January 2005 Ambulatory Quality Alliance (AQA) meeting and developed and owned by the National Committee for Quality Assurance (NCQA). With twenty cents of every Medicare dollar spent on cancer patients, CMS cannot afford to wait for inclusion of screenings scientifically proven to reduce the incidence and costs of cancer. ACS CAN remains ready and willing to work with and assist CMS staff with any questions it may have concerning these screenings. It is our belief that inclusion of these lifesaving screenings in the PQRI will encourage physicians and beneficiaries to take advantage of Medicare's coverage of these screenings and ultimately raise screening rates in the Medicare population.

Conclusion

This proposed physician fee schedule has the potential to affect millions of Medicare beneficiaries diagnosed and living with cancer. We appreciate the hard work that you and your agency have put into implementing the many provisions of this proposed rule. ACS CAN stands ready to work with you to improve the health outcomes and reduce the cancer burden among Medicare beneficiaries.

Respectfully,

Daniel E. Smith
President
ACS CAN

Wendy K. D. Selig
Vice President, Legislative Affairs
ACS CAN

Submitter : **Dr. Richard Reiling** **Date: 08/30/2007**

Organization : **Association of Community Cancer Centers**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-13119-Attach-1.PDF

#13119

The premier education and advocacy organization for the oncology team

ACCC

Association of Community Cancer Centers

August 30, 2007

Herb B. Kuhn, Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, DC 20201

Re: CMS-1385-P (Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2008)

Dear Deputy Administrator Kuhn:

On behalf of the Association of Community Cancer Centers (ACCC), we appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding revisions to payment policies under the Medicare physician fee schedule, published in the Federal Register on July 12, 2007 (the "Proposed Rule").[1] ACCC is a membership organization whose members include hospitals, physicians, nurses, social workers, and oncology team members who care for millions of patients and families fighting cancer. ACCC's more than 650 member institutions and organizations treat 45 percent of all U.S. cancer patients. Combined with our physician membership, ACCC represents the facilities and providers responsible for treating over 60 percent of all U.S. cancer patients.

Many cancer patients turn to physician offices to receive their treatment and related care, and it remains vitally important that physicians are properly reimbursed for these services. Since the implementation of the Medicare Modernization Act (MMA) of 2003,

1 72 Fed. Reg. 38121 (July 12, 2007).

ACCC has been concerned that reimbursement for cancer therapy, including drugs[2] and other services, may not be adequate to cover physicians' costs. In the past, we have been pleased to see CMS take steps to ensure access to quality care through measures such as implementing new codes for drug administration services, implementing supplying fees for oral anticancer and anti-emetic drugs, and creating the demonstration projects to improve the quality of care provided to patients undergoing chemotherapy in 2005 and 2006. This year, we also are pleased that CMS has proposed to continue to make add-on payments for the preadministration-related services associated with intravenous immoglobulin (IVIG) and will implement the expanded Physician Quality Reporting Initiative (PQRI). However, we are concerned that if the fee schedule is implemented as proposed, medical and radiation oncologists will face major cuts to reimbursement that ultimately may affect patient access to quality care.

In 2008, the number of Medicare beneficiaries is will continue to grow, and the number of beneficiaries needing care for cancer also is likely to expand. As the demand for care increases, however, physicians once again face a proposed cut in Medicare reimbursement that would make it more difficult to respond to the growing need for their services. If Congress does not act, hematologists and oncologists are scheduled to have an 11 percent decrease in Medicare reimbursement. These cuts are due to the Sustainable Growth Rate (SGR) formula, calling for a 9.9 percent decrease in the conversion factor, in addition to an application of a budget neutrality adjustment to the work Relative Value Units (RVUs) and the continued phase-in of the new practice expense methodology. Even if Congress does act to eliminate the cut to the conversion factor, as they have in recent years, a one percent reduction still is predicted for hematology and oncology services.[3] We encourage CMS to take the necessary steps to ensure physicians are reimbursed adequately for the quality cancer care that they deliver to their patients.

With these general concerns in mind, we recommend CMS make the following changes to the physician fee schedule for CY 2008:

- Work with Congress, the Medicare Payment Advisory Commission (MedPAC), and other parties to stabilize or replace the SGR formula so physicians do not face major cuts to reimbursement each year.
- Apply the budget neutrality adjustor to the conversion factor instead of to the work RVUs to distribute the impact of the reduction fairly among procedures.

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2 Throughout our comments, we use "drugs" to refer to both drugs and biologicals.

3 72 Fed. Reg. at 38213.

- Continue to assume a 50 percent usage rate and 11 percent interest in determining the costs of medical equipment for calculating practice expense RVUs.
- Continue to make the add-on payment for preadministration-related services for IVIG and develop a permanent additional payment for the acquisition of this important therapy.
- Implement the PQRI program in a manner that promotes the best quality of care possible. CMS also should work with specialty groups to ensure that the measures currently in place accurately reflect quality of care in each specialty.
- Develop a clear and timely process for accepting and evaluating requests to revise the list of compendia used to determine covered uses of drugs and biologicals used in anticancer chemotherapeutic drug regimens.
- Provide more guidance in the implementation of reporting of hemoglobin or hematocrit levels when reporting the use of erythropoiesis stimulating agents (ESAs).
- Give manufacturers clear instructions for reporting average sales price (ASP) data to ensure that Medicare reimbursement reflects market prices.
- Exercise caution in implementing the payment limits for imaging procedures to protect patient access to these services.
- Revise the Competitive Acquisition Program (CAP) to make it a viable option for more physicians.

We discuss these recommendations below.

I. Sustainable Growth Rate (SGR) (Background, Impact, TRHCA – Section 101(d): PAQI)

Under the existing formula for calculating the physician fee schedule updates, physicians have been threatened with severe payment reductions in each of the past several years. Only through "eleventh hour" congressional action have the payment rates instead been frozen or increased minorly. This happened again last year, although Congress also created bonus payments for reporting quality data under the PQRI. For 2008, physicians once again face a 9.9 percent cut to the conversion factor and are likely to see more cuts in years to come as well. Even if Congress acts again to freeze reimbursement, Medicare payments effectively will be cut because they have not been adjusted for inflation. Physicians cannot plan for the future in an unpredictable reimbursement environment that fails to keep pace with the costs of labor and supplies. ACCC is deeply concerned about this situation because unstable reimbursement may force physicians to reduce the number of Medicare beneficiaries they treat, delay investments in new technologies, or ask

patients to seek care from other settings. ACCC urges CMS to work with Congress and other stakeholders to develop a more stable and appropriate payment formula for the future. We also ask CMS to take any steps necessary to minimize the effect of the cuts if Congress does not act, including using the Physician Assistance and Quality Initiative (PAQI) Fund to buy down the negative update to the conversion factor.

II. Budget Neutrality and Relative Value Units (RVUs) (Background, Impact)

If Congress does not step in to halt the 9.9 percent cut to the conversion factor, hematology and oncology services face a projected 11 percent decrease. About 10 percent of this can be attributed to the SGR update, leaving a one percent decrease caused in part by the implementation of a budget neutrality adjustor to all of the RVUs. The actual impact on physicians will be even greater when the effect of inflation is considered. Even if Congress does act to eliminate the nearly 10 percent cut in the conversion factor, the negative one percent update is still a major cause for concern for the membership of ACCC.

ACCC suggests that CMS apply the budget neutrality adjuster to the conversion factor instead to the work RVUs. If a reduction must be made to remain budget neutral, we believe the fairest method to do that is by applying the reduction to the conversion factor. This American Medical Association, the Relative Value Scale Update Committee (RUC), and numerous other specialty societies recommended this approach for the 2007 physician fee schedule,[4] and we ask CMS to take this approach in 2008.

III. Equipment Usage and Interest Costs Included in Practice Expense RVUs (Resource-Based PE RVUs)

ACCC supports CMS's proposal to continue to apply an equipment usage assumption of 50 percent when determining amount of equipment costs to include in the practice expense RVUs.[5] We share CMS's concern that increasing the assumed equipment usage percentage would produce insufficient allowances for equipment costs at the service level and could discourage the appropriate use of medical technologies. It is critical that Medicare's payments reflect the significant costs of equipment used in cancer care, such as radiation therapy equipment or imaging equipment. We also agree that the 50 percent rate may not be accurate for

4 71 Fed. Reg. 69623, 69735 (Dec. 1, 2006).
5 72 Fed. Reg. at 38132.

all equipment, but we recommend that CMS continue to apply the 50 percent usage assumption until sufficient empirical data are available to justify a change.

We also agree with the proposal to continue to assume that 11 percent interest is incurred in the purchase of medical equipment for purposes of calculating practice expense RVUs.[6] CMS's analysis of the 2007 Small Business Administration data indicates that this rate continues to be appropriate. We concur with this conclusion, and we ask CMS to implement this proposal in the final rule.

IV. Preadministration-Related Services for IVIG (Coding – Payment for IVIG Add-On Code)

ACCC is pleased that CMS proposes to continue payment using code G0332 for preadministration-related services for IVIG.[7] As CMS noted when it established the code, physicians incur additional costs related to obtaining IVIG and scheduling administration for specific patients. Physicians also must ensure that patients receive the most appropriate IVIG available at the time, taking into consideration the patient's condition and medical history. We thank CMS for recognizing the importance of IVIG and addressing concerns about access and availability. We ask CMS to finalize its proposal to continue payment for G0332 at the same level of PE RVUs as in 2007.

CMS also indicates that it might discontinue payment for preadministration-related services after 2008. Before implementing any change in payment, CMS should carefully consider the market conditions for IVIG and stakeholders' concerns about access and availability. ACCC also supports the development of a permanent payment additional for acquisition of IVIG, similar to the payment for clotting factor, to help ensure access to this important therapy.

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6 Id.

7 Id. at 38146.

V. PQRI (TRHCA – Section 101(b): PQRI)

ACCC supported the creation of the PQRI by Congress in 2006. We hope that the implementation of pertinent quality reporting measures will lead to improved quality of care for patients. As CMS implements the program for 2008, we recommend that the agency use data from the initial PQRI reporting period in 2007 to determine if the current measures are appropriate and effective. We also recommend that CMS continually evaluate and revise the standards, if necessary, to ensure that they align with clinical practice and can be reported by physicians with minimal administrative burden.

ACCC recommends that CMS have an open dialogue with specialty societies to determine the best and most appropriate reporting measures. Oncologists have already seen that physicians are not able to report several of the current quality measures because the measures do not reflect accepted clinical practices. For example, several measures can be reported only when chemotherapy is provided on the same day as a physician evaluation and management (E&M) service, yet patients often receive chemotherapy without also receiving a physician E&M service. It also is possible that changes in treatments and procedures or regulations could render other reporting measures obsolete, and CMS should be ready to substitute those with more up-to-date measures. CMS can accomplish this by working closely with specialty societies to determine the best quality measures. In particular, we recommend that CMS replace several of the oncology measures with the more appropriate standards produced through the AMA-Physicians Consortium for Performance Improvement (AMA-PCPI). Specifically, measures 71, 72, 73, and 74 should be replaced with the new oncology measures developed by the AMA-PCPI.

Finally, we ask CMS to include the anemia quality indicators required by 110 of the Tax Relief and Health Care Act of 2006 (TRHCA) among the PQRI measures for oncology. As discussed in section VII below, section 110 requires physicians to report hemoglobin or hematocrit levels for patients receiving treatment for anemia in connection with treatment for cancer on or after January 1, 2008. CMS states that it will use these anemia quality indicators to measure the quality of care provided for this condition.[8] We believe that the mandatory anemia measures, like the voluntary PQRI measures, will help to serve the goal of improving the quality of care provided and we ask CMS to acknowledge that they are of equal importance by including the anemia measures in the list of PQRI measures. Adding the anemia measures to the list of PQRI measures also might encourage more physicians to participate in the PQRI. CMS could implement this recommendation without changing the frequency requirements for each type of standard. Physicians would

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8 Id. at 38204.

be required to report the anemia measures in all cases that meet the statutory requirements, and would be required to report other PQRI measures in at least 80 percent of the applicable cases.

VI. Compendia Process Changes (Drug Compendia)

ACCC appreciates CMS's goal of establishing a clear process for accepting and considering requests to revise the list of compendia used to determine medically-accepted indications for drugs used in an anti-cancer chemotherapeutic regimen. As CMS acknowledges, the Medicare statute identifies certain compendia that are used to determine the medically-accepted uses of a drug or biological used in an anti-cancer chemotherapeutic regimen.[9] By statute, Medicare must cover off-label uses of cancer drugs that are supported by citations in the American Hospital Formulary Service-Drug Information (AHFS-DI), the United States Pharmacopoeia-Drug Information (USP-DI) or its successor publications, or the American Medical Association Drug Evaluations (AMA-DE) or by clinical evidence in peer-reviewed literature.[10] This requirement protects beneficiary access to innovative therapies, used in conformity with evolving standards of care. At this time, however, the AMA-DE no longer is published, and USP-DI now is published by Thomson Micromedex® under the name DrugPoints®.

ACCC can not stress enough the importance of identifying several compendia for use in making coverage decisions so patients can have access to the most appropriate treatment option for their type of cancer. Because each compendium has a different review and publication schedule, CMS will best protect beneficiary access to care, provide physicians and carriers with more data regarding current treatment options, and increase the likelihood that at least one compendium will recognize a new development in a timely manner if it includes at least two compendia on the list for use by Medicare carriers.

ACCC agrees with CMS that all compendia used for Medicare coverage decisions should review research using the highest quality of standards and should abide by as many of the criteria identified by the Medicare Coverage Advisory Committee (MedCAC).[11] We recognize that any single publication might not meet all of the criteria, however. CMS should not refuse to recognize a compendium if it does not meet all of criteria, but instead should weigh the importance of the criteria and recognize publications that meet several of the factors.

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9 Id. at 38177.

10 Social Security Act (SSA) § 1861(t)(2), as amended by the Deficit Reduction Act, Pub. L. No. 109-171 § 6001(f).

11 72 Fed. Reg. at 38178.

We also appreciate CMS's desire to engage the public and stakeholders on this matter. The addition or subtraction of compendia from the approved listings is not a process that should be taken without consultation from the public to determine the validity of the claims about each publication. We are concerned that CMS's proposed timeline for revising the list of compendia is too drawn-out and would prevent timely changes to the list. As described in the Proposed Rule, the process would take, at a minimum, 225 days, including a 45-day period before requests are accepted after CMS publishes a notice in the Federal Register, a 30-day period to accept requests, a 30-day comment period on those requests, and a 120-day period to consider requests and publish a decision.[12] We appreciate CMS's efforts to provide adequate notice and opportunity for comment, but we believe the process could be accelerated by eliminating the first 45 day period. We also ask CMS to minimize the delay between its acceptance of completed requests and the announcement of the comment period on those requests.

VII. Reporting of Hemoglobin or Hematocrit Levels with ESA Usage (TRHCA – Section 110: Anemia Quality Indicators)

ACCC supports the broad goal of gathering information to improve the quality of care, as evidenced by our support of the PQRI program. Similarly, ACCC supports the reporting of hemoglobin or hematocrit levels with the usage of ESAs in cancer patients, as required by section 110 of the TRHCA. We urge CMS to implement this requirement in a manner that produces useful quality data and imposes minimal burdens on physicians.

In the Proposed Rule, CMS acknowledges that section 110 requires the agency to use rulemaking to address implementation of the hemoglobin or hematocrit reporting requirement.[13] CMS does not describe how it plans to implement this requirement, however. ACCC requests that CMS publish detailed guidance well in advance of the January 1, 2008 implementation date as to how exactly physicians should report these levels. A detailed set of instructions should be included in any final rule on this subject, similar to the instructions for reporting measures under the PQRI. The limited information released thus far regarding this proposal, including the new coding modifiers, has been limited and has caused confusion among our membership. CMS should provide clear instructions regarding the use of these modifiers. Alternatively, CMS could model the reporting process after the "hematocrit level in ESRD patients" measure that is currently in use in the PQRI.[14]

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12 Id. at 38178-79.

13 Id. at 38204.

14 Our support for this requirement should be viewed in conjunction with comments recently submitted to CMS regarding the reimbursement for ESAs in chemotherapy-induced anemia patients

VIII. More Accurate Reporting of ASP (ASP Issues)

ACCC is supportive of the basic idea of a more accurate ASP reporting methodology. We believe that CMS should provide clear instructions that will help manufacturers submit accurate and consistent data and ensure that the ASPs CMS uses to reimburse physicians reflect market prices.

IX. Payment for Imaging Procedures (Coding – Reduction in TC for Imaging Services)

ACCC remains concerned about the limit on payment for imaging services required by section 5102(b)(1) of the Deficit Reduction Act of 2005. We appreciate CMS's efforts to limit application of this requirement to certain procedures, and we ask the agency to continue to exercise great care in determining which procedures are subject to this limit. ACCC believes that this policy goes against the new CMS mission, which "...is changing from indemnity insurer-simply paying the bills-to trying to help people stay well, prevent complications, and avoid unnecessary healthcare costs."[15] Imaging services such as MRIs, CTs, PET and PET/CT scans help to reduce treatment costs by allowing identification of tumors at their earlier, more treatable stages, facilitating appropriate diagnoses, and measuring tumors' response to treatment. By cutting the reimbursement on these exams, CMS is making it more difficult for physicians to provide appropriate cancer care in a cost-effective manner.

X. Revisions to the Competitive Acquisition Program (CAP Issues)

Finally, we appreciate CMS's proposals to revise the CAP to make participation less burdensome for physicians. CMS proposes to define a new exigent circumstance for opting out of the CAP.[16] This exception would allow a physician to opt out of the CAP if, for example, participation poses a financial hardship, the practice is unable to update its billing system despite good faith efforts, or the practice relied on misleading information about the program from outside sources when it decided to enroll. In cases such as these, a physician could ask to withdraw from the program by submitting a written request within 30 days of the effective date of his or her participation election agreement. We support this proposal, but we ask CMS not to set a deadline for submitting requests. Thirty

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and in patients with Myelodysplastic Syndrome (MDS). Comments from Dr. Richard Reiling, President, ACCC to Steve Phurrough MD, MPA, CMS June 4, 2007. Comments can be viewed at: http://www.accc-cancer.org/PUBPOL/pdf/ESA_comments_may07.pdf.

15 H. Kuhn; speech at ACCC President's Council Reception, Jan. 26, 2007.

16 72 Fed. Reg. at 38157.

days may not be sufficient time for a physician to fully identify the hardship of participating in the CAP or make good faith efforts to upgrade his or her billing system. In addition, these hardships could emerge after the 30-day deadline. Instead of setting a time limit for requests to withdraw from the CAP, CMS should consider the timing of the request as one of several factors when processing it.

We also thank CMS for reconsidering the restriction on transporting CAP drugs between a physician's offices or other care settings.[17] As other stakeholders have noted, allowing physicians to transport drugs between settings would allow greater flexibility in scheduling patients and may make the CAP a viable option for physicians who practice in several locations. We ask CMS to revise the CAP to allow physicians to transport drugs between locations.

XI. Conclusion

In summary, ACCC continues to be concerned that the expected substantial reduction in the conversion factor, combined with other cuts in reimbursement pursuant to the DRA and budget neutrality, will have a serious negative effect on patients battling cancer. Physicians simply cannot continue to absorb the significant cuts in payment rates for cancer services without substantial ramifications for patient care. In order to ensure that Medicare patients continue to have access to essential cancer services, we respectfully request that CMS adopt the following recommendations:

- Work with Congress, MedPAC, and other parties to stabilize or replace the SGR formula so physicians do not face major cuts to reimbursement each year.
- Apply the budget neutrality adjustor to the conversion factor instead of to the work RVUs to distribute the impact of the reduction fairly among procedures.
- Continue to assume a 50 percent usage rate and 11 percent interest in determining the costs of medical equipment for calculating practice expense RVUs.
- Continue to make the add-on payment for preadministration-related services for IVIG and develop a permanent additional payment for the acquisition of this important therapy.
- Implement the PQRI program in a manner that promotes the best quality of care possible. CMS should also work with specialty groups to ensure that the measures currently in place accurately reflect quality of care in each specialty.

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17 Id. at 38158.

- Develop a clear and timely process for accepting and evaluating requests to revise the list of compendia used to determine covered uses of drugs and biologicals used in anticancer chemotherapeutic drug regimens.
- Provide more guidance in the implementation of reporting of hemoglobin or hematocrit levels when reporting the use of ESAs.
- Give manufacturers clear instructions for reporting ASP data to ensure that Medicare reimbursement reflects market prices.
- Exercise caution in implementing the payment limits for imaging procedures to protect patient access to these services.
- Revise CAP to make it a viable option for more physicians.

ACCC appreciates the opportunity to offer these comments, and we look forward to continuing to work with CMS to address these vital issues. Please contact Matthew Farber at 301-984-9496, ext. 221, if you have any questions or if ACCC can be of further assistance. Thank you for your attention to this very important matter.

Respectfully submitted,

Richard B. Reiling

Richard B. Reiling, MD, FACS
President
Association of Community Cancer Centers

Submitter : Dr. Nasim Riazati **Date:** 08/30/2007

Organization : Long Beach Memorial Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#13124

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Ms. Katherine Dieringer** **Date: 08/30/2007**

Organization : **D&D Sports Med**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified/licensed athletic trainer who owns and operates 3 outpatient rehabilitation clinics in the Dallas/Ft Worth area. I have worked in a number of settings during my 20+ years as a healthcare professional, and have always believed that what is best for the patient should always supercede politics.

With this in mind, 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.

I am very concerned that these proposed changes have not been properly considered through the usual procedures. Of more concern, however, is 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. I also submit that it is arrogant of CMS to assume that they know better how to staff our country's healthcare facilities, rather than allowing the professionals who are charged with this task to complete it. If a healthcare provider is properly educated, trained and credentialed to treat patients in these settings, as athletic trainers clearly are, then why should CMS be determining who should and should not be permitted to perform these services. Isn't that what licensure and other means of credentialing is intended to do? 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,

Kathy I. Dieringer EdD, ATC, LAT, OPA-C

Submitter : Mr. Michael Becker **Date:** 08/30/2007

Organization : GE Healthcare

Category : Private Industry

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

#13132

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Mr. Daniel Smith **Date:** 08/30/2007

Organization : American Cancer Society Cancer Action Network

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13140-Attach-1.PDF

#13140

August 30, 2007

Herb B. Kuhn
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

RE: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008; Proposed Rule

Dear Mr. Kuhn:

On behalf of the American Cancer Society Cancer Action Network (ACS CAN) and its many volunteers and supporters, we respectfully submit the following comments for your consideration regarding the Centers for Medicare & Medicaid Services' (CMS') revision to payment policies under the Physician Fee Schedule (PFS) for Calendar Year (CY) 2008, CMS-1385-P, as published in the Federal Register on July 12, 2007. ACS CAN is the sister advocacy organization of the American Cancer Society, which is the nation's largest community-based voluntary health organization dedicated to eliminating cancer as a major health problem.

As you may know, cancer is a disease that disproportionately affects the elderly—according to the American Cancer Society's 2007 Facts & Figures, more than 60 percent of all new cancer diagnoses occur in the elderly population. As the nationwide voluntary health organization committed to eliminating cancer as a major health problem, ACS CAN has a particular interest in ensuring that our nation's seniors have access to high quality cancer prevention, early detection, and treatment tools through the Medicare program. Given the importance of outpatient services to cancer patients, ACS CAN appreciates the opportunity to provide you with comments on the PFS and looks forward to working with CMS to strengthen the Medicare program.

Summary

The American Cancer Society Cancer Action Network is dismayed that CMS has chosen not to include tobacco, colorectal cancer and breast cancer screenings in the 2008 Physician Quality Reporting Initiative (PQRI). With twenty cents of every Medicare dollar spent on cancer (according to the Medical Expenditure Panel Survey 1996-2001),

CMS cannot afford to not include these scientifically proven preventive measures. Cancer screenings are critical to preventing cancer and/or detecting cancer in its earliest, most curable stage.

ACS CAN is also very concerned about the potential detrimental effect of the proposed reductions in payment proposed in this regulation. Of particular concern is the availability and ease of access to services for cancer patients if providers feel they can no longer afford to perform mammography or colorectal cancer screenings.

ACS CAN is pleased by the inclusion of a process by which CMS will accept and consider suggestions for the addition and deletion of compendia to the list of recognized compendia under Medicare. Nonetheless, ACS does not believe that adoption of additional compendia should be delayed until September 2008. .

Proposed Physician Fee Schedule Changes

Provisions

ACS CAN is committed to ensuring that Medicare beneficiaries have access to necessary cancer screenings and quality care. ACS CAN is concerned that the 9.9% reduction in payments to physicians, combined with the adjustments in the relative value units and the conversion factor could diminish Medicare beneficiaries' access to quality care. Specifically, we are concerned that the proposed payment reductions may limit or delay access to preventive services and diagnostic procedures critical to their receiving optimal care. We ask that CMS carefully monitor and evaluate the effects on access of any final changes.

We are particularly troubled by the cuts to imaging services under Medicare. For example, while the payments for all imaging services are being reduced, screening mammograms (CPT/HCPCS 77057) are being cut by approximately $7 and digital screening mammograms (CPT/HCPCS G0202) are being reduced by even deeper cuts of up to $13. Similarly, the combined impact of these proposed reductions indicates that Radiology will see a 10 percent reduction in reimbursement. ACS CAN is concerned that reimbursement for mammography services may be insufficient to cover the costs for many providers and that further disincentives through reductions in payments will increase delays or reduce access to breast cancer screening for women by encouraging sites to do fewer procedures and train fewer skilled mammographers.

Of particular concern to ACS CAN is the significant reduction in reimbursement for colorectal cancer screening (CPT/HCPC G0105 & CPT/HCPC G0121) of $38 in the non-facility setting and $18 in the facility setting. These cuts potentially could have serious consequences on beneficiary health, despite CMS' recent positive efforts to increase screening by eliminating the deductible for these tests. While eliminating the deductible may encourage beneficiaries to avail themselves of these lifesaving screenings, the reduced payment can decrease access as fewer providers are willing to offer them.

In addition, ACS CAN is concerned with the effects that these reductions will have on such important services as the "Welcome to Medicare" visit (initial preventive exam, CPT/HCPCS G0344) which currently has a very low utilization rate of about four percent. The "Welcome to Medicare Visit" is being cut by roughly $10 in the both the physician office and hospital settings. The Society has expressed concerns in the past that the payment for the Welcome to Medicare Visit may be insufficient to compensate physicians for the services provided. The proposed payment may not adequately compensate physicians for their time, and result in visits that fail to include all of the appropriate education, counseling, and referrals. The Society urges you to reconsider the proposed reductions in payment for this benefit and other life-saving cancer screenings, and raise them to levels that will not act as disincentives for providers and make them unavailable to patients.

DRA Proposals

Payment for subsequent surgical procedures performed during the same operative session by same physician

ACS CAN is concerned with the impact of the proposed multiple procedure payment reduction for Mohs Micrographic Surgery (MMS) (CPT codes 17311 through 17315). MMS surgery codes have been exempt from the multiple procedure payment reduction rules since the inception of the Physician Fee Schedule. MMS is one of the many surgical procedures where a significant portion of the work (in this case, the pathology portion) must be repeated when two or more procedures are performed during the same surgery. The Society is concerned that applying the multiple surgery reduction rule to Mohs codes would reduce reimbursement to a level less than the cost of providing the service. Providers may refuse to perform more than one Mohs procedure on any patient in a single day, leading to inconvenience for many patients and their families, and possibly dangerous delays in treatment. Furthermore, this policy indicates that when a Mohs surgery is reimbursed at a rate less than a reconstructive procedure on the same

day, the first Mohs code will be subject to the multiple surgery reduction rule, which may require patients to have their Mohs surgery and their reconstruction done on separate days, unnecessarily increasing health care costs. Given the high rates of new skin cancer diagnoses, the Society is very concerned about the potential detrimental effects on patient access to this life-saving treatment that the proposed policy represents.

Compendia for Determination of Medically Accepted Indications for Off Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen

ACS CAN is pleased that CMS has designed a process to consider requests for the addition or deletion of compendium to the list of recognized compendia. As you know, off-label use of cancer chemotherapy drugs and biologics has been part of the standard care for patients with cancer for many years. In a rapidly changing area such as cancer care, FDA approved cancer chemotherapy drugs and biologics for specific uses do not accurately reflect current state-of-the art treatment options for cancer patients in the United States.

Currently, only two recognized compendia are available to the Medicare program to determine medically-appropriate chemotherapy and biologic treatments for cancer. ACS CAN believes it is important that a mechanism exist to provide other authoritative expert reference sources to support off-label uses of drugs and biologics in the treatment of cancer. The development of drugs and biologics for the treatment of cancer is one of the most rapidly evolving areas of medicine; ACS CAN believes that the present two recognized compendia are not keeping up-to-date with regulatory approval as well as published scientific, clinical evidence.

ACS CAN is concerned however, that the implementation schedule outlined in the proposed rule is unnecessarily lengthy. It would appear that the earliest that CMS intends to act to revise the list of compendia utilized for coverage determination of drugs and biological products for anticancer chemotherapy treatment is September 2008. Given that an extensive review by the Medicare Coverage Advisory Committee (MedCAC) of six compendia has already been undertaken,

Section 101(b) --Physician Quality Reporting Initiative (PQRI)

ACS CAN is dismayed that CMS has not included vital primary care prevention measures in its proposed expanded list of measures to be included in the 2008 Physician Quality Reporting Initiative (PQRI). ACS CAN has worked closely with CMS staff to facilitate inclusion of three critical measures: breast cancer screening, colorectal cancer

screening and tobacco use. These quality measures are taken directly from the recommended starter set of clinical measures for physician performance approved at the January 2005 Ambulatory Quality Alliance (AQA) meeting and developed and owned by the National Committee for Quality Assurance (NCQA). With twenty cents of every Medicare dollar spent on cancer patients, CMS cannot afford to wait for inclusion of screenings scientifically proven to reduce the incidence and costs of cancer. ACS CAN remains ready and willing to work with and assist CMS staff with any questions it may have concerning these screenings. It is our belief that inclusion of these lifesaving screenings in the PQRI will encourage physicians and beneficiaries to take advantage of Medicare's coverage of these screenings and ultimately raise screening rates in the Medicare population.

Conclusion

This proposed physician fee schedule has the potential to affect millions of Medicare beneficiaries diagnosed and living with cancer. We appreciate the hard work that you and your agency have put into implementing the many provisions of this proposed rule. ACS CAN stands ready to work with you to improve the health outcomes and reduce the cancer burden among Medicare beneficiaries.

Respectfully,

Daniel E. Smith
President
ACS CAN

Wendy K. D. Selig
Vice President, Legislative Affairs
ACS CAN

Submitter : Mr. John Kiefhaber **Date:** 08/30/2007

Organization : Kansas Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13144-Attach-1.DOC

#13144

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Mrs. Kathleen Deloplaine** **Date: 08/30/2007**

Organization : **Allegheny General Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13145-Attach-1.DOC

#13145

August 30, 2007

ALLEGHENY GENERAL HOSPITAL

WEST PENN ALLEGHENY HEALTH SYSTEM

www.wpahs.org

BY ELECTRONIC DELIVERY

Herb Kuhn, Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1385-P (Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008)

Dear Acting Deputy Administrator Kuhn:

I appreciates this opportunity to comment on a proposal related to the reporting of cardiac rehabilitation services contained in the Centers for Medicare & Medicaid Services (CMS) Proposed Rule regarding revisions to payment policies under the physician fee schedule and other Part B payment policies for calendar year 2008 (the "Proposed Rule").[1] Next week, we also will submit to CMS comments on your proposed rule regarding payments to hospital outpatient departments (HOPD) under Medicare. Although I am not involved in the delivery of these services through a physician office, I wanted to comment on this Proposed Rule as the favorable implementation of both the Proposed Rule for physician payment and the proposed rule for HOPD are critical to allowing patients to benefit from proven programs for reversing heart disease.

I am Kathy Deloplaine, Director of Hospital Operations, Department of Cardiology, at Allegheny General Hospital in Pittsburgh, PA. Administratively I am over the Dr. Dean Ornish Program for Reversing Heart Disease. This program is a comprehensive lifestyle modification program based on a low-fat, whole foods eating plan, moderate exercise, stress management and group support. During the past 30 years of conducting randomized controlled trials and demonstration projects, Dr. Ornish and his colleagues have consistently shown that they can motivate people throughout the U.S. to make and maintain bigger changes in diet and lifestyle,

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1 72 Fed. Reg. 38,122 (July 12, 2007).

achieve better clinical outcomes and larger cost savings than have ever before been reported. They were able to prove, for the first time, that the progression of even severe coronary heart disease can be reversed in most patients by making comprehensive lifestyle changes. They also have shown that there were 2½ times fewer cardiac events such as heart attacks, operations, and hospital admissions for patients participating in the Ornish program. These findings were published in the leading peer-reviewed medical journals, including *Journal of the American Medical Association*, *The Lancet*, *American Journal of Cardiology*, *The New England Journal of Medicine*, *Circulation*, *Journal of Cardiopulmonary Rehabilitation, Yearbook of Medicine, Yearbook of Cardiology, Homeostasis, Journal of the American Dietetic Association, Hospital Practice, Cardiovascular Risk Factors, World Review of Nutrition and Dietetics, Journal of Cardiovascular Risk, Obesity Research, Journal of the American College of Cardiology,* and others.

In addition to these randomized controlled trials, Dr. Ornish has conducted three demonstration projects that confirmed these findings in over 2,000 patients throughout the U.S. The results from [my/our] institution and our patients are among those in these data sets. Our clinical and cost outcomes parallel those in the clinical trials. In the first demonstration project, Mutual of Omaha found that almost 80% of patients who were eligible for bypass surgery or angioplasty were able to safely avoid it for at least three years, saving almost $30,000 per patient in the first year. In the second demonstration project, Highmark Blue Cross Blue Shield found that their overall health care costs were reduced by 50% in the first year and by an additional 20-30% in subsequent years. We have also found that the Ornish Program achieved similar improvements in Medicare patients as in these earlier demonstration projects and randomized controlled trials.

I am writing to comment on the proposal regarding reporting of cardiac rehabilitation services under the physician fee schedule. I am pleased that CMS in its proposed rule recognized the need to clarify coding and payment for these services that can dramatically improve the health and quality of life for the growing numbers of Medicare beneficiaries with heart disease. However, I believe that CMS must do more to support the expanded use of cardiac rehabilitation programs - especially those with published, peer-reviewed research showing that they achieve quantifiable results.

I appreciate the time and effort CMS has dedicated to ensure that Medicare beneficiaries can participate in proven cardiac rehabilitation programs under the national coverage determination (NCD) issued last year.[2] Under that revised NCD, Medicare requires cardiac rehabilitation programs to provide a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education, and counseling. This contrasts markedly with the prior NCD for cardiac rehabilitation, under which only exercise was reimbursed by Medicare. In addition, the revised NCD contemplates contractors extending coverage, on a case-by-case basis, to 72 sessions. Under the former NCD, coverage of more than 36 sessions was highly exceptional, with contractors required to have significant documentation

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[2] NCD for Cardiac Rehabilitation Programs, National Coverage Determinations Manual (CMS Pub. 100-3), § 20.10.

of the need for sessions beyond 36. By explicitly citing the Ornish program, in fact, the NCD made clear that it was the intention of CMS to provide coverage under Medicare for this program.

Without several further clarifications and modifications, however, we are concerned that Medicare's current reimbursement for cardiac rehabilitation services may make it difficult for providers to offer effective programs, such as the Ornish Program, to Medicare beneficiaries in a sustainable manner. As a provider of the Ornish Program, there are still certain specific steps that need to occur to ensure that beneficiaries have meaningful access to these programs, as intended by CMS in issues the NCD. I understand that Dr. Dean Ornish and the Preventive Medicine Research Institute (PMRI) has made several recommendations to CMS in regards to these steps.

I am pleased to see that in the Proposed Rule CMS proposes to implement one of PMRI's recommended steps by creating two new Level II Healthcare Common Procedure Coding System (HCPCS) G-Codes for cardiac rehabilitation services.[3] These codes are Gxxx1, Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per hour), and Gxxx2, Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per hour), and would replace the Current Procedural Terminology (CPT) codes, 93797 and 93798, respectively, for these services when billed under the Medicare physician fee schedule.[4] The G-codes would have the same descriptions as 93797 and 93798, except that they would apply to an hour of cardiac rehabilitation services instead of a "session."

I agree that this change will help to "clarify the coding and payment for these services"[5] by more accurately describing the services provided. Those furnishing cardiac rehabilitation will be able to use these codes to bill for one hour of a modality of cardiac rehabilitation identified in the NCD, such as prescribed exercise or education, rather than an undefined "session" of services. I support this proposal and we ask CMS to implement it in the final rule. I do however, respectfully request that the description in the payment tables included in the proposed rule be modified to ensure the Medicare fiscal intermediaries and carriers/Medicare Administrative Contractors (MACs) do not misinterpret the codes as requiring physician presence. To avoid any confusion or any unwarranted reading by MACs that immediate physician supervision is required for the provision of these services, the term "cardiac rehabilitation services", as has been used in previous payment tables in relation to the CPT codes 93797 and 93798, should be used in those tables in lieu of the term "physician services."

While I applaud CMS's proposal to create new G-codes, I believe that beneficiary access to proven cardiac rehabilitation programs will be limited unless CMS implements PMRI's other recommendations. First, I/we strongly urge CMS to state clearly and explicitly in the final rule that multiple sessions of cardiac rehabilitation can be covered on the same day. I believe that this was in fact CMS' intent in proposing the two new G-codes in the proposed rule. But a more explicit statement to this effect would go a long way toward avoiding any confusion in the future

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3 72 Fed. Reg. at 38,419.

4 Id.

5 Id.

on the part of MACs, providers and beneficiaries. In the Ornish program, patients participate in several modalities of cardiac rehabilitation, such as a medical evaluation, prescribed exercise, education, and counseling, in a single day. Providers of the program should be reimbursed for each hour of each modality a beneficiary receives. Fortunately, Medicare already has a mechanism to recognize when a code is billed multiple times in a single day for distinct services. Modifier 59 indicates that "a procedure or service was distinct and independent for other services performed on the same day."[6] CMS should facilitate payment for these services by clearly stating in the final rule that payment may be made for each session when modifier 59 is used and documentation in the patient's record explains that each use of the code represents an hour of a component of the cardiac rehabilitation program.

Second, CMS proposes to crosswalk the new G-codes to payment for 93797 and 93798, respectively. I recommend that both codes be cross-walked to payment for 93798 to ensure that Medicare reimbursement is adequate to support the full range of modalities provided in these programs. The non-exercise components of our program should be reimbursed at this higher payment rate, whether services are provided through a physician, clinic or hospital-based program. I believe that this higher payment rate would apply whether or not a patient needed EKG monitoring, as determined by the supervising physician. The rationale for making payments consistent across provider settings is that Medicare's payment rates under the physician fee schedule appear to have been calculated based only on the resources needed to provide supervised exercise—but not the other, more intensive components of the Ornish program and other similar programs. To allow the full range of programmatic elements specifically outlined in the NCD to be made available to patients in the physician office setting as well as the HOPD setting, these payments need to be consistent.

Third, I ask CMS to explain in the final rule that it is likely to be reasonable and necessary to cover 72 cardiac rehabilitation sessions when multiple sessions are provided in one day. The NCD gives contractors the discretion to cover up to 72 sessions of cardiac rehabilitation.[7] Unlike many cardiac rehabilitation programs in which "patients generally receive 2 to 3 sessions per week,"[8] which has traditionally been comprised of only exercise, in our program, patients typically receive multiple sessions per day, not just limited to exercise. When a beneficiary participates in a program of several one-hour sessions of various modalities in a single day, coverage of 72 sessions is necessary to provide enough hours of each modality for the patient to receive the full benefit of the program. By advising contractors that 72 sessions are likely to be reasonable and necessary for programs providing multiple sessions per day, CMS will ensure that the goals behind the revised, expanded NCD can be met. In view of the fact that 36 sessions - only of exercise - were covered under the prior NCD, it makes little sense to limit coverage to 36 sessions for programs such as Ornish. I ask CMS, in the final rule or other guidance, to remind contractors of their discretion to cover up to 72 sessions and to explain that

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6 American Medical Association, CPT 2007, at 438.

7 NCD for Cardiac Rehabilitation Programs, National Coverage Determinations Manual (CMS Pub. 100-3), § 20.10(D).

8 NCD for Cardiac Rehabilitation Programs, National Coverage Determinations Manual (CMS Pub. 100-3), § 20.10(B)(1)(a).

72 sessions are likely to be reasonable and necessary where beneficiaries receive cardiac rehabilitation from programs that provide several one-hour sessions per day of the various modalities that are included in the cardiac rehabilitation NCD.

Finally, I ask CMS to encourage contractors to factor the proven results of a program into their coverage decisions. For example, 72 sessions should be presumptively covered when they are provided by a program, such as the Ornish program, with extensive peer-reviewed and published research showing that it achieves quantifiable results on important metrics, such as reductions in LDL-cholesterol, triglycerides, blood pressure, blood glucose, and weight, or that it affects the progression of coronary heart disease and/or reduces the need for bypass surgery, angioplasty, or stents and/or the need for medication. This consideration of a program's proven results would help to prevent over-utilization of programs that have not demonstrated positive results and is consistent with CMS's goals of furthering evidence-based medicine and improving actual health outcomes.

* * *

I greatly appreciate the opportunity to comment on the proposed changes to coding for cardiac rehabilitation services and to recommend additional changes that will help Medicare beneficiaries to receive the benefits of successful cardiac rehabilitation programs, such as the Ornish Program. Please feel free to contact me if you have any questions regarding these comments. Thank you for your attention to this very important matter.

Respectfully submitted,

Kathleen A. Deloplaine, RN, BS, BA
Director of Hospital Operations, Cardiology
Allegheny General Hospital
Phone: 412-359-3584
E-mail: kdelopla@wpahs.org

Submitter : **Dr. Charles Mick** **Date: 08/30/2007**

Organization : **North American Spine Society**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Attached please find comments submitted on behalf of the North American Spine Society.

CMS-1385-P-13149-Attach-1.DOC

#13149

NASS
NORTH AMERICAN SPINE SOCIETY

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Toll-free: (866) 960-6277 Phone: (630) 230-3600
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August 30, 2007

Herb Kuhn, Acting Director
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: CMS-1385-P Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008

Dear Mr. Kuhn:

The North American Spine Society (NASS) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Notice on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2008, published in the July 12, 2007 *Federal Register*.

NASS appreciates and supports the proposed increase of 2.47 in the Practice Expense (PE) Relative Value Units (RVUs) for CPT 22857. It is our understanding that this increase in PE RVUs is due to a change of the specialty mix used for the PE calculation from the "all physician" modifier to orthopedic surgery.

CPT-22857 is coded to report insertion of a total disc arthoplasty (TDA). There are two other recently added codes in this family - 22862 (for revision) and 22865 (for removal) of a disc arthoplasty. These are executed with much lower frequency than the base code. They are performed by the same physicians (predominantly orthopedic surgeons) who insert the TDA.

NASS respectfully requests that CMS use a similar specialty mix, as was used for code 22857, in the calculation of the PE RVUs for related CPT codes 22862 and 22865.

Thank you for your time and attention to this matter. We would be happy to discuss this issue further.

Sincerely,

Charles Mick

Charles Mick, MD
Director, NASS Socioeconomic Council

c: NASS Executive Committee
Eric Muehlbauer, CAE, MJ, Executive Director

Submitter : Mr. David Seigneur **Date:** 08/30/2007

Organization : Allegheny General Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13150-Attach-1.DOC

13150

August 30, 2007

ALLEGHENY GENERAL HOSPITAL

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BY ELECTRONIC DELIVERY

Herb Kuhn, Acting Deputy Administrator
Centers for Medicare & Medicaid Services
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200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1385-P (Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008)

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I appreciates this opportunity to comment on a proposal related to the reporting of cardiac rehabilitation services contained in the Centers for Medicare & Medicaid Services (CMS) Proposed Rule regarding revisions to payment policies under the physician fee schedule and other Part B payment policies for calendar year 2008 (the "Proposed Rule").[1] Next week, we also will submit to CMS comments on your proposed rule regarding payments to hospital outpatient departments (HOPD) under Medicare. Although I am not involved in the delivery of these services through a physician office, I wanted to comment on this Proposed Rule as the favorable implementation of both the Proposed Rule for physician payment and the proposed rule for HOPD are critical to allowing patients to benefit from proven programs for reversing heart disease.

I am David Seigneur, Program Director for the Dr. Dean Ornish Program for Reversing Heart Disease at Allegheny General Hospital in Pittsburgh, PA. This program is a comprehensive lifestyle modification program based on a low-fat, whole foods eating plan, moderate exercise, stress management and group support. During the past 30 years of conducting randomized controlled trials and demonstration projects, Dr. Ornish and his colleagues have consistently shown that they can motivate people throughout the U.S. to make and maintain bigger changes in diet and lifestyle, achieve better clinical outcomes and larger cost

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1 72 Fed. Reg. 38,122 (July 12, 2007).

savings than have ever before been reported. They were able to prove, for the first time, that the progression of even severe coronary heart disease can be reversed in most patients by making comprehensive lifestyle changes. They also have shown that there were 2½ times fewer cardiac events such as heart attacks, operations, and hospital admissions for patients participating in the Ornish program. These findings were published in the leading peer-reviewed medical journals, including *Journal of the American Medical Association*, *The Lancet*, *American Journal of Cardiology*, *The New England Journal of Medicine*, *Circulation*, *Journal of Cardiopulmonary Rehabilitation, Yearbook of Medicine, Yearbook of Cardiology, Homeostasis, Journal of the American Dietetic Association, Hospital Practice, Cardiovascular Risk Factors, World Review of Nutrition and Dietetics, Journal of Cardiovascular Risk, Obesity Research, Journal of the American College of Cardiology,* and others.

In addition to these randomized controlled trials, Dr. Ornish has conducted three demonstration projects that confirmed these findings in over 2,000 patients throughout the U.S. The results from [my/our] institution and our patients are among those in these data sets. Our clinical and cost outcomes parallel those in the clinical trials. In the first demonstration project, Mutual of Omaha found that almost 80% of patients who were eligible for bypass surgery or angioplasty were able to safely avoid it for at least three years, saving almost $30,000 per patient in the first year. In the second demonstration project, Highmark Blue Cross Blue Shield found that their overall health care costs were reduced by 50% in the first year and by an additional 20-30% in subsequent years. We have also found that the Ornish Program achieved similar improvements in Medicare patients as in these earlier demonstration projects and randomized controlled trials.

I am writing to comment on the proposal regarding reporting of cardiac rehabilitation services under the physician fee schedule. I am pleased that CMS in its proposed rule recognized the need to clarify coding and payment for these services that can dramatically improve the health and quality of life for the growing numbers of Medicare beneficiaries with heart disease. However, I believe that CMS must do more to support the expanded use of cardiac rehabilitation programs – especially those with published, peer-reviewed research showing that they achieve quantifiable results.

I appreciate the time and effort CMS has dedicated to ensure that Medicare beneficiaries can participate in proven cardiac rehabilitation programs under the national coverage determination (NCD) issued last year.[2] Under that revised NCD, Medicare requires cardiac rehabilitation programs to provide a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education, and counseling. This contrasts markedly with the prior NCD for cardiac rehabilitation, under which only exercise was reimbursed by Medicare. In addition, the revised NCD contemplates contractors extending coverage, on a case-by-case basis, to 72 sessions. Under the former NCD, coverage of more than 36 sessions was highly exceptional, with contractors required to have significant documentation of the need for sessions beyond 36. By explicitly citing the Ornish program, in fact, the NCD made clear that it was the intention of CMS to provide coverage under Medicare for this program.

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[2] NCD for Cardiac Rehabilitation Programs, National Coverage Determinations Manual (CMS Pub. 100-3), § 20.10.

Without several further clarifications and modifications, however, we are concerned that Medicare's current reimbursement for cardiac rehabilitation services may make it difficult for providers to offer effective programs, such as the Ornish Program, to Medicare beneficiaries in a sustainable manner. As a provider of the Ornish Program, there are still certain specific steps that need to occur to ensure that beneficiaries have meaningful access to these programs, as intended by CMS in issues the NCD. I understand that Dr. Dean Ornish and the Preventive Medicine Research Institute (PMRI) has made several recommendations to CMS in regards to these steps.

I am pleased to see that in the Proposed Rule CMS proposes to implement one of PMRI's recommended steps by creating two new Level II Healthcare Common Procedure Coding System (HCPCS) G-Codes for cardiac rehabilitation services.[3] These codes are Gxxx1, Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per hour), and Gxxx2, Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per hour), and would replace the Current Procedural Terminology (CPT) codes, 93797 and 93798, respectively, for these services when billed under the Medicare physician fee schedule.[4] The G-codes would have the same descriptions as 93797 and 93798, except that they would apply to an hour of cardiac rehabilitation services instead of a "session."

I agree that this change will help to "clarify the coding and payment for these services"[5] by more accurately describing the services provided. Those furnishing cardiac rehabilitation will be able to use these codes to bill for one hour of a modality of cardiac rehabilitation identified in the NCD, such as prescribed exercise or education, rather than an undefined "session" of services. I support this proposal and we ask CMS to implement it in the final rule. I do however, respectfully request that the description in the payment tables included in the proposed rule be modified to ensure the Medicare fiscal intermediaries and carriers/Medicare Administrative Contractors (MACs) do not misinterpret the codes as requiring physician presence. To avoid any confusion or any unwarranted reading by MACs that immediate physician supervision is required for the provision of these services, the term "cardiac rehabilitation services", as has been used in previous payment tables in relation to the CPT codes 93797 and 93798, should be used in those tables in lieu of the term "physician services."

While I applaud CMS's proposal to create new G-codes, I believe that beneficiary access to proven cardiac rehabilitation programs will be limited unless CMS implements PMRI's other recommendations. First, I/we strongly urge CMS to state clearly and explicitly in the final rule that multiple sessions of cardiac rehabilitation can be covered on the same day. I believe that this was in fact CMS' intent in proposing the two new G-codes in the proposed rule. But a more explicit statement to this effect would go a long way toward avoiding any confusion in the future on the part of MACs, providers and beneficiaries. In the Ornish program, patients participate in several modalities of cardiac rehabilitation, such as a medical evaluation, prescribed exercise,

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3 72 Fed. Reg. at 38,419.

4 Id.

5 Id.

education, and counseling, in a single day. Providers of the program should be reimbursed for each hour of each modality a beneficiary receives. Fortunately, Medicare already has a mechanism to recognize when a code is billed multiple times in a single day for distinct services. Modifier 59 indicates that "a procedure or service was distinct and independent for other services performed on the same day."[6] CMS should facilitate payment for these services by clearly stating in the final rule that payment may be made for each session when modifier 59 is used and documentation in the patient's record explains that each use of the code represents an hour of a component of the cardiac rehabilitation program.

Second, CMS proposes to crosswalk the new G-codes to payment for 93797 and 93798, respectively. I recommend that both codes be cross-walked to payment for 93798 to ensure that Medicare reimbursement is adequate to support the full range of modalities provided in these programs. The non-exercise components of our program should be reimbursed at this higher payment rate, whether services are provided through a physician, clinic or hospital-based program. I believe that this higher payment rate would apply whether or not a patient needed EKG monitoring, as determined by the supervising physician. The rationale for making payments consistent across provider settings is that Medicare's payment rates under the physician fee schedule appear to have been calculated based only on the resources needed to provide supervised exercise—but not the other, more intensive components of the Ornish program and other similar programs. To allow the full range of programmatic elements specifically outlined in the NCD to be made available to patients in the physician office setting as well as the HOPD setting, these payments need to be consistent.

Third, I ask CMS to explain in the final rule that it is likely to be reasonable and necessary to cover 72 cardiac rehabilitation sessions when multiple sessions are provided in one day. The NCD gives contractors the discretion to cover up to 72 sessions of cardiac rehabilitation.[7] Unlike many cardiac rehabilitation programs in which "patients generally receive 2 to 3 sessions per week,"[8] which has traditionally been comprised of only exercise, in our program, patients typically receive multiple sessions per day, not just limited to exercise. When a beneficiary participates in a program of several one-hour sessions of various modalities in a single day, coverage of 72 sessions is necessary to provide enough hours of each modality for the patient to receive the full benefit of the program. By advising contractors that 72 sessions are likely to be reasonable and necessary for programs providing multiple sessions per day, CMS will ensure that the goals behind the revised, expanded NCD can be met. In view of the fact that 36 sessions – only of exercise – were covered under the prior NCD, it makes little sense to limit coverage to 36 sessions for programs such as Ornish. I ask CMS, in the final rule or other guidance, to remind contractors of their discretion to cover up to 72 sessions and to explain that 72 sessions are likely to be reasonable and necessary where beneficiaries receive cardiac

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6 American Medical Association, CPT 2007, at 438.

7 NCD for Cardiac Rehabilitation Programs, National Coverage Determinations Manual (CMS Pub. 100-3), § 20.10(D).

8 NCD for Cardiac Rehabilitation Programs, National Coverage Determinations Manual (CMS Pub. 100-3), § 20.10(B)(1)(a).

rehabilitation from programs that provide several one-hour sessions per day of the various modalities that are included in the cardiac rehabilitation NCD.

Finally, I ask CMS to encourage contractors to factor the proven results of a program into their coverage decisions. For example, 72 sessions should be presumptively covered when they are provided by a program, such as the Ornish program, with extensive peer-reviewed and published research showing that it achieves quantifiable results on important metrics, such as reductions in LDL-cholesterol, triglycerides, blood pressure, blood glucose, and weight, or that it affects the progression of coronary heart disease and/or reduces the need for bypass surgery, angioplasty, or stents and/or the need for medication. This consideration of a program's proven results would help to prevent over-utilization of programs that have not demonstrated positive results and is consistent with CMS's goals of furthering evidence-based medicine and improving actual health outcomes.

* * *

I greatly appreciate the opportunity to comment on the proposed changes to coding for cardiac rehabilitation services and to recommend additional changes that will help Medicare beneficiaries to receive the benefits of successful cardiac rehabilitation programs, such as the Ornish Program. Please feel free to contact me if you have any questions regarding these comments. Thank you for your attention to this very important matter.

Respectfully submitted,

David Seigneur, MS
Program Director
Dr. Dean Ornish Program for Reversing Heart Disease
Allegheny General Hospital
Phone: 412-359-3276
E-mail: dseigneu@wpahs.org

Submitter : Dr. Thomas Moody **Date:** 08/30/2007

Organization : Urology Centers of Alabama PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13181-Attach-1.DOC

#13181

Thomas Moody, M.D.
President
Urology Centers of Alabama, PC
3485 Independence Drive
Homewood, Al 35209

August 30, 2007

Sent via Electronic Mail to:

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1385– P
P.O. Box 8018
Baltimore, MD 21244– 8018.

Dear Mr. Kuhn:

I am a practicing Urologist and the President of Urology Centers of Alabama, PC an 18 physician medical group consisting urologists, radiologists, pathologists and radiation oncologists who practice in Birmingham, Homewood, Bessemer and Sylacauga Alabama. We are a private medical group and over 40% of our patients have Medicare as their primary insurance. We treat approximately 38,000 Medicare patients per year. Most of these patients are seen by us for the treatment of prostate, bladder and kidney cancer, BPH, urinary incontinence and erectile dysfunction. I am writing to comment on behalf of all of our physicians about the proposed changes to the Physician Fee Schedule rules that were published on July 12, 2007 concerning the Stark self-referral rule and the reassignment and purchased diagnostic tests rules.

As physicians, our primary concern is for our patients to get the best treatment possible and in such a way that makes it easy for them to comply. We decided to enter the medical field to treat sick patients and deciding what is the most appropriate treatment to heal or help the patient is the only reason that guides that decision. In the process we do make a legitimate profit just like any other business but it is not the reason we choose a particular treatment, nor should it be the reason used to deny a patient what we see as the best treatment option.

We see most of these proposed regulations as only addressing the cost issue and they fail to take into account the best treatment for the patient. In addition it appears that CMS is trying to impose regulations to limit financial relationships between physicians and other physicians, the hospital and other health care facilities when CMS has not shown any evidence of fraudulent billing, over-utilization, kickbacks, abusive billing patterns or any other program abuses. This is evidenced by the fact that the OIG has just finalized audits in 2007 of several pathology labs owned by Urologists which confirmed there were no abuses.

With respect to the In-Office Ancillary Service Exemption we feel no additional changes are needed. The current exemption allows the physician to provide needed services in their office. Physicians as a rule are willing to provide their patients with the most up to date technology and service whereas hospitals have not kept up to date. As an example we have invested over $5,000,000 to establish a radiation therapy area in our practice with a state of the art IGRT Varian Linear Accelerator. The local hospitals also offer radiation therapy but some of their equipment is over 10 years old and several generations out of date. These result in excess radiation exposure and do not provide the optimal treatment for patients.

We have established a urologic pathology lab for our patients and it is staffed by Pathologists who specializes in evaluating just urologic pathology specimens. By specializing in just urologic pathology, these pathologists will see and diagnosis thousands of urologic biopsies each year. They have more expertise and experience in urologic pathology than a local community pathologist that sees only a few hundred urologic specimens per year. This lab is set up in conjunction with other Urology practices in a centralized medical office building to aggregate and control our expenses and to provide access for our patients to the highest level of Urologic Pathology sub-specialization in the most economical manner. Our group purchased all of the equipment to operate this lab, in excess of $200,000, lease the building and has all the staff needed to process these specimens. We took considerable business risk to set up this laboratory and the result has been improved pathology service for our patients.

While it is true that the number of prostate biopsies and cores have increased over the past 3-4 years, this is not the result of Urologists establishing pathology pod labs. Instead prostate biopsy volume has increased due to (1) improved diagnostic capabilities of ultrasound to find early, curable cancer (2) Medicare and other insurances adding PSA screening which has led to a greater number of referrals with elevated PSAs and (3) the medical criteria for when to perform a biopsy has been lowered which resulted in a greater number of biopsies. None of these reasons are related to the fact the Urologist may have their own pathology lab and a pathologist in their medical group. Nor is the increase in volume due to the financial relationship or the location of the centralized building. CMS has not demonstrated that pathology "pod labs" increase utilization or costs to the Medicare program but instead is being manipulated by some large pathology organizations with vested interests to use regulations to resolve a turf battle between medical specialties. Our utilization of pathology services would be exactly the same and the cost to the Medicare program would be exactly the same if we were required to utilize an unknown third party pathologist

As proposed, our pathologist would not be paid the same amount as other pathologists who work under other arrangements. The allowance would not include any amount for overhead, medical equipment, computers, administrative support staff, billing, bad debt expense or any other expenses. There is no rationale for a pathologist in a Urology group or any other specialty group to be paid a lower allowance regardless of where he is she is located, or what type of building or the number of hours they work for that group. Deciding how a physician in a medical group is to be compensated is between the physician and the medical group. CMS has no justification for regulating these arrangements particularly when it has not been shown that the compensation arrangement results in abuse and extra

cost to the program. There is no rationale to establish a 2nd class physician with lower payments based solely on hours worked or the environment. By that rationale CMS could expand this to other medical specialties which will impinge on the patient – physician relationship and lower the quality of care available for the Medicare patient.

With respect to the proposed change for equipment lease exceptions based on a per unit of serviced basis, we are strongly opposed to this change. This proposal is contradictory to Congressional intent and to court rulings. There is no evidence of increased utilization under the per service lease for therapeutic services. At the same time these per unit of service type leases truly are the best indicator of fair market value since the facility is actually only paying for the service as needed rather than being obligated to pay a set lease payment regardless of whether the equipment is used to treat patients. Furthermore as previously discussed, leasing from physicians frequently enables the hospital to offer the patient with the most up to date technology with the costs shared rather than the cash starved hospital being required to make an outright purchase of costly equipment that is only partially utilized at any one location. Even in a large urban area such as Birmingham, we have encountered a for profit hospital that was unwilling to purchase a $350,000 Cryotherapy instrument yet they were willing to sign a per use lease with the physicians who were willing to put up the capital to purchase the instrument. This instrument offers both the kidney and prostate cancer patient an alternative treatment choice when more radical surgery is not option. Per unit of service for, therapeutic services such as lithotripsy, Cryotherapy, lasers have little risk of over utilization because they are therapeutic rather than diagnostic.

The sweeping changes to the Stark regulations and the reassignment and purchased diagnostic test rules go far beyond what is necessary to protect the Medicare program from fraud and abuse. These proposals have the potential to limit services, lower quality and decrease efficiencies for all health care providers. The rules should be revised to only prohibit those specific arrangements that are not beneficial to patient care.

Thank you for your consideration,

Thomas Moody, M.D.
President

CC: American Urological Association
Medical Group Management Association

Submitter : **Ms. Karen Clark** **Date: 08/30/2007**

Organization : **United Medical Solutions, Inc**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13183-Attach-1.DOC

CMS-1385-P-13183-Attach-2.TXT

#13183

United Medical Solutions, Inc.

"solutions for your medical billing needs"

August 29, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008.

Dear Ms. Norwalk:

Our organization provides billing services for the ambulance providers in the communities which we serve. The proposed rule would have a direct negative impact on our operations and the ability to effectively provide emergency transport services to Medicare beneficiaries. We believe this proposed rule will inappropriately provide incentives to seek signatures from patients who are in need of medical care and under mental duress. Additionally, this proposed rule could have a negative impact on wait times in the emergency department, impacting ambulance operations and the operations of emergency departments throughout the country. We therefore submit the following comments in objection to the proposed rule.

In summary, here are the points we would like you to consider:

- Beneficiaries under duress should not be required to sign anything;
- Exceptions where beneficiary is unable to sign already exist and should not be made more stringent for EMS billing;
- Authorization process is no longer relevant (no more paper claims, assignment now mandatory, HIPAA authorizes disclosures);
- Signature authorizations requirement should be waived for emergency encounters.

We understand that the proposed rule was inspired by the intention to relieve the administrative burden for EMS providers. However, the "relief" being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services, hospitals and their billers, and would result in shifting the payment burden to the patient if they fail to comply with the signature requirements at the time of transport. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for emergency ambulance services.

Current Requirement

When the beneficiary is physically or mentally incapable of signing, the industry has been following the requirements listed in the CMS Internet Only Manual, Pub. 100-02, Chapter 10, Section 20.1.2 and Pub. 100-04, Chapter 1, Section 50.1.6(A) (3) (c). These sections allow for a representative of the ambulance provider or hospital to sign on behalf of the beneficiary when the patient is unable to sign, document that the beneficiary was unable to sign, the reason and that no one could sign for the beneficiary.

The proposed rule directly conflicts with the existing rule. It requires that the provider representative sign **contemporaneously** with the transport and **seek an additional signature** from the hospital in the event a patient is unable to sign.

A BENEFICIARY UNDER DURESS SHOULD NOT BE REQUIRED TO SIGN ANYTHING IN ORDER TO QUALIFY FOR MEDICARE PAYMENT OF SERVICES

Emergency ambulance providers have no admission department and no registration desk. The same individuals responsible for providing medical care and transportation to the hospital are also responsible for fulfilling the administrative functions. All EMS encounters are emergency in nature and medically necessary ambulance transports in particular are stressful events on patients.

CMS has recognized this and modified its rules for obtaining Advance Beneficiary Notice and Acknowledgement of HIPAA Privacy Notices, creating exceptions that do not require ambulance crews to interrupt their service to seek a signature from a patient under their care.

In fact, CMS has deemed that all emergency encounters put the patient under great duress. Under such duress, patients would sign anything in order to get the care they require. Therefore, any signature obtained in an emergency situation cannot be relied upon.

Yet the proposed rule is so burdensome on ambulance crews that they will have every incentive to obtain a patients signature even though the patient is under mental duress. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

EXCEPTIONS WHERE BENEFICIARY IS UNABLE TO SIGN ALREADY EXIST AND SHOULD NOT BE MADE MORE STRINGENT FOR EMS

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. The proposed exception essentially mirrors the existing requirements that the beneficiary is unable to sign and that no authorized person was available or willing to

sign on their behalf, while adding additional documentation requirements. Therefore, we believe that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed sub-division (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, we do not object to the requirement that an ambulance provider obtain documentation of the date, time and destination of the transport. Nor do we object to the requirement that this item be maintained for 4 years from the date of service. However, we do not see any reason to include these in the Regulation, as they are already required and standard practice.

The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. Our organization **strongly objects** to this new requirement as:

- Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.
- Hospital personnel will often refuse to sign <u>any</u> forms when receiving a patient.
- If the hospital refuses to sign the form, it will be the beneficiary that will be responsible for the claim.
- The ambulance provider or supplier would in every situation now have the additional burden in trying to communicate to the beneficiary or their family, at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.
- Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ED Admitting Record, etc.

We also strongly object to the requirement that ambulance providers or suppliers obtain this statement from a representative of the receiving facility *at the time of transport*. Since the proposed rule makes no allowances for the inevitable situations where the ambulance provider makes a good faith effort to comply, but is ultimately unable to obtain the statement, we believe this requirement imposes an excessive compliance burden on ambulance providers and on the receiving hospitals. Consider what this rule requires—the ambulance has just taken an emergency patient to the ED, often overcrowded with patients, and would have to ask the receiving hospital to take precious time away from patient care to sign or provide a form. Forms such as an admission record will become available at a later time, if CMS wants them for auditing purposes in addition to the trip transport that will already include date, time and receiving facility.

THE AUTHORIZATION SIGNATURE PROCESS IS NO LONGER RELEVANT (NO MORE PAPER CLAIMS, ASSIGNMENT NOW MANDATORY, HIPAA AUTHORIZES DISCLOSURES)

Purpose of Beneficiary Signature

a. Assignment of Benefits –The first purpose of the beneficiary signature is to authorize the assignment of Medicare benefits to the health care provider or supplier. However, assignment of covered ambulance services has been mandatory since April 2002. Furthermore, 42 C.F.R. §424.55(c), adopted November 15, 2004 as part of the Final Rule on the Physician Fee Schedule (67 Fed. Reg. 6236), eliminated the requirement that beneficiaries assign claims to the health care provider or supplier in those situations where payment can only be made on an assignment-related basis. Therefore, the beneficiary's signature is no longer required to effect an assignment of benefits to the ambulance provider or supplier.

   CMS recognized this in the Internet Only Manual via Transmittal 643, by adding Section 30.3.2 to Pub. 100-04, Chapter 1. As a result, the beneficiary signature is no longer needed to assign benefits of covered ambulance services.

b. Authorization to Release Records – The second purpose of the beneficiary signature is to authorize the release of medical records to CMS and its contractors. However, the regulations implementing the HIPAA Privacy Rule, specifically 45 C.F.R. §164.506(c) (3), permit a covered entity (e.g. an ambulance provider or supplier) to use or disclose a patient's protected health information for the covered entity's payment purposes, without a patient's consent (i.e. his or her signature). Therefore, federal law already permits the disclosure of medical records to CMS or its contractors, regardless of whether or not the beneficiary's signature has been obtained.

Signatures Not Required for ABNs for Emergency Transports

The Third Clarification of Medicare Policy regarding the Implementation of the Ambulance Fee Schedule states that Advanced Beneficiary Notifications only be issued for non-emergency transports. The ABN's which require beneficiary signature "may not be used when a beneficiary is under great duress" which would include emergency transports. Would not the requesting of a Medicare Beneficiary's signature for any other reason during an emergency transport be less duress?

Signature Already on File

Almost every covered ambulance transport is to or from a facility, i.e. a hospital or a skilled nursing facility. In the case of emergency ambulance transports, the ultimate destination will always be a hospital. These facilities typically obtain the beneficiary's signature at the time of

admission, authorizing the release of medical records for their services *or any related services*. The term "related services", when used by hospitals and SNFs, can mean more than only entities owned by or part of the facility. The term already includes physicians providing services at the facility. We believe that ambulance transport to a facility, for the purpose of receiving treatment or care at that facility, constitutes a "related service", since the ambulance transports the patient to or from that facility for treatment or admission. Therefore, we believe a valid signature will be on file with the facility. Additionally, for those transports provided to patients eligible for both Medicare and Medicaid, a valid signature is on file at the State Medicaid Office as a product of the beneficiary enrollment process.

Electronic Claims

It is also important to note that, as a result of section 3 of the Administrative Simplification Compliance Act and the implementing regulations at 42 C.F.R. §424.32, with very limited exceptions (e.g. providers or suppliers with less than 10 claims per month), ambulance suppliers must submit claims electronically. Thus, the beneficiary does not even sign a claim form. When submitting claims electronically, the choices for beneficiary signature are "Y" or "N". An "N" response could result in a denial, from some Carriers. That would require appeals to show that, while the signature has not been obtained, an alternative is accepted. As a result, many Carriers allow a "Y", even though the signature was not actually obtained, if one of the exceptions is met.

While this may be a claims processing issue, because amendments to the regulation are now proposed, it would be appropriate to add language indicating that the signature requirement will be deemed to be met if one of the exceptions to the requirement exists.

Program Integrity

It is important for CMS to realize that, for every transport of a Medicare beneficiary, the ambulance crew completes a trip report listing the condition of the patient, treatment, origin/destination, etc. AND the origin and destination facilities complete their own records documenting the patient was sent or arrived via ambulance, with the date. These records are always available for audit or claims processing purposes, and are corroborated in the facility records for the patient admission. Thus, the issue of the beneficiary signature should not be a program integrity issue.

SIGNATURE AUTHORIZATIONS REQUIREMENT SHOULD BE WAIVED FOR EMERGENCY ENCOUNTERS.

Conclusion

Based on the above comments, it is respectfully requested that CMS:

- Amend 42 C.F.R. §424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that "good cause for ambulance services is

demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported."

- Amend 42 C.F.R. §424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
- Amend 42 C.F.R. §424.36(b) (5) to add "or ambulance provider or supplier" after "provider."

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

Thank you for your consideration of these comments.

Sincerely,

Karen L. Clark, VP
Director of Operations
United Medical Solutions, Inc.
PO Box 51906
Idaho Falls, ID 83405-1906
208-523-4906

Submitter : Dr. Byron Work **Date:** 08/30/2007

Organization : Atlantic Anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-13185-Attach-1.DOC

#13185

G. Byron Work, M.D.
3749 Lynnfield Dr.
Virginia Beach, VA 23452
(757) 340-6456

August 30, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation's seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation—a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully

and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

G. Byron Work, M.D.

Submitter : **Dr. Ray Bologna** **Date: 08/30/2007**

Organization : **Physicians Urology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13190-Attach-1.DOC

#13190

THE CONTINENCE CENTER
FEMALE PELVIC MEDICINE & RECONSTRUCTIVE PELVIC SURGERY
*UROGYNECOLOGY & GENERAL UROLOGY **
*FEMALE AND MALE *URINARY INCONTINENCE & VOIDING DYSFUNCTION*
ROBERT F. FLORA, M.D. RAYMOND A. BOLOGNA, M.D.* CHRISTOPHER M. ROONEY, M.D.

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385- P
P.O. Box 8018
Baltimore, MD 21244- 8018.

Dear Mr. Kuhn:
I am a urologist who practices in Akron, Ohio. I am fellowship trained in female urology and I am in a group of 12 urologists. I am writing to comment on the proposed changes to the physician fee schedule rules that were published on July 12, 2007 that concern the Stark self-referral rule and the reassignment and purchased diagnostic test rules.

Because of my specialty I see numerous patients over the age of 65 with bladder control problems. Many of my older patients have transportation problems and are dependent upon family members or community services. Often family members must take time off work to bring their family member to the office. We try to accommodate our patients with in office testing and services. I feel this improves the efficiency of their visit and care.

My father underwent treatment for prostate cancer with external beam radiation. Each day he would park in the hospital parking deck and walk at least 1 mile to the radiation center in the center of the hospital. Unfortunately, he has back problems and this became a burden. My group's prostate cancer treatment center was not open. If it was open, my father could have parked at the curb and walked 20 feet for his treatments.

I strongly feel that the ability for urologist to provide in office services such as IMRT, pathology and other testing enhances patient care, decreases cost and improves patient satisfaction.

The changes to the Stark regulations and the reassignment and purchased diagnostic test rules go far beyond what is necessary to protect the Medicare program from fraud and abuse. The rules should be revised to only prohibit those specific arrangements that are not beneficial to patient care.

Thank you for your consideration, please contact me if I can provide any further information.

95 Arch St. Ste. 165, Akron, Ohio 44303 Phone 330-434-0543, Fax 330-434-0599

THE CONTINENCE CENTER
FEMALE PELVIC MEDICINE & RECONSTRUCTIVE PELVIC SURGERY
*UROGYNECOLOGY & GENERAL UROLOGY **
*FEMALE AND MALE *URINARY INCONTINENCE & VOIDING DYSFUNCTION*
ROBERT F. FLORA, M.D. RAYMOND A. BOLOGNA, M.D.* CHRISTOPHER M. ROONEY, M.D.

Raymond A. Bologna, MD

95 Arch St. Ste. 165, Akron, Ohio 44303 Phone 330-434-0543, Fax 330-434-0599

Submitter : Dr. Paul Webster **Date:** 08/30/2007

Organization : Doctors' Pain Management

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1385-P-13202-Attach-1.DOC

#13202

Doctors' Pain Management Associates

PAUL S. WEBSTER, M.D.
Board Certified, American Board of Pain Medicine
Board Certified, American Board of Anesthesiology

Interventional Pain Medicine Specialists

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

Thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, "Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008" (the "Proposed Rule") published in the *Federal Register* on July 12, 2007. As requested, I have limited my comments to the issue identifiers in the Proposed Rule.

There are approximately 7,000 physicians practicing interventional pain management in the United States, of which I am one. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the "all physicians" crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians' ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. We are fast approaching the point where it is impractical to treat Medicare beneficiaries and maintain a viable practice. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries' access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional

pain or pain management as their primary Medicare specialty designation, as "interventional pain physicians" for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to "all physicians" for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. Interventional pain is an inter-disciplinary practice that draws on various medical specialties of anesthesiology, neurology, medicine & rehabilitation, and psychiatry to diagnose and manage acute and chronic pain. Many interventional pain physicians received their medical training as anesthesiologists and, accordingly, clinically view themselves as anesthesiologists. While this may be appropriate from a clinically training perspective, their Medicare designation does not accurately reflect their actual physician practice and associated costs and expenses of providing interventional pain services.

This disconnect between the Medicare specialty and their practice expenses is made worse by the fact that anesthesiologists have the lowest practice expense of any specialty. Most anesthesiologists are hospital based and do not generally maintain an office for the purposes of rendering patient care. Interventional pain physicians are office based physicians who not only furnish evaluation and management (E/M) services but also perform a wide variety of interventional procedures such as nerve blocks, epidurals, intradiscal therapies, implant stimulators and infusion pumps, and therefore have practice expenses that are similar to other physicians who perform both E/M services and surgical procedures in their offices.

Furthermore, the utilization rates for interventional pain and pain management specialties are so low that they are excluded from Medicare rate-setting or have very minimal affect compared to the high utilization rates of anesthesiologists. CMS utilization files for calendar year 2007 overwhelming report anesthesiologists compared to interventional pain physicians and pain management physicians as being the primary specialty performing interventional pain procedures. The following table illustrates that

anesthesiologists are reported as the primary specialty providing interventional pain services compared to interventional pain physicians

CPT Code	Anesthesiologists - 05 (Non-Facility)	Interventional Pain Management Physicians - 09 (Non-Facility)
64483 (Inj foramen epidural l/s)	59%	18%
64520 (N block, lumbar/thoracic)	68%	15%
64479 (Inj foramen epidural c/t)	58%	21%
62311 (Inject spine l/s (cd))	78%	8%

The high utilization rates of anesthesiologists (and their extremely low practice expenses) drive the payment rate for the interventional pain procedures, which does not accurately reflect the resource utilization associated with these services. This results in payment rates that are contrary to the intent of the Medicare system—physician payment reflects resources used in furnishing items and services to Medicare beneficiaries.

I urge CMS to make a modification to its practice expense methodology as it pertains to interventional pain services such that its methodology treats physicians who list anesthesiology as their primary specialty and list interventional pain as their secondary specialty designation as interventional pain physicians for rate-setting. This pool of physicians should be cross-walked to "all physicians" for practice expenses. This will result in a payment for interventional pain services that is more aligned with the resources and costs expended to provide these services to a complex patient population.

I urge CMS not to delay implementing our proposed recommendation to see if the updated practice expenses information from the Physician Practice Information Survey ("Physician Practice Survey") will alleviate the payment disparity. While I believe the Physician Practice Survey is critical to ensuring that physician services are appropriately paid, I do not believe that updated practice expense data will completely resolve the current underpayment for interventional pain services. The accurate practice expense information for interventional pain physicians will continue to be diluted by the high utilization rates and associated low practice expenses of anesthesiologists.

II. CMS Should Develop a National Policy on Compounded Medications Used in Spinal Drug Delivery Systems

We urge CMS to take immediate steps to develop a national policy as we fear that many physicians who are facing financial hardship will stop accepting new Medicare beneficiaries who need complex, compounded medications to alleviate their acute and chronic pain. Compounded drugs used by interventional pain physicians are substantially different from compounded inhalation drugs. Interventional pain physicians frequently use compounded medications to manage acute and chronic pain when a prescription for a customized compounded medication is required for a particular patient or when the prescription requires a medication in a form that is not commercially available. Physicians who use compounded medications order the medication from a compounding pharmacy. These medications typically require one or more drugs to be mixed or

reconstituted by a compounding pharmacist outside of the physician office in concentrations that are not commercially available (*e.g.*, concentrations that are higher than what is commercially available or multi-drug therapy that is not commercially available).

The compounding pharmacy bills the physician a charge for the compounded fee and the physician is responsible for paying the pharmacy. The pharmacy charge includes the acquisition cost for the drug ingredients, compounding fees, and shipping and handling costs for delivery to the physician office. A significant cost to the physician is the compounding fees, not the cost of drug ingredient. The pharmacy compounding fees cover re-packaging costs, overhead costs associated with compliance with stringent statutes and regulations, and wages and salaries for specially trained and licensed compounding Pharmacists bourn by the compounding pharmacies. The physician administers the compounded medication to the patient during an office visit and seeks payment for the compounded medication from his/her carrier. In many instances, the payment does not even cover the total out of pocket expenses incurred by the physician (*e.g.*, the pharmacy fee charged to the physician).

There is no uniform national payment policy for compounded drugs. Rather, carriers have discretion on how to pay for compounded drugs. This has lead to a variety of payment methodologies and inconsistent payment for the same combination of medications administered in different states. A physician located in Texas who provides a compounded medication consisting of 20 mg of Morphine, 6 of mg Bupivacaine and 4 of mg Baclofen may receive a payment of $200 while a physician located in Washington may be paid a fraction of that amount for the exact same compounded medication. In many instances, the payment to the physician fails to adequately cover the cost of the drug, such as the pharmacy compounded fees and shipping and handling. Furthermore, the claim submission and coding requirements vary significantly across the country and many physician experience long delays in payment.

We urge CMS to adopt a national compounded drug policy for drugs used in spinal delivery systems by interventional pain physicians. Medicare has the authority to develop a separate payment methodology for compounded drugs. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA") mandated CMS to pay providers 106% of the manufacturer's Average Sales Price ("ASP") for those drugs that are separately payable under Part B. The language makes clear that this pricing methodology applies only to the sale prices of manufacturers. Pharmacies that compound drugs are not manufacturers, and Congress never contemplated the application of ASP to specific drug compounds created by pharmacies. Accordingly, CMS has the discretion to develop a national payment policy.

We believe that an appropriate national payment policy must take into account all the pharmacy costs for which the physicians are charged: the cost of the drug ingredient, the compounding fee costs, and the shipping and handling costs. We stand ready to meet with CMS and its staff to discuss implementing a national payment policy.

III. CMS Should Incorporate the Updated Practice Expenses Data from Physician Practice Survey in Future Rule-Making

I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

IV CMS Should Work Collaboratively with Congress to Fix the SGR Formula so that Patient Access will be preserved.

The sustainable growth rate ("SGR") formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

Because of the flawed formula, physicians and other practitioners disproportionately bear the cost of providing health care to Medicare beneficiaries. Accordingly, many physicians face clear financial hardship and will have to make painful choices as to whether they should continue to practice medicine and/or care for Medicare beneficiaries.

CMS should work collaboratively with Congress to create a formula that bases updates on the true cost of providing healthcare services to Medicare beneficiaries.

Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

Paul S. Webster, MD
825 E Oak Street
Kissimmee, Florida 34744
(321) 442-8009

Submitter : Saboora Chaudhry **Date:** 08/30/2007

Organization : Saboora Chaudhry

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#13205

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Dr. M. Joshua Haber **Date:** 08/30/2007

Organization : Dr. M. Joshua Haber

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008

PLEASE SEE ATTACHMENT

CMS-1385-P-13209-Attach-1.DOC

#13209

M. JOSHUA HABER, MD
P.O. Box 2281
Walnut Creek, California, 94595-0281
925-817-8544; mj97701@yahoo.com

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, "Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008" (the "Proposed Rule") published in the *Federal Register* on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.

There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the "all physicians" crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians' ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries' access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional

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925-817-8544; mj97701@yahoo.com

pain or pain management as their primary Medicare specialty designation, as "interventional pain physicians" for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. **CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.**

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to "all physicians" for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. Interventional pain is an inter-disciplinary practice that draws on various medical specialties of anesthesiology, neurology, medicine & rehabilitation, and psychiatry to diagnose and manage acute and chronic pain. Many interventional pain physicians received their medical training as anesthesiologists and, accordingly, clinically view themselves as anesthesiologists. While this may be appropriate from a clinically training perspective, their Medicare designation does not accurately reflect their actual physician practice and associated costs and expenses of providing interventional pain services.

This disconnect between the Medicare specialty and their practice expenses is made worse by the fact that anesthesiologists have the lowest practice expense of any specialty. Most anesthesiologists are hospital based and do not generally maintain an office for the purposes of rendering patient care. Interventional pain physicians are office based physicians who not only furnish evaluation and management (E/M) services but also perform a wide variety of interventional procedures such as nerve blocks, epidurals, intradiscal therapies, implant stimulators and infusion pumps, and therefore have practice expenses that are similar to other physicians who perform both E/M services and surgical procedures in their offices.

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Furthermore, the utilization rates for interventional pain and pain management specialties are so low that they are excluded from Medicare rate-setting or have very minimal affect compared to the high utilization rates of anesthesiologists. CMS utilization files for calendar year 2007 overwhelming report anesthesiologists compared to interventional pain physicians and pain management physicians as being the primary specialty performing interventional pain procedures. The following table illustrates that anesthesiologists are reported as the primary specialty providing interventional pain services compared to interventional pain physicians

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I urge CMS not to delay implementing our proposed recommendation to see if the updated practice expenses information from the Physician Practice Information Survey ("Physician Practice Survey") will alleviate the payment disparity. While I believe the Physician Practice Survey is critical to ensuring that physician services are appropriately paid, I do not believe that updated practice expense data will completely resolve the current underpayment for interventional pain services. The accurate practice expense information for interventional pain physicians will continue to be diluted by the high utilization rates and associated low practice expenses of anesthesiologists.

II. CMS Should Develop a National Policy on Compounded Medications Used in Spinal Drug Delivery Systems

M. JOSHUA HABER, MD
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Walnut Creek, California, 94595-0281
925-817-8544; mj97701@yahoo.com

We urge CMS to take immediate steps to develop a national policy as we fear that many physicians who are facing financial hardship will stop accepting new Medicare beneficiaries who need complex, compounded medications to alleviate their acute and chronic pain. Compounded drugs used by interventional pain physicians are substantially different from compounded inhalation drugs. Interventional pain physicians frequently use compounded medications to manage acute and chronic pain when a prescription for a customized compounded medication is required for a particular patient or when the prescription requires a medication in a form that is not commercially available. Physicians who use compounded medications order the medication from a compounding pharmacy. These medications typically require one or more drugs to be mixed or reconstituted by a compounding pharmacist outside of the physician office in concentrations that are not commercially available (*e.g.*, concentrations that are higher than what is commercially available or multi-drug therapy that is not commercially available).

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We urge CMS to adopt a national compounded drug policy for drugs used in spinal delivery systems by interventional pain physicians. Medicare has the authority to develop a separate payment methodology for compounded drugs. The Medicare

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Walnut Creek, California, 94595-0281
925-817-8544; mj97701@yahoo.com

Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA") mandated CMS to pay providers 106% of the manufacturer's Average Sales Price ("ASP") for those drugs that are separately payable under Part B. The language makes clear that this pricing methodology applies only to the sale prices of manufacturers. Pharmacies that compound drugs are not manufacturers, and Congress never contemplated the application of ASP to specific drug compounds created by pharmacies. Accordingly, CMS has the discretion to develop a national payment policy.

We believe that an appropriate national payment policy must take into account all the pharmacy costs for which the physicians are charged: the cost of the drug ingredient, the compounding fee costs, and the shipping and handling costs. We stand ready to meet with CMS and its staff to discuss implementing a national payment policy.

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I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

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CMS should work collaboratively with Congress to create a formula that bases updates on the true cost of providing healthcare services to Medicare beneficiaries.

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Walnut Creek, California, 94595-0281
925-817-8544; mj97701@yahoo.com

***

Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

M. Joshua Haber, MD

Submitter : **Dr. Dennis Chen** **Date: 08/30/2007**

Organization : **CAA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13215-Attach-1.DOC

#13215

08/30/2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation's seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation—a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Dennis Chen, M.D.
925 E. San Antonio Dr. # 16

Long Beach, Ca 90807

Submitter : Ms. Wendy Biedrzycki **Date:** 08/30/2007

Organization : AANA

Category : Individual

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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,
__Wendy Biedrzycki CRNA_____
Name & Credential
_750 Hoffman Drive_____
Address
___Harrisburg, Pa.17111_____
City, State ZIP

Submitter : Dr. Grace Elta **Date:** 08/30/2007

Organization : American Society for Gastrointestinal Endoscopy (A

Category : Physician

Issue Areas/Comments

TRHCS--Section 101(b): PQRI

TRHCS--Section 101(b): PQRI

See attachment.

CMS-1385-P-13217-Attach-1.PDF

#13217

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Web site: www.asge.org

OFFICE OF THE PRESIDENT
GRACE H. ELTA, MD, FASGE
University of Michigan
E-mail: gelta@umich.edu
734/936-4775 – Phone
734/936-7392 - Fax

August 30, 2007

Mr. Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
7500 Security Boulevard
Baltimore, MD 21244-8018

Re: CMS 1385-P--Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for CY 2008, TRHCA-Section 101(b): PQRI

Dear Director Kuhn:

The American Society for Gastrointestinal Endoscopy (ASGE) would like to submit the following comments in addition to the comments submitted with the American College of Gastroenterology (ACG) and the American Gastroenterological Association (AGA). We appreciate and are supportive of the work put forth by the Centers for Medicare and Medicaid Services (CMS) to improve the quality of care for Medicare beneficiaries. In that spirit the comments below focus on the Physician Quality Reporting Initiative (PQRI) provisions in the proposed rule.

ASGE compliments the efforts of CMS to implement the Physician Quality Reporting Initiative (PQRI). In a very short time period the Agency has helped to shepherd the development of numerous measures, implement a complex new program, and conduct a national educational initiative. CMS outreach staff has been very responsive and generous with their time by responding quickly to questions and requests for information and clarification on the program. We especially appreciated the outreach staff's willingness to conduct an educational conference call exclusively for our membership as they have done for many other medical specialty societies. We found it to be highly successful and beneficial to our members.

As a specialty whose measures are still being developed we are especially concerned with the measure development process. ASGE strongly supports the

concept of a voluntary consensus standards body, which is the foundation of the PQRI program. Having a body with broad membership, openness, balance of interest and a defined voting process will ensure the integrity of the program and provide the best promise of ensuring the development of measures that reflect the best of current scientific knowledge and practice.

Two consensus organizations were referenced in the legislation: the National Quality Forum (NQF) and the AQA. In regards to the 2008 measures, the proposed regulations state, "...we propose to limit measures that are endorsed or adopted by NQF or AQA."

ASGE strongly believes that the NQF, through their formal organization and methodological consensus process, meets the criteria for a consensus organization. While the AQA has many of the characteristics of a consensus body it fails to meet all the criteria. The proposed rule states, "However, the AQA does not have a defined organizational structure intended to meet the requirements of the NTTAA and the OMB A-119 and has no formal due process or appeals structure. Therefore, the AQA does not meet the requirements of the NTTAA for a 'voluntary consensus standards body.'" We agree with this statement and feel that this lack of a formal process or appeals structure makes it impossible for the AQA to function as a consensus body.

The current role that AQA plays in this process adds bureaucracy and confusion to the measure development process with little appreciable benefit. For example, since as indicated in the proposed regulation, AQA adoption is withdrawn when the NQF fails to endorse a particular measure we are confused as to the value AQA adds to the measure development process. The resources societies and other stakeholders invest in preparing for the NQF and AQA approval process is considerable. We believe that these efforts are better focused on the NQF approval process.

ASGE recommends that CMS limit recognized consensus organizations to the NQF. As stated in the proposed rule, "As currently established, the principal purpose of AQA for physician quality measures is to select among NQF endorsed measures for coordinated implementation." We urge CMS to limit the role of AQA to such activities.

ASGE appreciates the opportunity to provide continued input on this important issue. Thank you once again for your attention to our comments. If you have any questions or need additional information, please contact Mr. Randy Fenninger, of MARC Associates. He can be reached at 202-833-0007 or randy@marcassoc.com. Thank you in advance for your consideration.

Sincerely yours,

Grace H. Elta, M.D.

Grace Elta, MD, FASGE
President
American Society for Gastrointestinal Endoscopy (ASGE)

Submitter : **Ms. Heidi Herbst Paakkonen** **Date: 08/30/2007**

Organization : **Arizona Board of Physical Therapy**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-13218-Attach-1.PDF

#13218

ARIZONA STATE BOARD OF PHYSICAL THERAPY
1400 WEST WASHINGTON, SUITE 230 PHOENIX, ARIZONA 85007
(602) 542-3095 Fax (602) 542-3093
www.ptboard.state.az.us

August 30, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-1850

Re: CMS-1385-P
THERAPY STANDARDS AND REQUIREMENTS

Dear Sir or Madam:

The Arizona Board of Physical Therapy met today and voted to submit the following comments on the proposed rules changing the definition of "physical therapist" in Section 484, Title 42 of the Code of Federal Regulations. The proposed rules are part of the 2008 Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 2008, found in Volume 72 of the Federal Register, published on July 12, 2007.

Under subsection (i)(B) and (ii)(B) of the proposed definition of "physical therapist" an applicant would need to have "[p]assed the National Examination approved by the American Physical Therapy Association." We strongly suggest that CMS rely on state licensure and that the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist" be deleted from the final rule. At the very least, the Centers for Medicare and Medicaid Services ("CMS") should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We, along with all of the other state boards of physical therapy examiners, have already adopted a national qualifying exam for physical therapists, the National Physical Therapy Examination ("NPTE"). The Federation of State Boards of Physical Therapy ("FSBPT") develops and administers the NPTE in close collaboration with the state boards. Working together, we have developed a national passing score. The FSBPT has done an outstanding job of meeting our needs. Likewise, the NPTE has been a valuable tool in screening physical therapist applicants. Through the NPTE, we have been able to successfully filter applicants. In turn, we, as a policing body, have been able to protect the public by ensuring that only qualified therapists are licensed care for our citizens.

CMS should not usurp the states' function of licensing physical therapists and other professionals. Health care professional credentialing and licensing is a classically state function. Licensing and credentialing are the domain of the states. CMS' proposal would inappropriately transform a state function into a federal function. There is no justification for this action, and CMS should prevent it by removing the proposed rule.

CMS respects states' rights and state licensure for other health care professions, and it should continue to do so with respect to physical therapists. For example, CMS' regulations define a physician as a "doctor of medicine ... legally authorized to practice medicine and surgery by the State in which such function or action is performed." 42 C.F.R. § 484.4 (2006). Likewise, a registered nurse is defined as "[a] graduate of

an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing." 42 C.F.R. § 484.4. Establishing requirements that are different than what the states require for licensing PTs would be inconsistent with not only the rights of the states, but also CMS' own standards.

Moreover, the federal government should not impose an additional burden on the states, particularly since its stated desire for a national examination already satisfied and its other stated goals would not be better met by the burden it proposes to impose. The proposed unfunded mandate could result in the development of a second exam, which would create confusion and more work for the states, without benefit. Our resources are already limited and stretched.

In the preamble to the proposed regulations, CMS says that it is seeking uniformity. The fact of the matter is that uniformity and consistency across the nation and across provider settings already exists. State licensing requirements apply to physical therapists without regard to where they practice. All states accept CAPTE accreditation. All states accept the NPTE and have adopted the same passing score. No federal regulation is required.

In fact, the proposed regulations would likely defeat CMS' own goal of uniformity. If, for example, the APTA were to approve a different exam than the NPTE, which the regulations would permit it to do, physical therapists, patients, including Medicare and Medicaid beneficiaries and recipients, and others could face substantial confusion and interruption of service. As a state board of physical therapy examiners, we would continue to have authority to select an exam of our choice for licensing purposes. However, under the proposed rule, a physical therapist would have to pass a second exam approved by the APTA to qualify for Medicare reimbursement. Thus, patients might be forced to change physical therapists as they become Medicare or Medicaid eligible, and the current uniformity and continuity of standards across the country would be lost. Thus, the proposed rules undermine CMS' ambition for uniformity of standards.

CMS and the federal government should not empower an advocacy group, like the APTA, to establish an examination or any qualifications for professionals to provide healthcare services to patients. The APTA's mission is to advocate and promote the profession. As a licensing body, our mission is to ensure that physical therapists are qualified to provide physical therapy services and are authorized to do the work for which they are trained. The FSBPT, the organization to which we look for the national licensing exam, was created to eliminate, protect against and prevent the inherent conflict of interest that the APTA would have if it were to have authority over the examination and credentialing processes. Even the APTA recognized this conflict of interest problem two decades ago when it created the Federation of State Boards of Physical Therapy. CMS must not allow this conflict of interest to become a rule.

The Arizona Board of Physical Therapy strongly urges CMS to require only state licensure. Most importantly, CMS should remove the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist." At a minimum , CMS should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We appreciate the opportunity to comment on the proposed rules regarding physical therapist and physical therapy assistant qualification requirements.

Regards,

Heidi Herbst Paakkonen
Executive Director

Submitter : **Ms. KAthleen Boyd** **Date: 08/30/2007**

Organization : **University Of Massachusetts**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name Is Kathleen A. Boyd and I am a certified Liscensed Athletic Trainer with a Masters Degree From Southern Illinois University. I have been employed as an Athletic Trainer for more than 30 years the last 18 for the University of Massachusetts at Amherst.
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,

Kathleen A. Boyd MS, ATC LAT

Submitter : **Dr. Reza Abusaidi** **Date: 08/30/2007**

Organization : **San Mateo Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

TECHNICAL CORRECTIONS
CMS-1385-P
Please abolish the recommendation that reimbursement would no longer be allowed for X-rays taken by a non-treating physician such as a radiologist and used by a Doctor of Chiropractic to determine a subluxation.

Submitter : Dr. Jan GUFFEY **Date:** 08/29/2007

Organization : Back to Health Chiropractic

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Changing of this CMS-1385-P not allowing Chiropractors to refer to Radiologist for Xrays when necessary is a crime against the medicare clint and the doctor. This will cost patient's to have a delay in treatment, potentially unneccessary suffering, and aggravation. Chiropractor's need to take care of their patient without inderhence. Chiropractor's on a whole save medicare money there treatments are conservative we make diagnosis without a 101 different tests or sending the patient to several specialists, and in general our patients to better without all the drugs and tests.

Submitter : Dr. Matthew Wallace **Date:** 08/30/2007

Organization : Dr. Matthew Wallace

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 : **Date: 08/30/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Colleen Nolan** **Date: 08/30/2007**

Organization : **Cape Cod Healthcare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Colleen Nolan and I am a Certified Athletic Trainer from Massachusetts. I have been a Certified Athletic Trainer since 1994 and I have worked in several areas of sports: collegiate, secondary and semi-professional. In each instance I found that having a Certified Athletic Trainer accessible has made a profound impact on the athletes, coaches and parents.

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,

Colleen Nolan,MS,ATC,CSST

Submitter : **Miss. Amy Christiaens** **Date: 08/30/2007**

Organization : **Apex Physical Therapy**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician Self-Referral Issues
August 30, 2007
Mr. Kerry N. Weems
Administrator Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule
Dear Mr. Weems:
I am an independent physical therapist in the Spokane area of Washington State, and I wish to comment of the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception. These comments are intended to highlight the abusive nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.
I have been a co-owner of a private, outpatient physical therapy clinic since 1998. During this time, our clinic has had a good working relationship with the local physicians and referral source; however, in the past 2 years, these local physicians have begun their own physical therapy clinics and have forced their patients to utilize only those services.
Examples of abusive arrangements our clinic has noted include patients who are encouraged strongly by their physician or health care provider to attend physical therapy only at the physician s physical therapy clinic. A frustrated Medicare patient told me that he was encouraged strongly to attend physical therapy at the physician s owned clinic which was approximately a 30 minute drive from his home. Unfortunately, there are eleven independent physical therapy clinics within five to fifteen minutes from this patient s home. The patient refused to drive 30 minutes and the physician s staff reluctantly gave this patient our clinic s name. Another patient seen by the same physician group was instructed that further testing, to include x-rays, was being delayed because our clinic documentation was not readily available. She was also told that had she attended physical therapy at the physician s physical therapy clinic the delay would not have occurred. This statement was misleading, because all clinical documentation was available to the physician and was located in the patient s chart which was located in the exam room.
Many patients do not know that they have a choice as to the physical therapy clinic that they attend. Patients who already have a history or a relationship established with a certain clinic have been told that the physician would prefer that they discontinue that relationship and attend therapy at the physician s physical therapy clinic. The inability to attend physical therapy at a clinic of the patient s choosing is poor care and is abusive.
I do feel the in-office ancillary services is defined so broadly in the regulations that it facilitates the creation of abusive referral arrangements. Because of Medicare s referral requirements, these local physicians have a captive referral base of physical therapy patients in their offices.
I would like to thank you for your consideration into this matter. I hope that these issues can be resolved in the Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule.
Sincerely,

Amy K. Christiaens, PT, OCS
Apex Physical Therapy, PLLC
1951 1st St.
Cheney, WA 99004

Submitter : **Mr. MacKenzie McDonald** **Date: 08/30/2007**

Organization : **University of Tennessee**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is MacKenzie McDonald, and I am a Certified Athletic Trainer at the University of Tennessee at Chattanooga. In this position, I work with both our Division I Men's Basketball team, and teach in our athletic training education program. I received my certification to practice after earning a Bachelor of Science degree and furthered my professional education by getting a Master of Science in Advanced Athletic Training. I work with both the sick and the healthy providing state of the art care in the areas of rehabilitation, conditioning, and injury care.

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,

MacKenzie L. McDonald,MS, ATC, LAT

Submitter : **Mr. James Young** **Date: 08/30/2007**

Organization : **American Assiciation of Nurse Anesthetists**

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.

Submitter : **Mr. Brad Shores** **Date: 08/30/2007**

Organization : **Foot Fitness Plus**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an owner of a DME supplier in the state of Massachusetts. My certification are License Certified Athletic Trainer, Board Ceritified Orthotics, and A Certified Pedorthist. I have worked in Professional Baseball for 6 years, and Physical Therapy clinics for 10 years, now I make custom molded orthotics along with bracing.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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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,

Brad Shores, ATC,BOCO,CPed

Submitter : **Ms. Gina DiCrocco** **Date: 08/30/2007**

Organization : **Franklin Memorial Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer who has worked in a hospital physical therapy outpatient clinic for over 10 years. In addition to my national athletic training certification and State of Maine athletic trainer license, I hold a Master's degree in Exercise Science from Auburn University. Athletic Training is my chosen career and profession, I have worked in high schools in Maine for more then 12 years, all of which time has through a hospital based physical therapy outpatient clinic. In 2006 I conducted a survey in the State of Maine which revealed that more than 80% of the high schools that provided athletic training services to their students, obtained those services by outsourcing from hospital clinics or other therapy clinics. High schools in Maine rely heavily on the support from hospitals to provide a much needed and extremely hard to find healthcare service.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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Sincerely,

Gina DiCrocco, MEd, LATC

Submitter : **Date: 08/30/2007**

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.

Chandrappa Balikai, M.D

Submitter : **Mrs. Ellen Young** **Date: 08/30/2007**

Organization : **American Association of Nures Anesthetists**

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:

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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).
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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.

Submitter : **greg marino** **Date: 08/30/2007**

Organization : **Anesthesia Associates Inc**

Category : **Physician** .

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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Submitter : Mr. Conn Wittwer **Date:** 08/30/2007

Organization : Apex Physical Therapy

Category : Health Care Provider/Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician Self-Referral Issues
August 30, 2007
Mr. Kerry N. Weems
Administrator Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule
Dear Mr. Weems:
I am an independent physical therapist in the Spokane area of Washington State, and I wish to comment of the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception. These comments are intended to highlight the abusive nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.
I am a physical therapist who is currently working for a privately owned outpatient clinic. In my experience competition improves quality and efficiency of care. A physician-owned clinic eliminates this healthy competition and therefore does not serve the best interests of the patient.
Examples of abusive arrangements our clinic has noted include patients who are encouraged strongly by their physician or health care provider to attend physical therapy only at the physician s physical therapy clinic. A frustrated Medicare patient told me that he was encouraged strongly to attend physical therapy at the physician s owned clinic which was approximately a 30 minute drive from his home. Unfortunately, there are eleven independent physical therapy clinics within five to fifteen minutes from this patient s home. The patient refused to drive 30 minutes and the physician s staff reluctantly gave this patient our clinic s name. Another patient seen by the same physician group was instructed that further testing, to include x-rays, was being delayed because our clinic documentation was not readily available. She was also told that had she attended physical therapy at the physician s physical therapy clinic the delay would not have occurred. This statement was misleading, because all clinical documentation was available to the physician and was located in the patient s chart which was located in the exam room.
Many patients do not know that they have a choice as to the physical therapy clinic that they attend. Patients who already have a history or a relationship established with a certain clinic have been told that the physician would prefer that they discontinue that relationship and attend therapy at the physician s physical therapy clinic. The inability to attend physical therapy at a clinic of the patient s choosing is poor care and is abusive.
I do feel the in-office ancillary services is defined so broadly in the regulations that it facilitates the creation of abusive referral arrangements. Because of Medicare s referral requirements, these local physicians have a captive referral base of physical therapy patients in their offices.
I would like to thank you for your consideration into this matter. I hope that these issues can be resolved in the Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule.
Sincerely,

Conn Wittwer, PT, DPT, CSCS
Apex Physical Therapy, PLLC
1951 1st St.
Cheney, WA 99004

Submitter : **Mr. Jeffrey Rounds** **Date: 08/30/2007**

Organization : **Mr. Jeffrey Rounds**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I work for Decatur Memorial Hospital Sports Medicine and Physical Therapy in Decatur, Illinois as part of their outreach program. I am a certified/licensed athletic trainer who treats patients and cares for athletes at a local high school. I have a masters degree and ten years experience at my current job.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jeffrey B. Rounds, M.S., ATC/L

Submitter : **Ms. Ursula Vollkommer** **Date: 08/30/2007**

Organization : **Waynflete School**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Ursula Vollkommer, I am a Certified Athletic Trainer living and working in Maine. I currently work in a private school and soon will start working in an outpatient physical therapy clinic.

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,

Ursula Vollkommer,MS LATC

Submitter : **Dr. Katya Hernandez** **Date: 08/30/2007**

Organization : **Dr. Katya Hernandez**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Jose Dominguez** **Date: 08/30/2007**

Organization : **Physicians Anesthesia Associates, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Jose E. Dominguez, M.D.

Submitter : **Dr. Joseph Floyd** **Date: 08/30/2007**

Organization : **Dr. Joseph Floyd**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Joseph B. Floyd,M.D.

Submitter : **Mrs. Susan Haskell** **Date: 08/30/2007**

Organization : **Mrs. Susan Haskell**

Category : **Individual**

Issue Areas/Comments

Impact

Impact

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Ms. Jamie Lambert** **Date: 08/30/2007**

Organization : **University of Delaware**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Jamie Lambert, and I am a recently certified and licensed Athletic Trainer. I graduated from Springfield College with a Bachelors of Science with my focus of study being Athletic Training, and am currently seeking my Master s degree at the University of Delaware. Currently I serve as a graduate assistant for the University of Delaware, and provide athletic health care to the teams of John Dickinson High School in Wilmington.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jamie Lambert, ATC

Submitter : **Mrs. Shirley Mayes** **Date: 08/30/2007**

Organization : **Mrs. Shirley Mayes**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Michael Hulton** **Date: 08/30/2007**

Organization : **Daly City Anesthesia Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Ms. M. Carolina Hinestrosa **Date:** 08/30/2007

Organization : National Breast Cancer Coalition Fund

Category : Consumer Group

Issue Areas/Comments

TRHCS--Section 101(b): PQRI

TRHCS--Section 101(b): PQRI

See Attachment.

CMS-1385-P-13243-Attach-1.PDF

#13243

NBCCF

NATIONAL BREAST CANCER COALITION FUND

grassroots advocacy in action

August 30, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P; TRHCA – SECTION 101(b): PQRI

To Whom It May Concern:

The National Breast Cancer Coalition Fund (NBCCF) appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services proposed rule on *Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions* **[CMS-1385-P; TRHCA – SECTION 101(b): PQRI]**.

The document places so much emphasis on NQF-endorsed measures, NBCCF is surprised that not all of the recently endorsed breast cancer measures were included in the PQRI set.

The CMS proposed rule emphasizes the importance of using endorsed measures. NBCCF is surprised that two of the recently NQF-endorsed breast cancer measures are not included in the 2007 PQRI measure set. The two NQF-endorsed measures not in the set are:

- Combination chemotherapy considered or administered within 4 months of diagnosis for women under the age of 70 with AJCC T1c, Stage II or Stage III hormone receptor negative breast cancer
- College of American Pathologists Breast Cancer Protocol

NBCCF strongly believes that these two NQF-endorsed accountability measures should also be included by CMS in the 2008 PQRI quality measure set.

The National Breast Cancer Coalition Fund is a grassroots organization dedicated to ending breast cancer through the power of action and advocacy. The Coalition's main goals are to increase federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; improve access to high quality health care and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates in all aspects of the breast cancer decision making process.

We hope you take these comments into consideration, and we look forward to reviewing the final rule. Please feel free to contact us with any questions or concerns.

Sincerely,

M. Carolina Hinestrosa, MA, MPH
Executive Vice President, Programs & Planning

1101 17th Street, NW, Suite 1300, Washington, DC 20036 Phone: (202) 296-7477 Fax: (202) 265-6854 http://www.stopbreastcancer.org

Submitter : **Dr. Jeremy Kukafka** **Date: 08/30/2007**

Organization : **UNiversity of Pennsylvania, Dept Anesthesiology an**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Anne Hill** **Date: 08/30/2007**

Organization : **Ms. Anne Hill**

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Anne Hill and I am certified athletic trainer attempting to assist in the medical field with continued care of the active population. Graduating from Minnesota State University, Mankato, one of the longest credentialed colleges preparing students with an athletic training major for the national certification exam, has provided me with a strong base of medical knowledge. One specific topic we were requested to research, included the examination of a medical team. Upon the education I received, I would like to point out the important role athletic trainers play in this essential team to the active population, and by active I would like to include all ages and life-style types.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

Anne P. Hill, ATC, ATR

Submitter : Dr. usha sen **Date:** 08/30/2007

Organization : resource anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

payment should increase

Submitter : **Miss. Rebecca Haskell** **Date: 08/30/2007**

Organization : **Miss. Rebecca Haskell**

Category : **Individual**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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In my own area of practice on California's central coast, we have experienced a great deal of difficulty recruiting and retaining anesthesiologists as our average reimbursements are low due to a relatively large Medicare population.
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,

Brian Robertson, M.D.

Submitter : **Mr. Sam Colgate** **Date: 08/30/2007**

Organization : **Mr. Sam Colgate**

Category : **Individual**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Submitter : **Mr. Aaron Boggs** **Date: 08/30/2007**

Organization : **Coordinated Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Aaron Boggs. I am a Certified Athletic Trainer for a large orthopedic and rehabilitation center with our own ambulatory surgery center. I have held a state license to practice Athletic Training for 10 years in the state of Pennsylvania.

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,

Aaron Boggs, MA, ATC

Submitter : **Dr. Angela Amin** **Date: 08/30/2007**

Organization : **UTMB-Galveston**

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 : **Mr. Ross Blomme** **Date: 08/30/2007**

Organization : **Mr. Ross Blomme**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Ross Blomme and I am a student at Mankato State University Mankato in the Athletic Training Program.

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 would be qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Ross Blomme, ATC Student

Submitter : **Mrs. Jessica Haskell** **Date: 08/30/2007**

Organization : **Mrs. Jessica Haskell**

Category : **Individual**

Issue Areas/Comments

Background

Background

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : Mr. Justin Cobb **Date:** 08/30/2007

Organization : Mr. Justin Cobb

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an athletic trainer and certified strength and conditioning specialist, who has just recieved my Masters degree in physical therapy.

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,
Justin Cobb, ATC/LAT,CSCS

Submitter : **Anna Johnson** **Date: 08/30/2007**

Organization : **Fairview Lakes Health Services**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer working in the state of Minnesota. I have gone to great lengths to serve and care for my patients and students in a clinic setting and at a local high school. I typically see anywhere from 20-30 students in an afternoon with needs ranging from pre-participation preparations to emergency care of athletic injuries to rehabilitation of said injuries.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

Anna Johnson, ATC, EMT-B

Submitter : Mrs. Cathy Aron **Date:** 08/30/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.

ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.

ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.

ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Cathy Aron, CRNA
37W386 Maryhill Lane
Elgin, IL 60124

Submitter : **Mr. Brandon Haskell** **Date: 08/30/2007**

Organization : **Mr. Brandon Haskell**

Category : **Individual**

Issue Areas/Comments

Background

Background

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. John McWilliams** **Date: 08/30/2007**

Organization : **Bellingham Physical Therapy, LLC**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

John E. McWilliams, Jr., P.T.
Bellingham Physical Therapy, LLC
306 36th St.
Bellingham, WA 98225

August 30, 2007

Mr. Kerry N. Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attentiion: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
RE: Physician Self-Referral Issue
Medicare Program; Proposed Revisions to Payment Policies under the
The Physician Fee Schedule and Other Part B Payment Policies for
CY 2008; Proposed Rule

Dear Mr. Weems,

I have owned a small private physical therapy practice in Bellingham, WA for twenty six years. I would like to request that CMS remove physical therapy from the in office ancillary services exception to the federal physician self-referral laws.

This will reduce the incidence of going to physical therapy and having those services provided by personnel other than a licensed physical therapist, under the guise of physical therapy. This has become a confusing and expensive issue for patients seeking physical therapy expertise. The patients are sent to either an athletic trainer, personal trainer, aide or other personnel and receive services neither under the care or guidance of a licensed physical therapist.

Removal of the anciallary services portion will help ensure that physical therapy services are provided by physical therapists and appropriately utilized.

If you have any questions, please do not hesitate to contact me.

Sincerely,

John E, McWilliams, Jr., P.T.
360-647-0444
bptherapy1@qwest.net

Submitter : **Mr. Paul Osterman** **Date: 08/30/2007**

Organization : **Bethany Lutheran College**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Paul Osterman and I am the Head Athletic Trainer at Bethany Lutheran College in Mankato, Minnesota.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Paul J. Osterman, ATC

Submitter : **Dr. Rubin Chandran** **Date: 08/30/2007**

Organization : **Northwest Renal Clinic**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

My Word document with comments is attached.

CMS-1385-P-13260-Attach-1.DOC

#13260

August 29, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS--138--P
Mail Stop C4--26--05
7500 Security Boulevard
Baltimore, MD 21244-1850

Subj: RESOURCE-BASED PE RVUs – THERAPEUTIC PLASMA EXCHANGE

Dear Sir or Madam:

I am writing to you to express my concerns about the looming reductions in reimbursement for therapeutic plasma exchange (TPE, CPT 36514). Medicare proposes a valuation of 10.41 RVUs for TPE by the year 2010. This amounts to approximately $400 per procedure based on the Medicare rates for Portland, Oregon. I am deeply concerned that these reimbursement reductions would make it impossible for our practice to provide TPE in an office based setting. I strongly believe that CMS needs to significantly increase the valuation of the plasma exchange procedure so that it is feasible to offer it in an outpatient clinic.

Plasma exchange is a life-saving procedure for a variety of medical conditions spanning multiple sub-specialties. It has been validated for many diseases by peer-reviewed clinical trials, and has been used clinically for decades. It is considered vital first-line therapy for a variety of neurological, renal and hematological disorders. Like all other extra-corporeal therapies however, it is expensive to perform.

A reimbursement of $400 per plasma exchange procedure is simply not enough to cover the costs involved. I have tried to estimate some of the expenses below:

- The disposable supplies alone cost approximately $250 per treatment. This is almost two-thirds of the total proposed reimbursement!
- The nurse specialists that provide the treatment are highly trained and it takes approximately 3 hours of their time for each procedure. This includes the machine setup, monitoring during the treatment, and post-procedure work. The nurse cannot be involved in any other activities during this period and the TPE takes up their entire time. Using the salary and benefit packages that we offer our nurses, I estimate that the labor cost is approximately $50/hr or $150 per procedure.
- There are other direct out-of-pocket costs including amortization of the machine and the cost of a maintenance contract ($5,000/Spectra machine/year) which amount to about $40 per treatment.
- Obviously, there are the usual overhead expenses including rent, administrative staff, utilities and insurance. It is important to point out that the provision of

plasma exchange in the outpatient setting requires a considerable amount of clinic floor space which cannot be used for any other purpose.

As you can see, the multiple costs involved in providing the plasma exchange procedure greatly exceed the proposed $400 in reimbursement per treatment. I frankly don't understand how the new RVU formula was calculated for TPE given the above-mentioned costs. It is critical that CMS appropriately increase the reimbursement for TPE so that it can continue to be offered in the outpatient setting.

I strongly believe that Medicare should encourage physicians to provide plasma exchange in the office-based setting rather than deter them with Draconian reimbursement cuts. There are also very important patient-oriented factors to consider in the discussion of office-based apheresis treatments.

Many apheresis patients require regularly scheduled treatments a few times a week similar to outpatient hemodialysis. When these patients come to an acute care hospital for their treatments, they always risk unforeseen delays due to emergencies that often arise. They are virtually immune from these delays if the procedures are electively scheduled in an outpatient clinic. The inpatient environment also tends to be very hectic, and it is undoubtedly a much more pleasant and calming experience for the patient to come to an outpatient clinic than an inpatient hospital ward. The diseases that require TPE tend to be very morbid and are significantly burdensome to the patients. These individuals are invariably anxious about coming in for their treatments, and the acute inpatient environment does little to soothe their fears.

In our hospital Medicare patients are required to present to the admitting department before each plasma exchange procedure (which can be up to three times a week). They are assigned a different account number each day and are essentially admitted to the hospital for a few hours while they are undergoing the procedure. This is obviously very inconvenient for the patients, and requires them to waste a lot of time waiting to be admitted and then discharged. Since I am not involved in hospital billing, I do not know how much the hospital charges Medicare for each procedure. However since our hospital performs TPE as an inpatient treatment, I have no doubt in my mind that it is a substantially higher cost setting than an office-based clinic. I believe that office-based plasma exchange is more cost-effective from a Medicare standpoint than hospital-based treatments.

All patients undergoing plasma exchange treatments are immunosuppressed because of the obligate loss of infection-fighting immunoglobulins from the procedure. We are very concerned about infections in these patients and routinely advise them to minimize their exposure to sick contacts. We currently provide hospital-based TPE in our acute dialysis unit and there are numerous hospitalized patients undergoing hemodialysis with active infections. I feel that if we direct our immunocompromised TPE patients to an office based setting instead of the hospital, we would potentially reduce their risk of exposure to virulent nosocomial pathogens that could result in life-threatening infections.

In summary, I believe the proposed reimbursement cuts for TPE will make it impossible to provide these treatments in the outpatient setting. Office-based plasma exchange improves the quality of the patient experience and is more cost-effective than hospital based treatments. CMS should re-evaluate the costs associated with providing this valuable extracorporeal therapy and significantly increase reimbursement in the outpatient setting.

Thank you very much for your consideration in this very important matter. If you require any additional information or have any questions, please do not hesitate to contact me.

Sincerely,

Rubin Chandran, MD, FASN, HP (ASCP)
Medical Director, Acute Dialysis and Apheresis Programs
Providence St. Vincent Medical Center, Portland, OR
rubin_chandran@hotmail.com
Office: (503) 292-7704

Submitter : **Dr. Yolanda Tam** **Date: 08/30/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. Penna Bui **Date:** 08/30/2007

Organization : Alameda Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Blake Wendelburg** **Date: 08/30/2007**

Organization : **Midwest Anesthesia Associates, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Submitter : Ms. Megan Iwanski **Date:** 08/30/2007

Organization : University Suburban Sports Medicine Center

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Megan Iwanski and I am a Certified Athletic Trainer. I graduated from Wilmington College in Ohio in 2005. I also will be graduating from massage school in November. I currently work for University Suburban Sports Medicine Center and out-reach to Hawken Upper.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,
Megan E. Iwanski, ATC

Submitter : **Dr. Jagan Devarajan** **Date: 08/30/2007**

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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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,
Jagan Devarajan

Submitter : Mr. Gary Briggs **Date:** 08/30/2007

Organization : Utah Jazz Basketball Team

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

Dear Sir or Madam:

My name is Gary Briggs and I have been a high school teacher/athletic trainer, a university athletic trainer, and for the past twenty - five years a professional athletic trainer in the NBA.

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,

Gary E. Briggs, ATC, LAT, PES, CES

Head Athletic Trainer

Utah Jazz Basketball Team

Submitter : **Dr. Xiaoning Zhou** **Date: 08/30/2007**

Organization : **Dr. Xiaoning Zhou**

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

Rc: 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.

Submitter : **Dr. Noelle DeSimone** **Date: 08/30/2007**

Organization : **Duke University**

Category : **Physician**

Issue Areas/Comments

Coding– Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Javier Centurion **Date:** 08/30/2007

Organization : Centurion Chiropractic Center

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

This comment is in response to the following: CMS-1385-P - Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies; Revisions to Payment Policies for Ambulance Services for CY 2008;
I would like to respectfully remind those involved in the decision to introduce this revision and those who hope to pass it that chiropractors are legally classified as primary care physicians. This revision illegally denies chiropractors diagnostic ordering rights afforded by the primary care physician classification. Why are chiropractors being singled out here among the other primary care physicians such as medical doctors and osteopaths? In order to diagnose disease and namely subluxations, the ability to order diagnostic imaging is necessary. The use of radiologist only benefits the patient by improving the quality of diagnostic interpretation and delivery of care. Forcing chiropractors to go through a PCP (MD, DO) to order diagnostic imaging is again trespassing on our legal rights as primary care physicians. Honestly, what is next? Are you going to deny our use of HCFA-1500 forms? Please respect our rights and postion as primary care physicians and more importantly do not harm medicare's patients by decreasing their quality of care. Thank you for your attention to this matter.

Submitter : Nicole Stone **Date:** 08/30/2007

Organization : Nicole Stone

Category : Health Care Professional or Association

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,
Nicole Stone, CRNA, MSN
416 South St Ext
Middlebury, VT 05753

Submitter : Mrs. Elizabeth Lauxen **Date:** 08/30/2007

Organization : Mrs. Elizabeth Lauxen

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As citizen on Medicare Disability, I feel strongly that a high potential for abuse exists whenever a physician owns a physical therapy service, and may thereby refuse to issue a prescription to any other PT service, taking the choice away from the patient. As a patient who has in early years actually been harmed by a PT Service, I can personally see that it might tempting for a physician who owned a PT facility to abuse the prescription of those services to a patient. We all would like to think that doctors would be more ethical than that; however, a look at various professions across a broad spectrum of our society has shown that where temptation for abuse exists, apparently there will be some who will abuse their power for their own benefit. I don't believe doctors as a group are exempt from this spectrum. Word of mouth is an excellent referral, and if a patient knows of a particularly outstanding facility that comes highly recommended, they should be allowed to make their own choices. I believe even allowing doctors to own this type of facility is a conflict of interest that is begging for unethical individuals to take huge advantages over our tax dollar and our health choices. Please consider this matter thoroughly, and don't let this get out of hand and have patients suffer the multiple consequences. It seems clear and obvious to me that this is a "no brainer"....just don't allow it.

Submitter : Dr. Daniel Jones **Date:** 08/30/2007

Organization : California State University Long Beach

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Pleas note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Dr. gulshan doulatram** **Date: 08/30/2007**

Organization : **Dr. gulshan doulatram**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Gulshan Doulatram.M.D.

Submitter : **Mrs. Geraldine Piscopio** **Date: 08/30/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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
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Submitter : Ms. Heidi Kirby **Date:** 08/30/2007

Organization : Access Rehablitation

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Heidi Kirby. I am a certified licensed athletic trainer. I have nine years of experience and I am currently working on my master's degree in exercise science. I have worked for Access Rehabilitation in Exeter, New Hampshire for six years in a clinic outreach setting. I am contracted to a local high school of approximately 1600 students where I provide athletic training coverage to 51 teams.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Heidi J. Kirby, ATC

Submitter : **Dr. Keith Phillippi** **Date: 08/30/2007**

Organization : **Anesthesia Associates of Macon**

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 scrvices. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Keith N. Phillippi, MD
380 Hospital Drive, Suite 410
P.O. Box 2564
Macon, Georgia 31203

Submitter : Dr. James Wickham **Date:** 08/30/2007

Organization : Dr. James Wickham

Category : Physician

Issue Areas/Comments

Medicare Economic Index (MEI)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Steven Samoya **Date:** 08/30/2007

Organization : Dr. Steven Samoya

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

While the proposed increase in the anesthesia reimbursement is still below what is fair, I strongly support the decision you have made to increase this from the original proposal. Thanks.

Submitter : **Dr. Francis VanWisse** **Date: 08/30/2007**

Organization : **Yale-New Haven Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Dr. Dorothy Gaal** **Date: 08/30/2007**

Organization : **Yale University**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Respectfully,

Dorothy J. Gaal, MD

Submitter : **Dr. Ihab Ibrahim** **Date: 08/30/2007**

Organization : **Soleil LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

"Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008." I dont know why this is occuring. In the last 20 years, we haven't even made enough for a raise to staff and now we get even less??? Would you like the time spent with each patient to be 5 minutes?

Why aren't you decreasing CEO of insurance companies pay?

Submitter : Mr. Jeff Carlson **Date:** 08/30/2007

Organization : Nova Care Rehabilitation

Category : Individual

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Jeff Carlson and I am a Certified Athletic Trainer in the Minneapolis area. I have worked in the school setting, clinically and on site in industry working to prevent and when necessary aid in the recovery of function following injury.
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,
Jeff Carlson, M Ed, ATC, CDMS

Submitter : Dr. Catherien Chimenti **Date:** 08/30/2007

Organization : ASE

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS 392-P

Please DO NOT stop payment for contrast echocardiographic agents. These agents are necessary in a limited number of imaging studies to get the proper diagnosis. To not pay for them, when it is a agent requiring IV access, monitoring for side-effects and proper delivery DURING a skilled diagnostic exam is ludicrous.

Submitter : Dr. Robert Kersey **Date:** 08/30/2007

Organization : California State University, Fullerton

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am Robert Kersey, a professor of kinesiology and athletic training at California State University, Fullerton. I have been a certified athletic trainer for almost 30 years. I have practiced and taught in this area at virtually all levels and presently am the director of our undergraduate education program at Cal State Fullerton.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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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. Although in California, we currently are not regulated, in most states, state statutes and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

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Respectfully,

Robert D. Kersey, PhD, ATC, CSCS
Professor of Kinesiology
California State University, Fullerton

Submitter : **Ms. Anne Lally** **Date: 08/30/2007**

Organization : **Thayer Academy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer currently working at the secondary school level. I have been involved in athletic training for over 20 years. I am also an EMT-Paramedic and certified strength and conditioning specialist. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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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,

Anne M. Lally, ATC, CSCS, EMT-P

Submitter : Dr. John Richardson **Date:** 08/30/2007

Organization : Dr. John Richardson

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

I fully support the increased reimbursement for anesthesia services.

Submitter : **Dr. Keith Phillippi** **Date: 08/30/2007**

Organization : **Anesthesia Associates of Macon**

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,

Keith N. Phillippi, M.D.

Anesthesia Associates of Macon, LLP
380 Hospital Drive Suite 410
Macon, Georgia 31203

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

the in office ancillary services provision is inappriopriate in the case of physical therapy services. It has been established that it is inappropriate for a therapist to give kickbacks or other monitary rewards for the referral of patients. With in office services the physician benefits financially from another medical providers services. This promotes over-utilization of services as well as reduces the quality of care. By changing the current exception Medicare will be increasing the quality of care delivered in the country, promote interdisciplinary coordination of care and reduce the cost of physical therapy services. This will be done without having to deny servides to the or aging population.

Submitter : Mr. Arturo Villamil **Date:** 08/30/2007

Organization : Fresenius Medical Care Puerto Rico Operations

Category : End-Stage Renal Disease Facility

Issue Areas/Comments

ESRD ProvisionS

ESRD ProvisionS

Please see attachment.

CMS-1385-P-13289-Attach-1.DOC

#13289

Fresenius Medical Care

August 30, 2007

BY ELECTRONIC MAIL
Centers for Medicare and Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue
Washington, DC 20201

Re: File Code CMS-1385-P
ESRD Provisions

Dear Sir or Madam:

The Puerto Rico Operations Division of Fresenius Medical Care North America (FMC) appreciates the opportunity to comment upon certain aspects of the above-referenced rule, in particular regarding the ESRD provisions and their impact upon reimbursement for renal dialysis services rendered in Puerto Rico. Medicare is the primary source of reimbursement for dialysis services rendered to approximately 80% of the census in Puerto Rico, which currently stands at about 4,100 patients.

Therefore, any negative updates have an increased effect upon the operating budgets of dialysis providers in Puerto Rico. The proposed rule again seeks to further reduce the wage index floor, this time from the current .80 to .75, which because of the budget neutrality adjustment results in an actual wage index of .7912 or approximately $1 reduction in per-treatment reimbursement. In CY 2006 the floor had already been reduced to .85 from .90. Therefore, in a three-year span, we have observed the wage index floor reduced three times. Although we acknowledge the concern that the drafters have that any further wage index floor reductions will affect beneficiary access in low wage index areas such as ours, we disagree with the appropriateness of any further reductions without taking into consideration the peculiarities facing service providers such as FMC in Puerto Rico.

As we have stated in prior comment letters, there have been a number of increases in operational costs in Puerto Rico over the last couple of years that have significantly impacted dialysis service providers' operations. Water costs alone have risen between 166% to 387% over the last two to three years. Electricity costs have increased as well, to the point that the average kilowatt-hour charge in Puerto Rico is around 13 cents, compared to a US average of about 7.42 cents. Transportation costs into Puerto Rico are also a significant factor, since on average rates are 15% higher than in the US and all equipment and supplies are imported since there is no local manufacturing. Finally, new facility building cost is $125 per square foot, or about approximately 25% higher than the average construction cost in the US.

Fresenius Medical Care North America
FMS/ Puerto Rico Region Office: 461 Francia Street, San Juan, PR 00917 (787) 764-3172

Fresenius Medical Care

Further, mandated nurse wage increases (for both public and private sector nurses), phased-in over a three-year period, accentuate the operational cost differences between Puerto Rico and US-based operations. In Puerto Rico, new dialysis technicians have not been licensed for a long period of time because the licensing board has been defunct. Therefore, by default, only registered nurses can furnish dialysis to patients since they are the only group of licensed professionals available to the dialysis providers. To use our operations as an example, we employ approximately 400 nurses in our 19 facilities throughout Puerto Rico. Once the three year phase-in period has concluded, on July 20, 2008, the minimum wage will have increased from $8.65 to $14.43 (without including fringe benefits of approximately 30%), for an impact of over $2.7MM on our payroll expense during the period, with small increases in reimbursement over the same period from our primary source of reimbursement, Original Medicare. CMS will use wage data from CY 2004 to calculate CY 2008 values. Therefore, the wage data used from Puerto Rico, which in and of itself is simply not accurate and needs to be re-evaluated in its totality, will not reflect the impact of the legislatively mandated increases because the phase-in period started on July 20, 2006.

FMC has been a proactive voice and our employees have been in constant communication with Commonwealth and federal authorities regarding the high incidence of ESRD in Puerto Rico and have been available to offer expertise in crafting solutions to address the problem, starting with the development of comprehensive CKD programs. However, additional reimbursement cuts that may face us in future years, given the uncertainty of what might occur in CY 2009 and what reimbursement change proposals CMS might publish under a bundled PPS for dialysis facilities, could ultimately jeopardize the quality and frequency of attention that ESRD facilities furnish to Medicare beneficiaries.[1]

We are available to discuss these comments in further detail. Should you wish to contact us, my telephone number is (787) 764-3172 and my electronic mail address is arturo.villamil@fmc-na.com.

Sincerely,

/s/

Arturo Villamil
Vice President, Operations
Puerto Rico Region

AV/hgg

cc: James Kerr, CMS Regional Administrator, Region II
Delia Lasanta, Director, CMS Puerto Rico/USVI District Office
Henry Richter, Technical Assistant, CMS Central Office

[1] The Report to Congress on bundling is not available as of the date of this comment letter.

Submitter : Dr. Ona Kareiva **Date:** 08/30/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

Background

Background

The current reimbursement schedule will force my move from a rural to an urban area. This action is not necessarily by choice but necessity.

Submitter : SUNIL GERA **Date: 08/30/2007**

Organization : Pain Management Medical Clinic

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 (the Proposed Rule) published in the Federal Register on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.
There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the all physicians crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as interventional pain physicians for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

Sunil Gera
Pain Management Medical Clinic
2601 Southwest Square
Jonesboro, AR 72404

Submitter : Mr. Robert Volski **Date:** 08/30/2007

Organization : Robert Volski and Associates Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The use is physical therapists in a physicians is a misuse of the
relationship between the physician and the patient. Pharmacists cannot own a drug store and a physician should not be able to refer to their own physical therapy department for like reasons. Several studies have been done and show that the physician owned physical therapy facilities over utilize the service.
I own my facility and the reason for the referral of paticnts to
our facility is because we do a good job and the physicians know
that the outcome is good. It is my opinion that physicians should practice medicine for which they are licensed and not physical therapy for which in most cases they are not. As the field of physical therapy as expanded in reccnt years the amount of knowledge required to keep current as also increased. The physicians have faced
the same type of problems in the respective fields of specialty.
How than can they supervise us in the self referral setting when they
done know our specialty.
The use of the free marketplace is an has always been the best price control.Stop physician self referral and give the patient access to a better and more cost effective therapy option.
Sincerely,
Robert Volski, P.T.

Submitter : **Dr. charles maine** **Date: 08/30/2007**

Organization : **Dr. charles maine**

Category : **Physician**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

I practice in rural S.W. Virginia and I think decreasing the reimbursement for DXA(bone density) would have a negative impact on the diagnosis of osteoporosis for my patients and would likely increase their chances of suffering a fracture. If physicians are paid less than their cost they will eventually have to stop offering the services. I think we owe our patients this valuable service since osteoporotic fractures are preventable with proper treatment. However we cannot prevent the fractures if we cannot diagnose them. Please do not cut reeimbursement for this test. Thank you.

Submitter : **Miss. Michelle Strauch** **Date: 08/30/2007**

Organization : **Augsburg College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As A Certified Athletic Trainer, registered in the state of MN, and working very closely with Physicians and outpatient care. I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Thank you
Michelle 'Missy" Strauch MS ATC

Submitter : Dr. christina warneck **Date:** 08/30/2007

Organization : Dr. christina warneck

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I fully support the idea of increased reimbursment for anesthesiologists

Submitter : **Dr. Prakash Patel** **Date: 08/30/2007**

Organization : **HUP Anesthesiology**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work eompared 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. Kristin Murphy** **Date: 08/30/2007**

Organization : **Excel Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Kristin M. Murphy. I have been working in the clinical setting at Excel Physical Therapy in Chittenden County Vermont for the past two years as a Certified Athletic Trainer. I perform both clinical duties with patients of numerous diagnoses, as well as on field evaluations and rehabilitation of injuries with a local high school. I received my degree from Endicott College in Beverly, MA but chose to return to Vermont for my family and friends, as well as all it has to offer.

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 reeeive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kristin M. Murphy, ATC

Submitter : Dr. Daniel Kim **Date:** 08/30/2007

Organization : TARPON, P.A.

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

The sustainable growth rate (SGR) formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

Because of the flawed formula, physicians and other practitioners disproportionately bear the cost of providing health care to Medicare beneficiaries. Accordingly, many physicians face clear financial hardship and will have to make painful choices as to whether they should continue to practice medicine and/or care for Medicare beneficiaries.

CMS should work collaboratively with Congress to create a formula that bases updates on the true cost of providing healthcare services to Medicare beneficiaries.

Submitter : **Nathan Seedall** **Date: 08/30/2007**

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.

? 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,

Nathan Seedall CRNA, MS
6170 Panorama Dr.
Idaho Falls, ID, 83401

Submitter : Dr. Joel Cohen **Date:** 08/30/2007

Organization : AboutSkin Dermatology

Category : Health Care Provider/Association

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Mohs surgery remains the treatment with the highest cure rate for basal cell and squamous cell carcinoma. Mohs surgeons can provide a wonderful service to our patients with this technique, and do this on the same day as an in office procedure. If this were to go into effect, I think many mohs surgeons would start doing delayed closures and perhaps sending to another colleague or plastic surgeon who would do the closure in an ambulatory surgery center or hospital. This would likely be done at least with sedation, and incur additional expenses for the insurance and additional risk to patient by no longer local and additional hassle to patients with next day closures.

Submitter : **Mr. Mark Van Riper** **Date: 08/30/2007**

Organization : **Mount San Antonio College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an assistant athletic trainer at Mount San Antonio College in Walnut California. I am responsible for providing medical coverage during practices along with providing rehabilitation services to athletes before and after practice. I have been a Board of Certification Certified Athletic Trainer since 2006. I earned my bachelor's degree in athletic training from California State University, Fullerton in the Spring of 2006, and a subsequent master's degree in athletic training from the University of Virginia in the Summer of 2007. And I plan on returning to school in the Fall of 2008 to earn a degree in Physical Therapy. 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,

Mark Van Riper, MEd, ATC

Submitter : **Dr. Joshua Malenbaum** **Date: 08/30/2007**

Organization : **University of Pennsylvania**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. Andrew Astrove **Date:** 08/30/2007

Organization : BROAD Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Dr. Adam Wacher** **Date: 08/30/2007**

Organization : **UTMB Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Richard O'Leary **Date:** 08/30/2007

Organization : AAMG

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Ms. Margaret O'Kane **Date:** 08/30/2007

Organization : National Committee for Quality Assurance (NCQA)

Category : Health Care Industry

Issue Areas/Comments

TRHCS--Section 101(b): PQRI

TRHCS--Section 101(b): PQRI

NCQA is submitting comments on the PQRI 2008. This is a duplicate submission of Comment #:206744, but this attachment is a PDF version. The attachment function was not clearly working when I attempted to attach the Word version.

CMS-1385-P-13306-Attach-1.PDF

#13306

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance Comments on Medicare's Physician Quality Reporting Initiative (PQRI):

CMS Rulemaking (CMS-1385-P)

August 30, 2007

Issue Identifier: "T" Division B of the Tax Relief and Health Care Act – Medicare Improvements and Extension Act of 2006

The National Committee for Quality Assurance (NCQA) supports the goals of the Medicare Physician Quality Reporting Initiative (PQRI). Measuring physician performance using recognized, standardized, evidence-based measures will result in more meaningful information needed for quality improvement and increased accountability among the nation's physicians. While the PQRI is limited to physicians treating Medicare beneficiaries, it has the potential to improve care for all patients. As the private sector explores ways to encourage physicians to improve care and make better use of health care services through programs such as pay for performance, the common challenge is how to align these efforts to produce the best results. The Centers for Medicare & Medicaid Services (CMS) has the opportunity to help define the acceptable approaches for physician-level measurement and reporting that will likely impact the direction of future private initiatives.

NCQA places a high value on collaborating with others to identify best practices and minimize burden associated with measurement and data collection. One example of this has been our work with the American Medical Association (AMA) convened Physician Consortium for Performance Improvement® (PCPI) on developing a common set of physician level measures that are part of the 2007 PQRI measure set. NCQA and PCPI continue to work on a number of significant new physician-level measures. We have also been working with the American Board of Internal Medicine (ABIM) on a common set of principles for our respective work in the development and adoption of physician level measures. We have worked together to develop a streamlined process for the use of NCQA's Physician Recognition programs as part of ABIM's maintenance of certification (MOC) programs. The value of this partnership is to allow physicians to meet their board certification requirements while pursuing recognition for clinical excellence through one process.

We believe that the proposed rule takes too narrow an approach regarding measures eligible for inclusion in the 2008 PQRI measurement set. The current emphasis on the reporting of measures versus the actual performance of physicians themselves is also

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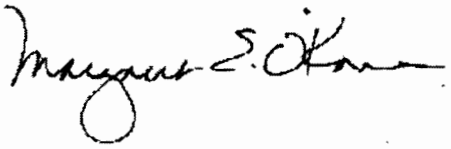
reason for concern. We believe that CMS will have greater flexibility to improve the quality of physician care for Medicare beneficiaries by utilizing existing data collection approaches beyond those included in the proposed rule. Our attached comments spell out a number of ways that we believe the proposed rule can be strengthened to achieve these critical goals. NCQA stands ready to work with CMS to make these changes and to advance our common goal of higher quality care for all Americans.

Sincerely,



Margaret E. O'Kane
President

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NCQA Comments and Recommendations

NCQA comments are specific to the PQRI program and the associated process for including physician measures in the 2008 program. We support a standardized and streamlined process for choosing measures. That requires the use of organizations such as the NQF and the AQA which, together, can serve as objective evaluators of reliable, appropriate and feasible measures for physician performance measurement and reporting.

Issue Identifier - TRHCA--SECTION 101(b): PQRI

P. 407: *Entities eligible for measure submission* - NCQA strongly supports the language in this section. We believe that measures should NOT be limited to those submitted by a single physician specialty. In fact, there is a strong argument that single physician specialty submissions may result in confusion and overlapping measures since in many instances multiple specialties provide the same procedures or care.

P. 419: *Entities eligible for measure submission* - We strongly endorse and agree with the formulation that "we (CMS) do not interpret the MIEA-TRHCA to place special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations." For example, NCQA's process of measure development and approval includes a broader and more balanced representation of clinical and scientific expertise, as well as input from users of measurement such as consumer, purchaser and plans, than is the case with single physician specialty organizations.

P. 424-427: *Measure approval process* - We take strong issue with the proposed language regarding inclusion of new PQRI measures for 2008. The proposed rule appears to establish two separate but unequal processes for inclusion in this important list. It is contrary to the careful assessment of the relative roles and capabilities of NQF and AQA to propose including yet unendorsed measures from the AMA/PCPI, or Quality Insight of Pennsylvania, in the 2008 PQRI, even with the caveat that they *" achieve NQF endorsement* **OR** *AQA adoption by November 15, 2007"* while proposing a different standard for other organizations. On page 428 it appears as if measures from other sources, including NCQA, would be subject to a higher standard, namely that "*We propose to include in the final 2008 PQRI measures other measures endorsed by NQF that were not included in the 2007 PQRI quality measures but that are relevant to Medicare beneficiaries ... Specifications necessary for reporting of these measures will be completed by November 15, 2007 and posted on the CMS web site.*" It appears as if the intent of this is to include measures, both structural and "non physician", from QIP, or the AMA/PCPI, that *may achieve* NQF endorsement, while others would need full NQF

endorsement by the November 15 cut off date. Further, we take strong issue with CMS if the intent of the citation of QIP is intended to limit the consideration by NQF of structural measures or "non physician" measures to those produced by QIP.

P. 424: *Structural measures* - It is unclear why it is necessary to have separate measures for "non physicians" such as those listed in Table 18. If they are different from existing NQF endorsed measures, it would seem undesirable to set different parameters based on the type of clinician. If they are essentially identical, it is unlikely they would be endorsed by either NQF (which is on record as striving for measure concordance) or by AQA which to our knowledge, does not include most "non physician" clinicians. Moreover, to allow these measures, which have not gone through any phase of NQF review, to be short circuited into the 2008 PQRI program would seem to set a very harmful precedent. Finally, and most importantly, CMS is aware of the existence of NCQA structural measures which have undergone extensive testing, are in broad use, and have been submitted to AQA for approval, and which NQF is awaiting funding to review. To exclude consideration of these measures if they are AQA approved, while allowing the inclusion of measures from QIP, would seem highly questionable.

P. 430-432: *Data collection approaches* - The description of the sampling procedure for programs as "information about a defined population of individual persons or events, collected using an observational study design in a systematic way, in order to serve a predetermined scientific, clinical, or policy purpose" is too narrow. There does not appear to be any provision for sampling, or even for inclusion of non Medicare patients in the data submitted. In order to avoid redundant data collection we urge a broader definition of allowable sampling. Any methodology should be sound and produce results that are representative of the physician's practice including Medicare beneficiaries but not necessarily limited to Medicare beneficiaries. We believe CMS has the opportunity to explore options other than registries that can yield a better end result through the evaluation of performance, not just reporting. Efficient, reliable measurement means that the physician does not measure every patient or episode, but uses a rigorous, validated sampling approach. The use of sampling, validation, and assessment against comparison thresholds is actually a higher bar than what is proposed in PQRI. CMS should not hold back progress by forcing the physician community to use older less efficient data collection methods when better methods are available.

P. 433: *Data collection approaches* - The five registry options outlined in the proposed rule do not take into consideration the availability of existing physician measurement programs such as the NCQA physician and practice recognition programs. These long-standing programs use a sampling methodology that allows NCQA to make a sound judgment about a physician's performance while minimizing the data collection burden.

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CMS should amend the definition of registries to allow physicians and practices recognized under these programs to be considered as meeting the PQRI requirements.

Measure Tables 16-22: *NCQA recommended measures* - We are encouraged that CMS is committed to using measures that have been endorsed by AQA or NQF, across a broad array of specialties and clinical topics. Success for PQRI will depend on measures being available for the broadest array of physicians and other clinicians as possible. To that end, we request that CMS include the measures listed below in Table 1 in the PQRI program for 2008. The NCQA Back Pain measures are undergoing NQF review, and have been submitted to the NQF membership for member comment. The PPC Structural measures have been submitted for AQA review. We also support CMS's inclusion of the measures in Table 2 as additional measures for consideration for use in PQRI 2008. These measures have been developed by nationally recognized measure developers, including NCQA and the AMA-PCPI, and all have been submitted for AQA review.

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Table 1: NCQA MEASURES Recommended for the PQRI 2008

Back Pain (Back Pain Recognition Program)
Measure #1: Back Pain Measurement Set (Aggregate Measure)
Measure #2: Initial Visit
Measure #3: Physical Exam
Measure #4: Mental Health Assessment
Measure #5: Appropriate Imaging for Acute Back Pain
Measure #6: Repeat Imaging Studies
Measure #7: Medical Assistance with Smoking Cessation
Measure #8: Advice for Normal Activities
Measure #9: Advice Against Bed Rest
Measure #10: Recommendation for Exercise
Measure #11: Appropriate Use of Epidural Steroid Injections
Measure #12: Surgical Timing
Measure #13: Patient Reassessment
Measure #14: Shared Decision Making
Measure #15: Patient Education
Measure #16: Post-Surgical Outcomes
Measure #17: Evaluation of Patient Experience
Physician Practice Systems (Physician Practice Connections Program)
Measure #1: Physician Practice Connections (Aggregate measure)
Measure #2: Use of E-Prescribing Systems
Measure #3: Alerts for Drug-Drug Interactions
Measure #4: Use of Patient Registries
Measure #5: Use of Electronic Health Records
Measure #6: Reminders for Preventive Care at Point of Service
Measure #7: Lab Test Tracking
Measure #8: Staff Assigned to Execute Standing Orders
Measure #9: Patient Reminders
Measure #10: Patient Self-Monitoring
Measure #11: Use of Feedback Reports for Quality Improvement

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Table 2: Additional Measures for Consideration for PQRI 2008

Dermatology *(AAD/AMA PCPI/NCQA)*
Measure #1: Process of care measures for Melanoma – Bundled
Measure #2: Continuity of Care – Recall System
Measure #3: Coordination of Care – communication with primary care physician
Measure #4: Overuse measure – Imaging for patients with stage 0 or 1A Melanoma
HIV/AIDS *(NCQA/AMA PCPI/IDSA/HRSA)*
Measure #1: Medical visit in an HIV care setting
Measure #2: CD4+ cell count and HIV Viral Load
Measure #3: PCP prophylaxis (as an indicator of OI prophylaxis)
Measure #4: Adolescent and adult clients with AIDS who are prescribed HAART
Measure #5: Pregnant women with HIV infection who are on antiretroviral therapy
Measure #6: TB (PPD) Screening
Measure #7: STD Screening
Measure #8: Vaccinations
Measure #9: High Risk Behavior
Measure #10: Appropriate Periodic Health Examinations
Nuclear Medicine (SNM/AMA PCPI/NCQA)
Measure #1: Radionuclide bone imaging; metastatic disease to the bone
Measure #2: Radionuclide bone imaging; osteomeyelitis
Measure #3: Radionuclide bone imaging; occult trauma
Eye Care *(AAO/AMA PCPI/NCQA)*
Measure #1: Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care
Measure #2: Primary Open-Angle Glaucoma: Counseling on Glaucoma
Measure #3: Cataracts: Postoperative Complications within 30 Days Following Cataract Surgery
Measure #4: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
Measure #5: Cataracts: Comprehensive Pre-operative Package for Cataract Surgery with IOL Placement
Measure #6: Cataracts: Counseling on Cataract Prevention
Revised Measure #7: Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplements

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Geriatrics *(AGS/AMA PCPI/NCQA)*
Revised Measure #1: Advance Care Plan Measure #2: Falls: Risk Assessment Measure #3: Falls: Plan of Care
Radiology *(ACR/AMA PCPI/NCQA)*
Measure #1: Classification of risk for nephrotoxicity in contrast media administration Measure #2: Monitoring patients at risk for nephrotoxicity: Measurement of serum creatinine Measure #3: Nephropathy prophylaxis for patients receiving contrast enhanced imaging procedures Measure #4: Use of acetylcysteine for patients receiving contrast enhanced imaging procedures Measure #5: CT radiation dose reduction Measure #6: Report of exposure time for fluoroscopic procedures Measure #7: Mammography screening – additional assessment Measure #8: Mammography screening - use of BIRADS codes Measure #9: Mammography screening - Communication with the physician managing ongoing care Measure #10: Stenosis measurement in carotid imaging reports - Broadening of clinical indications
Chronic Kidney Disease *(RPA/AMA PCPI)*
Measure #1: Blood Pressure Measurement Measure #2: Plan of Care for Elevated Blood Pressure Measure #3: ACE Inhibitor (ACE) or Angiotensin Receptor Blocker (ARB) Therapy Measure #4: Laboratory Testing (Calcium, Phosphorus, PTH and Lipid Profile) Measure #5: Plan of Care – Anemia Measure #6: Influenza Vaccination Measure #7: Referral for Permanent Vascular Access
Oncology *(ASTRO/ASCO/AMA PCPI)*
Measure #1: Cancer stage documented Measure #2: Hormonal therapy for stage IC-III, ER/PR positive breast cancer Measure #3: Chemotherapy for Stage III colon cancer patients Measure #4: Plan for chemotherapy documented before chemotherapy administered Measure #6: Treatment summary communicated – Radiation Oncology Measure #7: Normal tissue dose constraints specified Measure #8: Pain Intensity Quantified Measure #9: Plan of Care for Pain

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Measure #10: Pathology report – Medical Oncology Measure #11: Pathology report – Radiation Oncology
Anesthesiology and Critical Care *(ASA/AMA PCPI)*
Measure #1: Stress ulcer disease (SUD) prophylaxis considered in ventilated patients Measure #2: Perioperative temperature management for surgical procedures under general anesthesia
Atrial Fibrillation *(ACC/AHA/AMA PCPI)*
Measure #1: Assessment of thromboembolic risk factors Measure #2: Chronic anticoagulation therapy Measure #3: Monthly INR measurement
Perioperative Care *(AMA PCPI)*
Measure #1: Perioperative cardiac risk assessment (History) Measure #2: Perioperative cardiac risk assessment (Current symptoms) Measure #3: Perioperative cardiac risk assessment (Physical examination) Measure #4: Avoidance of electrocardiogram overuse Measure #5: Perioperative continuation of beta-blockers

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Submitter : Dr. **Date: 08/30/2007**

Organization : Dr.

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

This proposed change would put undo and unnecessary financial stress on Medicare benficiaries. There is no clinical reason to change this policy. X-rays are required in the majority of beneficiaries to properly diganos a condition, rule out pathology, consider advanced imaging and identify cases that need to be co-managed.

This small cost savings is really negligent in the big picture. Chiropractic claims account for .5% of all Medicare claims. There are billions of dollars to be saved by looking at the other 99.5% of claims. High on the cost savings list would be to discourage expensive and often ineffective spinal surgery. Consider this, before lumbar or cervical surgery is performed every beneficiary should have a 4 week trial of chiropractic care. Medicare would save billions of dollars per year because 7 of 10 beneficiaries wouldn't need surgery.

Stop this proposal and look for cost savings elsewhere.

Submitter : **Mr. Jonathan Drisko** **Date: 08/30/2007**

Organization : **Algonquin Regional High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Hello, my name is Jonathan Drisko, ATC/L and 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.

Submitter : Dr. Andrew Cohen, DC **Date:** 08/30/2007

Organization : American Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

Re: TECHNICAL CORRECTIONS

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

By limiting a Doctor of Chiropractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,

Andrew C Cohen, DC

Submitter : **Date: 08/30/2007**

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.

Submitter : **Dr. Michael Verber** **Date: 08/30/2007**

Organization : **Dr. Michael Verber**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

Enclosed is the ASA s form letter on this subject. It is well put.

I would like to add my own personal experience with this situation.

Formerly I was an anesthesiologist in an underserved rural hospital. The progressive cuts in Medicare payments, along with the rapid growth in the percentage of my patients who were on Medicare was a major factor in my relocating to a major city, with a different payer mix.

The patients are getting older, sicker, more difficult to care for at the same time as reimbursements are flat, or even are being cut back.

That does lead many of us, who have the option, to simply change our practices so that we do far fewer Medicare patients.

I am too old to be up in the middle of the night struggling to pull an even-older person through an emergency surgery for the unacceptably small amount of reimbursement offered by Medicare. .

Perhaps younger physicians and CRNAs will step up and eagerly do these difficult cases for 30% of the standard rate. Then again, perhaps not.

Thank you

Michael Verber, MD

ASA Form Letter (With which I agree, and of which I am sure you have many copies):

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Steven Mandelberg** **Date: 08/30/2007**

Organization : **Dr. Steven Mandelberg**

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
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Thank you for your consideration of this serious matter.

Steven Mandelberg, MD

Submitter : **Thomas Shelton** **Date: 08/30/2007**

Organization : **Dickson**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is TC Shelton. I am a certified and licensed athletic trainer in the state of Arkansas. I have worked at the high school, collegiate, and physician practice settings. I have over 8 years experience in treating and rehabilitating athletes at all levels.

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,

TC Shelton, ATC, LAT

Submitter : Dr. Thomas Young **Date:** 08/30/2007

Organization : Desert Valley Anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-13314-Attach-1.DOC

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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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 : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing today to voice my opposition to the physician self-referral provision proposed in 1385-P. I believe physical therapy services should be excluded from the in-office ancillary services exception. I am concerned that it would create an environment of a therapy mill in which patient quantity would supercede quality of care. I feel that physical therapists are trained professional in the realm of physical rehabilitation and patients require our autonomous judgement and clinical expertise without the constraints and management that in-office clinics often impose. The current situation in which medical doctors refer patients to privately owned physical therapy clinics must remain in ordered to preserve the appropriate checks and balances required to ensure quality of care with positive outcomes as the priorities for each and every patient.

Submitter : Mr. TERRY VENTRESCA **Date:** 08/30/2007

Organization : COMPREHENSIVE ATHLETIC TREATMENT CENTER

Category : Other Health Care Provider

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I am a Certified Athletic Trainer who has been practicing in the clinical setting for the past 25 years. In addition to my Degree I have and continue to attend continuing education courses in the field of Orthopaedic and Sports Rehabilitation.

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.

CMS has offered no explanation as to why these significant changes to Hospital Conditions of Participation are necessary. These changes have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

I am qualified to perform physical medicine and rehabilitation (PMR) services; physical therapy is only a small subset of PMR. 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 current and future workforce shortages 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 current standards of staffing provide hospitals and other rehabilitation facilities the flexibility to ensure patients receive the best, most cost-effective treatment available.

I 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,

Terry R. Ventresca,ATC
205 Mt. View Rd.
Reading, Pa. 19607

Submitter : **Dr. Daniel Rudzinski** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Michelle Nguyen** **Date: 08/30/2007**

Organization : **UTMB**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. ricardo buenaventura** **Date: 08/30/2007**

Organization : **Dr. ricardo buenaventura**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I respectfully ask that you reconsider the issue of payments for interventional pain physicians who perform procedures in the office. We are often mixed in with anesthesiologists when considering cost of our practices. Anesthesiologists have a low overhead because they don't maintain medial offices with a full complement of staff. The have less overhead than pain physicians who maintain offices. Please reconsider and increase the relative value and practice costs of interventional pain physicians practicing in the office.

Submitter : Mrs. Heather Chernyshov **Date:** 08/30/2007

Organization : Long Trail Physical Therapy/Burlington High School

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Heather Chernyshov, MS, ATC, NCTMB, and I am a certified athletic trainer currently employed by Long Trail Physical Therapy. Prior to working in a private outpatient physical therapy clinic, I have been employed for 13 years working as an athletic trainer for the collegiate as well as secondary school systems. I have been able to competently practice athletic training based upon successful completion of the National Athletic Trainers exam, after earning a bachelors degree in exercise science at the University of Connecticut. I have maintained 80 hours of continuing education and met the standards of athletic training per the board of regulations of the state of Vermont.

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, whieh you know is not the same as physical therapy. My education, clinical experiencc, 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,

Heather Chernyshov, MS, ATC, NCTMB

Submitter : **Dr. Steven Fogel** **Date: 08/30/2007**

Organization : **Dr. Steven Fogel**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. Chris Cowger** **Date: 08/30/2007**

Organization : **Mr. Chris Cowger**

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer working in a busy orthopedic sports medicine center where I provide outstanding patient care to several hundred patients a week through exercise instruction and patient education.

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,

Chris Cowger, MA, ATC

Submitter : **Dr. gurudatt setty** **Date: 08/30/2007**

Organization : **asa**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Allen cohen** **Date: 08/30/2007**

Organization : **Nova Surgicenter**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs:
I am writing to ask you to support the revision of the Anesthesia unit conversion. This RVBSS was undervalued in the original creation of the system. The current Anesthesia fees are not high enough to allow us in Los Angeles to continue to attract and maintain young physicians to practice Anesthesia. When those of us who are over 60 retire, we will have a terrible shortage of Anesthesiologists in all major (read that as high cost of living) cities. Please increase the Anesthesia conversion unit to allow us the ability to serve without compromising our ability to cover our hospital/surgicenter obligations. We really need your help on this issue.

Submitter : Dr. Leo Martin **Date:** 08/30/2007

Organization : Dr. Leo Martin

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

I am a physician, an anesthesiologist by training, and a member of the American Medical Association and the American Society of Anesthesiologists. I have been in practice since 1985.

It is becoming increasingly difficult for me and my colleagues to care for Medicare beneficiaries under the current system. On many days I have a choice of cases, and sometimes it comes down to... should I care for a healthy, young cosmetic surgery patient, or a frail, elderly Medicare beneficiary? I feel great responsibility to care for my fellow citizens who are older, but I know not all physicians are able to keep their doors open on Medicare reimbursements.

My relatives and friends of Medicare age tell me they are having problems finding physicians who will care for them, while relatives and friends with commercial insurance have no such access issues.

I am grateful CMS is taking steps to address the complicated issue of anesthesia reimbursement.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Leo A. Martin, MD
4441 E McDowell Road
Suite 101
Phoenix AZ 85008

Submitter : Dr. Michael Picone **Date:** 08/30/2007

Organization : ASIPP

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Dr. Sean Conroy** **Date: 08/30/2007**

Organization : **South Oakland Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sean Conroy,MD

Submitter : **Dr. Margaret Rose** **Date: 08/30/2007**

Organization : **Yale New Haven Hospital System**

Category : **Physician**

Issue Areas/Comments

GENERAL

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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.

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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,

Dr. Margaret Rose
Yale New Haven Hospital System

Submitter : Mr. Ryan Wantz **Date:** 08/30/2007

Organization : Drayer Physical Therapy Institute

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer employed by Drayer Physical Therapy Institute with concern about the recent changes to policies stated in "THERAPY STANDARDS AND REQUIREMENTS" and "CONDITIONS OF PARTICIPATION FOR HOSPITALS." I oppose the policies in regards to staffing for rehabilitation in hospitals and facilities proposed in 1385-P.

I am concerned partly because these policies will create additional problems for people in regards to accessing quality health care and services. Rehabilitation is a service provided by physical therapists and occupational therapists, but should not be limited to these providers. Certified athletic trainers are fully qualified to provide rehabilitation services.

As a certified athletic trainer, I am qualified to perform physical medicine and rehabilitation services. This is not the same as physical therapy. Physical therapists are not the sole provider of rehabilitation services and are not the only qualified professionals. My education, clinical experience, and national certification ensure my patients the quality care that they deserve. State law and hospital professionals have recognized me as qualified to perform the services that are addressed in these proposed policies. These regulations, however, are in direct conflict with the regulations that I presently practice under and would result in the inability of my patients to access my services.

There is already a known workforce shortage and many individuals have difficulty accessing qualified health care professionals. It would not be prudent for these regulations to be implemented as is. It is the responsibility of CMS to provide access to qualified services, and these regulations only restrict access further. Those that presently have access presently will lose that ability to receive care and only because of these regulations.

It would be appropriate the CMS to add additional providers so that these regulations are up to date as far as the current health care scene. Certified athletic trainers are qualified health care providers that patients deserve to have access to in ensuring that they receive the best, and 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 reconsider the recommendations of those profcssionals 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,

Ryan Wantz, ATC

Submitter : **Dr. Carol Myrick Brewer** **Date: 08/30/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Norman Pang **Date:** 08/30/2007

Organization : Alliance Pain Care

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See the following attachement

CMS-1385-P-13331-Attach-1.DOC

CMS-1385-P-13331-Attach-2.TXT

CMS-1385-P-13331-Attach-3.DOC

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, "Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008" (the "Proposed Rule") published in the *Federal Register* on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.

There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the "all physicians" crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians' ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries' access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as "interventional pain physicians" for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to "all physicians" for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. Interventional pain is an inter-disciplinary practice that draws on various medical specialties of anesthesiology, neurology, medicine & rehabilitation, and psychiatry to diagnose and manage acute and chronic pain. Many interventional pain physicians received their medical training as anesthesiologists and, accordingly, clinically view themselves as anesthesiologists. While this may be appropriate from a clinically training perspective, their Medicare designation does not accurately reflect their actual physician practice and associated costs and expenses of providing interventional pain services.

This disconnect between the Medicare specialty and their practice expenses is made worse by the fact that anesthesiologists have the lowest practice expense of any specialty. Most anesthesiologists are hospital based and do not generally maintain an office for the purposes of rendering patient care. **Interventional pain physicians are office based physicians who not only furnish evaluation and management (E/M) services but also perform a wide variety of interventional procedures such as nerve blocks, epidurals, intradiscal therapies, implant stimulators and infusion pumps, and therefore have practice expenses that are similar to other physicians who perform both E/M services and surgical procedures in their offices.**

Furthermore, the utilization rates for interventional pain and pain management specialties are so low that they are excluded from Medicare rate-setting or have very minimal affect compared to the high utilization rates of anesthesiologists. CMS utilization files for calendar year 2007 overwhelming report anesthesiologists compared to interventional pain physicians and pain management physicians as being the primary specialty performing interventional pain procedures. The following table illustrates that anesthesiologists are reported as the primary specialty providing interventional pain services compared to interventional pain physicians

CPT Code	Anesthesiologists - 05 (Non-Facility)	Interventional Pain Management Physicians - 09

		(Non-Facility)
64483 (Inj foramen epidural l/s)	59%	18%
64520 (N block, lumbar/thoracic)	68%	15%
64479 (Inj foramen epidural c/t)	58%	21%
62311 (Inject spine l/s (cd))	78%	8%

The high utilization rates of anesthesiologists (and their extremely low practice expenses) drive the payment rate for the interventional pain procedures, which does not accurately reflect the resource utilization associated with these services. This results in payment rates that are contrary to the intent of the Medicare system—physician payment reflects resources used in furnishing items and services to Medicare beneficiaries.

I urge CMS to make a modification to its practice expense methodology as it pertains to interventional pain services such that its methodology treats physicians who list anesthesiology as their primary specialty and list interventional pain as their secondary specialty designation as interventional pain physicians for rate-setting. This pool of physicians should be cross-walked to "all physicians" for practice expenses. This will result in a payment for interventional pain services that is more aligned with the resources and costs expended to provide these services to a complex patient population.

I urge CMS not to delay implementing our proposed recommendation to see if the updated practice expenses information from the Physician Practice Information Survey ("Physician Practice Survey") will alleviate the payment disparity. While I believe the Physician Practice Survey is critical to ensuring that physician services are appropriately paid, I do not believe that updated practice expense data will completely resolve the current underpayment for interventional pain services. The accurate practice expense information for interventional pain physicians will continue to be diluted by the high utilization rates and associated low practice expenses of anesthesiologists.

II. CMS Should Develop a National Policy on Compounded Medications Used in Spinal Drug Delivery Systems

We urge CMS to take immediate steps to develop a national policy as we fear that many physicians who are facing financial hardship will stop accepting new Medicare beneficiaries who need complex, compounded medications to alleviate their acute and chronic pain. Compounded drugs used by interventional pain physicians are substantially different from compounded inhalation drugs. Interventional pain physicians frequently use compounded medications to manage acute and chronic pain when a prescription for a customized compounded medication is required for a particular patient or when the prescription requires a medication in a form that is not commercially available. Physicians who use compounded medications order the medication from a compounding pharmacy. These medications typically require one or more drugs to be mixed or reconstituted by a compounding pharmacist outside of the physician office in concentrations that are not commercially available (*e.g.*, concentrations that are higher than what is commercially available or multi-drug therapy that is not commercially available).

The compounding pharmacy bills the physician a charge for the compounded fee and the physician is responsible for paying the pharmacy. The pharmacy charge includes the acquisition cost for the drug ingredients, compounding fees, and shipping and handling costs for delivery to the physician office. A significant cost to the physician is the compounding fees, not the cost of drug ingredient. The pharmacy compounding fees cover re-packaging costs, overhead costs associated with compliance with stringent statutes and regulations, and wages and salaries for specially trained and licensed compounding pharmacists bourn by the compounding pharmacies. The physician administers the compounded medication to the patient during an office visit and seeks payment for the compounded medication from his/her carrier. In many instances, the payment does not even cover the total out of pocket expenses incurred by the physician (*e.g.*, the pharmacy fee charged to the physician).

There is no uniform national payment policy for compounded drugs. Rather, carriers have discretion on how to pay for compounded drugs. This has lead to a variety of payment methodologies and inconsistent payment for the same combination of medications administered in different states. A physician located in Texas who provides a compounded medication consisting of 20 mg of Morphine, 6 of mg Bupivicaine and 4 of mg Baclofen may receive a payment of $200 while a physician located in Washington may be paid a fraction of that amount for the exact same compounded medication. In many instances, the payment to the physician fails to adequately cover the cost of the drug, such as the pharmacy compounded fees and shipping and handling. Furthermore, the claim submission and coding requirements vary significantly across the country and many physician experience long delays in payment.

We urge CMS to adopt a national compounded drug policy for drugs used in spinal delivery systems by interventional pain physicians. Medicare has the authority to develop a separate payment methodology for compounded drugs. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA") mandated CMS to pay providers 106% of the manufacturer's Average Sales Price ("ASP") for those drugs that are separately payable under Part B. The language makes clear that this pricing methodology applies only to the sale prices of manufacturers. Pharmacies that compound drugs are not manufacturers, and Congress never contemplated the application of ASP to specific drug compounds created by pharmacies. Accordingly, CMS has the discretion to develop a national payment policy.

We believe that an appropriate national payment policy must take into account all the pharmacy costs for which the physicians are charged: the cost of the drug ingredient, the compounding fee costs, and the shipping and handling costs. We stand ready to meet with CMS and its staff to discuss implementing a national payment policy.

III. CMS Should Incorporate the Updated Practice Expenses Data from Physician Practice Survey in Future Rule-Making

I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge

CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

IV CMS Should Work Collaboratively with Congress to Fix the SGR Formula so that Patient Access will be preserved.

The sustainable growth rate ("SGR") formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

Because of the flawed formula, physicians and other practitioners disproportionately bear the cost of providing health care to Medicare beneficiaries. Accordingly, many physicians face clear financial hardship and will have to make painful choices as to whether they should continue to practice medicine and/or care for Medicare beneficiaries.

CMS should work collaboratively with Congress to create a formula that bases updates on the true cost of providing healthcare services to Medicare beneficiaries.

***

Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

Norman Pang, MD
775 Baywood Dr., Suite 308
Petaluma, CA 94954

Submitter : Dr. David Richardson **Date:** 08/30/2007

Organization : Foothills Anesthesia, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"see attachment"

CMS-1385-P-13332-Attach-1.DOC

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation's seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation—a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. Malik Hamid **Date:** 08/30/2007

Organization : KUMC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under thc 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 : **Miss. Janielle Martin** **Date: 08/30/2007**

Organization : **Orthopaedic and Sports Medicine Specialists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Massachusetts licensed and nationally certified Athletic Trainer. I work for Orthopaedic and Sports Medicine Specialists in North Andover, Mass, as well as the Athletic Trainer for Methuen High School. I have also, in the past, provided health care as an EMT-Basic for Adams Ambulance in Adams, Mass. I obtained my Bachelors in Athletic Training, with a minor in Psychology, from Springfield College in December of 2005.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Janielle Martin, LATC

Submitter : Dr. Gerald Witt **Date:** 08/30/2007

Organization : Northwoods Chiropractic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1385-P-13335-Attach-1.DOC

13335

Centers For Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

Re: "Technical Corrections"

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. *I am writing in strong opposition to this proposal.*

While subluxation does not need to be detected by an X-Ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

By limiting a Doctor of Chiropractic from referring for an x-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist), etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as the result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,

Gerald W. Witt, D.C.

Submitter : Dr. Bruce Hultgren **Date:** 08/30/2007

Organization : Dr. Bruce Hultgren

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I urge your support of the increase in anesthesia unit value as recommended for 2008. This will help to correct the prior imbalance in anesthesia compensation for the care of senior citizens. Our seniors will have better access to anesthesia care because of this.
Thank you,
Bruce L. Hultgren MD

Submitter : **Dr. Robert Cordes** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

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.

Robert A. Cordes, M.D.

Submitter : **Ms. Karin Lundgren** **Date: 08/30/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 30, 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 markct 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,
Karin E. Lundgren, MSN,
Certified Registered Nurse Anesthetist (CRNA)
5070 Lauderdale Ave.
Virginia Beach, VA 23455

Submitter : Ms. Marie Kay Wincey **Date:** 08/30/2007

Organization : Ms. Marie Kay Wincey

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern:

Please remove physical therapy services from the allowed list of in-office ancillary services on the physician fee schedulcs. I am a physical therapist of almost two years. I have only worked in a physical therapist owned clinic, but in my schooling have seen how physician owned physical therapy practices can be abused. I don t like the fact that physicians can control the number of patients referred and seen by physical therapists in order to boost their economics. At times I have heard stories from friends and patients that their physician has told them that their PT s are better than other clinic s. This is unfair to the client, and is poor ethics. I also have known of clients informing me of their desire to have therapy but inability to obtain a prescription if it was to an outside clinic. Yes this may be second hand information, but it is critical and should be taken into account. Often times a client will listen to a physician because they are a trusted healthcare professional, but it is unfair for therapy services to be owned by a physician and not a physical therapist.

I know personally in the clinic environment I am in that I own my profession. No physician can tell me how many clients to see and how long I can spend with them. I am able to make professionally sound judgments in the best interest of my patient. I don t have worries about billing to meet any set standards, and no incentives are given for seeing a larger patient caseload. I don t feel pressured to see more patients than I can handle. I have the authority in my profession and don t feel pressured by the physicians. How can a physician fully understand the physical therapy profession and charge for these services when they are not a licensed physical therapist? Secondly, the patient should always feel free to choose the clinic they want to go to without feeling pressured by their physician. Physical therapy should not be owned and operated by another profession. Please separate out the billings for these two services and do not allow another profession to control the profession of physical therapy.

Thank you.

Kay Wincey
Licensed Physical Therapist

Submitter : Mrs. CORIE CONROY **Date:** 08/30/2007

Organization : Mrs. CORIE CONROY

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,
Corie Conroy

Submitter : **Mrs. Rachel Hermann** **Date: 08/30/2007**

Organization : **Pasco Cardiology**

Category : **Nurse Practitioner**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

see attached comment

CMS-1385-P-13341-Attach-1.DOC

13341

August 30, 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 nurse practitioner at Pasco Cardiology, and I am writing to discuss payment for Microvolt T-wave Alternans (MTWA) diagnostic test. MTWA is an important tool to determine patient's risk of sudden cardiac death. I am concerned that Medicare payment for physicians for MTWA is based on an incorrect 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 preventative 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 45-60 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 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 one time per week for four patients 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. I would be happy to provide documentation to demonstrate our actual utilization rate. Please do not hesitate to contact me for this information or if I can answer any other questions about MTWA.

Sincerely,

Rachel Hermann, ARNP

Submitter : Mrs. Catherine Stout **Date:** 08/30/2007

Organization : Oaa Orthopaedic Specialists

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified athletic Trainer working in the clinical 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,

Catherine Stout, ATC

Submitter : **Elizabeth Gillis** **Date: 08/30/2007**

Organization : **Boston College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a resident athletic trainer at Boston College and am currently one of the athletic trainers working with the football team. My responsibilities are far-reaching and range from prevention to evaluation and diagnosis of injuries and then to the rehabilitation of those injuries. I have graduated from an accredited undergraduate athletic training program and I have also received my Master of Arts in Teaching. I am also licensed and certified as an athletic trainer.

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,

Elizabeth A. Gillis, MAT, ATC

Submitter : **Dr. Mariko Ford** **Date: 08/30/2007**

Organization : **Dr. Mariko Ford**

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 on behalf of my private practice group of eighty anesthesiologists (Medical Anesthesia Consultants). 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,
Dr. Mariko Ford
Medical Anesthesia Consultants

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Thank you for taking my comment. I am a cardiologist practicing in NY. I currently use MTWA equipment on my patient to evaluate their risk for sudden death. I am concerned about the assumption that this equipment is used 50% of the entire minutes in a year which will result in an inappropriately low payment for this test. In my practice, it is used significant less than 50% of the time. Please reconsider your assumption that the machine is used 50% of the time which it is not.

Thank you for your consideration.

Submitter : Dr. Markq Newman **Date:** 08/30/2007

Organization : Tidewater Pain Management, PC

Category : Physician

Issue Areas/Comments

Impact

Impact

I would like to comment on the proposed changes to the physician fee schedule. The proposed cuts in reimbursement for interventional procedures will have a significant impact on my practice. The proposed cuts on top of the cuts of this year will make it very difficult to continue to treat medicare patients. Medicare reimbursement continues to decline while practice expenses continue to climb. As an example, it has cost me $8500.00 to upgrade my computer system to accept the new NPI number. This is one of the 'hidden' expenses/taxes that are mandated by the government but I receive absoulutly no benifit from. The continuing cuts in remimbursement with the increase in other expenses forces me to examine the business part of practicing medicine and consider whether it is cost effective to continue to treat medicare patients. I urge you to reconsider the way in which interventional pain procedures are reimbursed so that I and other interventional pain physicans do not have the make the 'business decision' of whether to continue treating medicare patients. Thank you for the oportunity to comment on CMS-1385-P.

Submitter : **Dr. Steven Johnson** **Date: 08/30/2007**

Organization : **Atlantic Anesthesia**

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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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
Steven C. Johnson M.D.

Submitter : Dr. John C. Makrides **Date:** 08/30/2007

Organization : American Society of Anesthesiologists (ASA)

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-13348-Attach-1.DOC

13348

#13348

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.

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Thank you for your consideration of this serious matter.

Sincerely,

John C. Makrides, MD
Maine Medical Center
Dept. Anesthesiology

Submitter : **Dr. Edwin Batte** **Date: 08/30/2007**

Organization : **Dr. Edwin Batte**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Edwin E. Batte, MD

Submitter : **Ms. Earlene Banville** **Date: 08/30/2007**

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
Baltimore, MD 21244-8018

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 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 longed 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 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.

Sinserely,
Earlene Banville,CRNA, MSNA
30 Sleepy Hollow Road
Atkinson, NH 03811

Submitter : **Dr. Bonny Carter** **Date: 08/30/2007**

Organization : **UTHSCSA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mr. Tim McAdams** **Date: 08/30/2007**

Organization : **Trident Anesthesia Group**

Category : **Other Health Care Professional**

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.

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? 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).

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Sincerely,

Tim McAdams CRNA

Submitter : **Alexander Haskins** **Date: 08/30/2007**

Organization : **Alexander Haskins**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Alex Haskins and I am senior Athletic Training major at Marietta College. Since I have attended Marietta College, I have worked closely with many student athletes in a clinical and on field setting. My instructors have taught me how to evaluate an injury, use modalities effectively and properly, and how to rehabilitate and care for a variety of injuries.

I am writing you today to voice my opposition to the new standards and requirements that are proposed in 1385-P.

With the implementation of the new standards, it will make it very difficult to find a job after graduation. Even though I will be qualified to provide rehabilitation services, physical therapy clinics will only be looking for physical therapists and physical therapy assistants if the new bill is passed. My four year degree, national certification exam, and experience will ensure that patients receive quality care.

I urge you to seriously, and deeply consider the proposed actions of 1385-P. Students in the field which I am graduating in are more than qualified to provide quality healthcare to Medicare and Medicaid patients.

Sincerely,

Alex Haskins, ATS

Submitter : **Dr. Sadiq Sohani** **Date: 08/30/2007**

Organization : **CSPM**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I am not in favor of any further payment cuts

Submitter : **Heather Webb** **Date: 08/30/2007**

Organization : **Team Tiger**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I am writing today to voice my disagreement with 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, my greater concern is that the proposed changes in the rules will create an additional barrier for my patients to access quality health care.

As a nationally certified and state licensed athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you should know is not the same as physical therapy. My education, clinical experience, national certification, and state licensure exams 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,

Heather E. Webb Ph.D., ATC, LAT

Submitter : **Date: 08/30/2007**

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

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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,

Christina LaBrie, ATC

Submitter : **Karen Marrocco** **Date: 08/30/2007**

Organization : **VSP**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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Sincerely,
Karen Marrocco MS ATC, LAT

Submitter : Dr. Nelangi Pinto **Date:** 08/30/2007

Organization : University of Utah

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Dear CMS:

I am writing regarding the proposed change to eliminate CPT 93325 (Doppler Color Flow Mapping) and bundle this code into other echocardiography CPT codes. As a cardiac specialist caring for patients with congenital heart disease, this is of particular concern to me for a number of reasons.

I do not believe the appropriate process has been followed with respect to this proposed change. After significant interaction and research between the Relative Value Scale Update Committee (RUC) and the appropriate specialty societies (ACC and ASE), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that other echo codes be bundled as well with the 93325. Because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

Importantly, there is no proposed change to the RVUs of the codes with which 93325 will be bundled. The proposal would simply eliminate reimbursement for CPT 93325, yet the amount of work performed and time spent by the physician for this service will remain the same.

Color Doppler is typically performed in conjunction with 2D echo to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow veloeities. The performance of echo in patients with congenital anomalies is unique in that it is frequently necessary to use color Doppler (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 code for the pediatric population stating that color Doppler is "& even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." There are many other complex anatomic and physiologic issues that we as cardiac specialists face on a daily basis when performing echos on patients with complex heart disease. Color Doppler imaging is a critically important part of many of these studies, requiring additional time and expertise from both the sonographer and the cardiologist interpreting the study. Bundling 93325 with other echo codes does not take into account this additional time, effort, and expertise. I am concerned that this change would adversely impact access to care for cardiology patients with congenital cardiac malformations. Programs caring for this select patient population do so not only for those with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for congenital cardiac services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to our patients will not be sufficient to continue to do so should the proposed bundling of 93325 with other echo codes be implemented.

I strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other cardiology echo codes until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Sincerely,

Nelangi Pinto, M.D.
Cardiology Attending
Primary Children's Medical Center
Salt Lake City, UT

Submitter : **Mrs. Andrea Shene** **Date: 08/30/2007**

Organization : **Warren General Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Andrea Shene and I am a Certified Athletic Trainer employed by Warren General Hospital, Warren Pennsylvania. I am currently providing service to two local high schools through a contract between the Warren County School District and Warren General Hospital. I have been practicing as a Certified Athletic Trainer since completing my masters degree in 1998.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Andrea L. Shene, MS,ATC

Submitter : Mr. Peter Mortensen **Date:** 08/30/2007

Organization : Yale New Haven Hospital

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

see attachment

#13360

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **Dr. James Flowerdew** **Date: 08/30/2007**

Organization : **Spectrum Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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,
James M.T. Flowerdew, M.D.

Submitter : **Mr. Thomas Lawrence** **Date: 08/30/2007**

Organization : **Agility Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an certified athletic trainer working for Agility Health at Battle Creek Health Systcm in Battle Creek Michigan. I am the team leader for outpatient services. I have nearly 20 years with my current employer and over 25 years experience in the athletic training field. I provide quality physical medicine to my patients and am a respected manager in my role as team leader. We use a team aproch to give the highest quality service to all our 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.

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Sincerely,

Thomas F. Lawrence, M.A., ATC

Submitter : Dr. Cynthia Hummel **Date:** 08/30/2007

Organization : Dr. Cynthia Hummel

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Referring to file code CMS-1385-Please abolish the recommendation that reimbursement would no longer be allowed for X-rays taken by a non-treating physician such as a radiologist and used by a Doctor of Chiropractic to determine a subluxation. These X-rays, if needed, are integral to the overall treatment plan of the Medicare patients and it is ultimately the patient that will suffer should this proposal become standing regulation.

As a chiropractic physician in Ohio, I find it amazing that Medicare is continuing its outdated practice of not reimbursing for medically necessary x-rays. Please consider reimbursement of x-rays taken or ordered by chiropractic physicians.
Sincerely,
Dr. Hummel

Submitter : **Mr. John Charbonneau** **Date: 08/30/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Administrator:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services. This increase in Medicare payment is important for several reasons.

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,

John Charbonneau, CRNA
1313 Roseview Drive
Jefferson City, Missouri 65101

Submitter : **Dr. Bruce Miron** **Date: 08/30/2007**

Organization : **Dr. Bruce Miron**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimore, Maryland 21244-8018

Re: "TECHNICAL CORRECTIONS"

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

By limiting a Doctor of Chiropractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources, seniors may choose to forgo X-rays and thus, needed treatment. If treatment is delayed, illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Submitter : **Dr. Kevin McKeown** **Date: 08/30/2007**

Organization : **Associated Anesthesiologists, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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.

Kevin J McKeown, MD

Submitter : **Ms. Kelleryn Wood** **Date: 08/30/2007**

Organization : **Greater Portland Bone and Joint Specialists**

Category : **Nurse Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Kerry Weems, Acting Administrator

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

Mail Stop C4-26-05

7500 Security Boulevard

Baltimore, Maryland 21244-1850

RE: CMS-1385-P Proposed Revisions to payment policies under the physician fee schedule and other Part B payment policies for CY 2008

Comments:

The Physician Work RVU-CPT 77080 (DXA)

The Direct Practice Expense RVU for 77080 (DXA)

Indirect Practice Expense for DXA and VFA

Deficit Reduction Act

Dear Mr. Weems:

I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.

As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:

a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;

b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:

? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;

? the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.

c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and

d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,

Kelleryn Wood FNP

Submitter : **Mrs. Kari Rickman** **Date: 08/30/2007**

Organization : **Mrs. Kari Rickman**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Kari N. Rickman, CRNA, MS
2510 Greenwich Circle
Midland, MI 48642

Submitter : **Miss. Anna August** **Date: 08/30/2007**

Organization : **American River College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Anna August. I am an athletic trainer certified through the National Athletic Trainers' Association. With this certification and a Master's of Science degree in Athletic Training, I provide health care services to 300-500 student-athletes at American River College. I am often their first line of defense against not only orthopedic injuries, but also against life threatening illnesses and medical conditions. I am skilled in many aspects of health care and have saved at least two athlete's lives - one from a diabetic coma and the other by early identification of a rare but life threatening blood clot. The physical medicine and rehabilitative services I provide save thousands of dollars of insurance money and create health care access for those athletes who have none.

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,

Anna M. August, MS, ATC, CSCS

Submitter : Miss. Rebecca Monroy **Date:** 08/30/2007

Organization : Physical Therapist Student at Regis University

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing in regards to the possible removal of physical therapist services from the "in-office ancillary services" unwriting in the Stark Laws. Currently, physicians own physical therapy clinics and receive financial gains from their referrals to their physical therapists. Studies have shown that this increases utilization, which increases insurance cost and in turn will be detrimental to patients because it decreases the funding available for patients that are most in need of physical therapy services. Physicians are restricted from owning pharmacies because it will increase the number of pharmacological prescriptions they write, why is this not true for the prescription of physical therapy. Physical therapists are currently doctorally trained and most states allow patients to have direct access to physical therapists. This better serves the community because therapists have been trained to recognize red flags and refer accordingly, they also help to triage patients so that physicians can see the patients that are more in need of acute medical care (Ex. a patient with an ankle sprain can go to a physical therapist and based on the Ottawa Ankle Rules they can rule out a fracture and manage the patient accordingly). This saves healthcare dollars because radiographs would not be necessary in many cases and the cost of a physical therapist as the entry-point into the healthcare system is minimal compared to the ER or a physician visit. Furthermore, as professionals our autonomy is important in that we own the care that we provide to decrease the financial bias associated with physician owned PT clinics or referral for profit centers. As a student physical therapist who will be practicing clinician within the next 8 months I accept the responsibility of being a primary entry point into the healthcare system. I sincerely ask that you consider revising this legislation for the sake of public safety, responsible fiscal behavior, and betterment in the provision of medical care.

Submitter : **Dr. Fedor Logvin** **Date: 08/30/2007**

Organization : **Alameda Medical Group**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Fedor Logvin MD

Submitter : **Brad Tully** **Date: 08/30/2007**

Organization : **Hooper, Lundy**

Category : **Device Industry**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

CMS-1385-P-13372-Attach-1.DOC

CMS-1385-P-13372-Attach-2.DOC

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FILE NO. 03154-901

August 29, 2007

Centers For Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, Maryland 21244-8018

Re: Physician Self-Referral Provisions

Ladies and Gentlemen:

Our firm represents a number of companies that are fully or partially owned by physicians and that supply hospitals and ASCs with implantable medical devices. This letter presents our comments on behalf of one of these companies, Allez Spine, LLC ("Allez Spine"), in response to the proposal of the Centers for Medicare & Medicaid Services ("CMS"), as set forth in connection with its July 12, 2007 proposed revisions to Medicare's physician fee schedule, to modify the Stark law's definition of "entity."

I. Summary Of Allez' Position

As is discussed below, CMS' proposal raises a number of difficult conceptual issues and we are concerned that CMS' proposal could potentially restrict the ability of physicians to hold ownership interests in medical device manufacturing/distribution companies. As is explained below, Allez Spine generates savings for its customers by supplying them with implantable devices at prices that are typically lower than those paid by the customers when they purchase equivalent medical devices from traditional non-physician owned companies. CMS' proposed change, if interpreted to apply to Allez Spine, therefore would be likely to result in unnecessarily decreased competition and in increased costs for hospitals and ASCs in obtaining medical devices.

Accordingly, as is set forth in more detail below, Allez Spine believes that CMS should take one or more of the following actions:

(i) Clarify that CMS' new proposal is limited to formal "under arrangements" relationships with hospitals, whereby an outside provider performs all components of the DHS for the hospital. If this is done, the new rule would not impact Allez Spine since the medical devices that it provides are not covered by Medicare on an "under arrangements" basis.

(ii) Clarify that a company that provides implantable medical devices used by a hospital in the performance of inpatient and outpatient hospital services or by an ASC will not itself be considered to "perform" any DHS, since the provision of an implant device is not the provision of a service. If this is done, the new rule would not impact Allez Spine since, while it provides devices, Allez Spine does not perform any services for hospitals or ASCs at all.

(iii) Clarify that implant devices are not DHS as they are provided by Allez Spine. Because the device company is not a hospital, referrals to it should not be considered to be for inpatient or outpatient hospital services. In addition, the referrals should not be considered to be for other DHS except when the services provided by the company are DHS in their own right (such as, for example, diagnostic imaging services). Allez Spine should not be considered to be providing DME, prosthetics, orthotics or prosthetic devices or supplies that are DHS in their own right under the Stark law, since that is not how the items provided by Allez Spine are characterized for Medicare coverage or payment purposes.

II. Explanation Of The Unique Contribution Of Physician-Owned Medical Device Companies

Before turning to a legal analysis of CMS' proposal, it will be helpful for CMS to understand the motivation underlying the formation of Allez Spine and many other physician-owned medical device manufacturing or distribution companies and the opportunity for savings that such companies create for their customers. To understand the business rationale of Allez Spine for having physician investors, it is important to understand the context of the company's founding by a group of spine surgeons approximately four years ago. These surgeons were frustrated by the extent to which they had become marginalized by the large spine companies. Whereas in years past many surgeons had meaningful interactions with the engineering and product development staff of device manufacturers, many more recently were finding their input and ideas largely ignored or just put on the shelf. At most, they were asked to try out new products or participate in clinical trials, but had no meaningful outlet for their own ideas and innovation.

Moreover, the surgeons saw how much money was being spent on marketing, promotion, and sales fees that were built into product costs, which in turn went up every year. The big companies exercised what was tantamount to oligopolistic sales practices and pricing power.

Sales representatives were making more money on commissions in some cases than the surgeons' fees, and they bore no risk and took no night call. The costs of marketing typically represent in the range of 30% of the total costs incurred by the large national device distribution companies. However, surgeons who own their own company can for the most part avoid these marketing expenses, and it was perceived that the elimination or reduction of the role played by expensive commissioned sales representatives would create substantial savings that could result in hospitals and ASCs ultimately saving money on their purchases of medical devices from surgeon-owned companies.

No single surgeon or small group could devote the time or raise the capital to compete in any meaningful way. The big spine companies were the only game in town. The only possible way to compete against the dominance of the big companies was for physicians to collaborate in a constructive, legal, and innovative manner.

Discussions among colleagues led to extensive analysis of the regulatory issues and the structural options. A physician-led enterprise was conceived that offered the opportunity, but not the guarantee, of a company that could put the surgeons on a more equal footing with the big device companies and create savings opportunities. Allez Spine was guided by the principles of shared intellectual property (IP), rapid product development cycles, lower cost structure, highly competitive pricing at the low end or bottom of the range, donating back to the research community, and continual innovation. Consequently, each surgeon investor committed to:

1) Share and contribute their ideas and innovations in a common enterprise - IP is assigned exclusively to the company;

2) Review and comment on emerging product concepts and designs;

3) Active participation on design teams with rapid turnaround of prototypes;

4) Place a substantial amount of money at risk with no promise of a return;

5) Equal ownership with no consulting fees, royalties, stipends, sponsored CME, etc;

6) Keep development costs low by combining surgeon-generated IP with in-house engineering and rapid prototyping capability;

7) Keep product costs low by controlling development costs, competitive outsourced manufacturing, and reduced marketing and cost of sales and distribution;

8) Provide full disclosure to patients in writing;

9) Donate each year to established, non-profit spine research foundations.

In summary, surgeons have always been essential to the progress and success of the medical device industry - as both sources of ideas and as end users of the products. As the spine industry has matured, several companies have come to dominate the sales and distribution of products, marginalizing the role of the individual surgeon. The "consulting" practices of these companies are under intense scrutiny. Any viable, competitive response to the status quo must find a way to incorporate solo or small groups of surgeons into an entrepreneurial venture in which the physician perceives a sense of ownership, participation, innovation, and influence. Even though each physician investor in Allez Spine holds no more than a fraction of 1%, Allez Spine believes that it has created such a venture, giving the surgeon a voice in the industry. Health system feedback confirms to Allez Spine that it is helping to create downward pressure on prices while providing a high quality product. Many of its surgeons are heavily involved in product development with several projects underway. Time will tell if Allez Spine can stake out a sustainable niche in a highly competitive field dominated by a few big firms, but Allez Spine feels that it has made a compelling start.

III. Background On The CMS Proposal

Absent some exception (and none is available for a small non-publicly traded company of the type that is the subject of this letter), the self-referral restrictions of the federal Stark law prohibit a physician from making a referral of a Medicare patient to an entity in which he or she directly or indirectly holds an ownership interest for the "furnishing" of a "designated health service" ("DHS"). The Stark law's current definition of what it means for an entity to be "furnishing" DHS includes only those persons or entities that directly bill the Medicare program for the DHS.

Allez Spine and similar companies do not themselves bill the Medicare program for the medical devices they provide. Indeed, they cannot bill directly, since their devices are not separately covered by Medicare, but are instead included in the DRG and ASC rates that are paid to their hospital and ASC customers. Therefore, no *per se* prohibition applies to physicians who order devices for their patients that are provided to hospitals and ASCs by companies in which they hold ownership interests. Instead, an indirect compensation relationship is created between the hospital or ASC which purchases the implant devices and the physician owners of the manufacturing/distribution company. Provided that the pricing applicable to the devices is held constant irrespective of the volume or value of the physicians' orders of the devices and is at fair market value, the requirements of the Stark law's exemption for indirect relationships can be satisfied, and, as has been recognized by CMS and MedPAC, the federal self-referral restrictions are not triggered.

However, under CMS' proposal, 42 C.F.R. Section 411.31's definition of when "a person or entity is considered to be furnishing DHS" would be expanded. CMS' proposed expansion of the definition of the entity that furnishes a service would retain the existing definition, which includes the entity that bills, but would add an additional alternative prong to

the definition under which persons and entities that do not themselves bill the Medicare program for any DHS would also be subject to the self-referral limitations if they are "the person or entity that has performed the DHS. . . ."[1] This proposed change would prevent indirect remuneration analysis from being used to permit a physician to have a non-exempt ownership relationship with a company "performing the DHS."

IV. CMS Should Not Throw Out The Baby With The Bath Water By Prohibiting Hospitals From Entering Into Arrangements That Achieve Savings For Them

It does not appear that any formal studies have been conducted by CMS or the GAO of either "under arrangements" relationships with hospitals generally or the specific type of implant device sale arrangement we consider herein. CMS, instead proceeding by its own admission based only on anecdotal evidence, has described its concern with arrangements by which companies perform DHS for other companies as follows:

> We have received anecdotal reports of hospital and physician joint ventures that provide hospital imaging services formerly provided by the hospital directly. There appears to be no legitimate reason for these arranged for services other than to allow referring physicians an opportunity to make money on referrals for separately payable services. . . . It appears that the use of these arrangements may be little more than a method to share hospital revenues with referring physicians in spite of unnecessary costs to the program and beneficiaries.

It must immediately be noted that, despite superficial similarities, the kind of joint venture we describe herein differs in many material ways from the arrangements over which CMS has expressed concern. First, implant devices are not anything that hospitals directly provide themselves – they invariably purchase them from outside companies. Second, the services would not otherwise be separately payable, since implant devices are not covered by the Medicare program in their own right. Third, since no direct payment is made for implant devices, the arrangements we consider herein are not a scheme for improving reimbursement. Fourth, as described above, there are legitimate reasons for physicians to be involved in the business that are wholly independent of any quest for profit. Fifth, and finally, rather than increasing costs, the type of venture at issue here will typically reduce costs.

When one traces the history of the issue of what entity will be considered to be furnishing DHS, it becomes clear that CMS is now considering a substantial change in policy that may

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[1] 72 Fed. Reg. 38122, 38187, col. 2 (July 12, 2007).

overturn a large number of long established relationships.[2] While overturning the table and starting on this issue afresh is not beyond CMS' power, it should nevertheless give careful consideration to making any such substantial change to already carefully worked ground. There is no necessity for such action by CMS with respect to the type of venture presented here, since the concerns which CMS has expressed do not arise in connection such a venture.

In any case, however, the "indirect" types of arrangements at issue here will still trigger the self-referral prohibition if they are not at fair market value. If CMS is skeptical as to what parties may consider to be fair market value, it appears that the public would be better served by CMS' providing more guidance on that issue and, if necessary, initiating some enforcement actions with respect to arrangements that it does not consider to be at fair market value, as opposed to expanding the scope of the existing prohibition so broadly so as to make the concept of fair market value irrelevant.

In any case, even if CMS concludes that the risks presented by certain arrangements are so great that they must be prohibited through a change in the definition of "entity," CMS should define the scope of such "*per se*" prohibited relationships with a narrow brush, as is discussed below.

V. The Meaning Of "Has Performed The DHS" Under CMS' Proposal Is Unclear And CMS Should Clarify That Its Proposal Applies Only To True "Under Arrangement" Relationships With Hospitals

CMS' proposal to define the person who is "furnishing" DHS to be the person who has "performed" the DHS is hardly illuminating when it comes to understanding what it in fact means to either "furnish" or "perform" DHS. No guidance at all is provided by the commentary for the not uncommon situation in which certain components going into the performance of the DHS are supplied by one company, while others are supplied by another. Instead, the new definition only makes sense when it is viewed simply in the broader context of rejecting the limits of the current definition, which defines "performed" by using the "bright line" test of who has billed Medicare for the DHS.

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[2] For example, without revisiting in detail the long history governing lithotripsy arrangements, it appears that CMS' contemplated change would be inconsistent with the balance that Congress intended to strike in this area with respect to lithotripsy services and which has been reaffirmed by a Court's holding that lithotripsy is neither an outpatient nor an inpatient hospital service. The example of lithotripsy supports the conclusion that services that are not inpatient or outpatient services in their own right should not now be considered in isolation and be deemed to be inpatient or outpatient services simply because they are being billed for by a hospital.

The problem presented when billing is not used to define "furnishing" is that, without further clarification from CMS, there is a danger that arrangements by which several parties are involved in the performance of a DHS may be prohibited when this was the not the intent of either CMS or Congress. Let us use the same example of diagnostic imaging services that is used by CMS in its commentary. Consider, for example, a physician-owned company that owns and operates an independent diagnostic testing facility ("IDTF") that is enrolled as a provider in the Medicare program and that performs services for a hospital on an "under arrangements" basis. That company will own or lease the relevant space and equipment, will employ or contract with the relevant personnel and will have the responsibility for organizing and administering the use of its space, personnel and equipment to conduct diagnostic studies for the hospital's patients. Under those circumstances, the IDTF can be fairly said to be "performing" the diagnostic services. If, as in CMS' example, the diagnostic services are radiology services, the IDTF can reasonably be considered to be performing DHS under the new definition.[3]

Let us consider what happens, however, if the services are not performed in a free-standing IDTF, but are instead radiology services that are provided in the hospital's space by a physician-owned company that is not itself enrolled in the Medicare program, but that will employ or contract with the relevant personnel and will have administrative responsibility for using the hospital's space and its own personnel and equipment to conduct diagnostic studies of patients. The commentary provides the example of a free-standing ASC or IDTF providing services to a hospital "under arrangement," and even goes so far as to address the situation where the joint venture entity leases space from the hospital. However, the commentary does not at any place address a situation where the service is not performed by an independent provider, but is instead performed within the space of the hospital itself. Most obviously (and any broader change would not appear to have been fairly telegraphed to the public by the proposed rule and its commentary), ***CMS should draw this extended line of "furnishing," if there is to be any extension at all, only as broadly as the commentary suggests CMS intended for it to be drawn – at formal "under arrangement" relationships by which free-standing providers that the Stark law would bar from billing Medicare directly for their own services when ordered by their physician owners instead bill their services through hospitals.***

If CMS were to interpret its proposal to apply beyond formal "under arrangement" relationships, it would be sliding down an impossibly slippery slope if it in fact intends for its approach to differ from the one that was proposed by MedPAC. For example, consider the then similar scenario under which radiology services are provided in the hospital's space by a physician-owned company that is not itself enrolled in the Medicare program, and that instead

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[3] The same would appear to be true if the facts were the same, except that the IDTF was not itself enrolled in the Medicare program.

provides the hospital with the personnel (including a radiology department administrator) and equipment to be used in conducting diagnostic studies for the hospital's patients, while the hospital takes the full administrative and regulatory responsibility for ensuring that the personnel and equipment are used to conduct diagnostic studies of the hospital's patients. Isn't this merely an arrangement where indirect remuneration analysis applies to the personnel and equipment relationships? Finally, consider a last scenario under which a physician-owned company merely provides the hospital with the non-supervisory technical personnel and equipment to be used in conducting diagnostic studies for the hospital's patients, while the hospital takes the full supervisory, administrative and regulatory responsibility for ensuring that the personnel and equipment are used to conduct diagnostic studies for the hospital's patients. Again, wouldn't this then be an arrangement where indirect remuneration analysis applies to the personnel and equipment relationships?

Drawing the line at formal "under arrangement" relationships is also consistent with the commentary's discussion of MedPAC's 2005 report to Congress. As CMS is aware, MedPAC recommended that CMS "should expand the definition of physician ownership in the physician self-referral law to include interests in an entity that derives a substantial portion of its revenue from a provider of designated health services." The CMS commentary makes it clear that CMS believes that the MedPAC proposal would impact "leasing, staffing, and similar entities." However, CMS chose not to make the same proposal that MedPAC had made. This clearly suggests that CMS believes that the reach of the MedPAC proposal would be broader than its own and, accordingly, that the CMS proposal was not intended to reach leasing, staffing or similar relationships. The most significant difference between the CMS and MedPAC approaches therefore appears to be that CMS' approach would only affect companies that perform DHS in its own right, while the MedPAC approach would also affect companies that only provide "inputs" to DHS or, indeed, services that have no relationship to DHS at all.

Unless the present definition of entity that is based on billing is retained unchanged or an "under arrangements" standard is used, whatever lines are ultimately drawn by CMS in the above scenarios will be arbitrary, since a flat out prohibition will apply on one side of the line (since there are no applicable ownership exemptions) and arrangements on the other side of the line will be permitted under the favorable analysis that applies to indirect remuneration. In any case, however, turning our attention to the physician-owned medical device manufacturing and distribution companies that are the subject of this letter, it seems manifestly clear that a company that merely sells an implantable medical device to a hospital or to an ASC cannot be considered to have performed a hospital inpatient or outpatient service or ASC service when performing the patient's "service" is the operational and regulatory responsibility of the hospital or ASC and the patient's physician who performs the surgery procedure in which the medical device is in fact implanted into the patient. Thus, ***if CMS does not limit its proposed change to true "under arrangement" relationships with hospitals, it should nevertheless clarify that its proposal would apply only where a completed "service" is being sold to a billing entity, and that the***

proposal was not intended to affect a medical device joint venture of the type at issue here which does not perform any services at all.[4]

VI. Even If CMS Extends "Entity" To Cover A Company That Provides Implantable Devices To Hospitals And ASCs, CMS Should Clarify That Implant Devices So Provided Are Not DHS.

Our final comment is that if CMS extends its definition of "entity" so as to include a physician-owned company that provides implantable medical devices to hospitals and ASCs, CMS should at the same time clarify that the self-referral ban still then will not apply to the situation at hand, since implant devices are not DHS when they are so provided. Because the device company is not a hospital, referrals to it should not be considered to be for inpatient or outpatient hospital services.

Similarly, the referral should not be considered to be for other DHS except when the services provided by the company are DHS in their own right (such as, for example, diagnostic imaging services). In addressing this issue, CMS should therefore also clarify that implantable medical devices provided to hospitals or ASCs which are paid for by Medicare under DRGs or ASC flat rates will not be considered to be DME or prosthetics, orthotics or prosthetic devices or supplies that are DHS in their own right under the Stark law.

Instead, as CMS has noted in its Phase III commentary in connection with its discussion of the whole hospital exemption, hospitals (and the same is true of ASCs as well), as such, are not authorized by Medicare to provide DME, prosthetics, orthotics or prosthetic devices or supplies. They instead only provide implant devices as components of their broader hospital or ASC services. A separate enrollment as a DMEPOS supplier would be required in order for a hospital or ASC (or for Allez Spine for that matter) to provide DME, prosthetics, orthotics or prosthetic devices or supplies. The hospitals and ASCs either will not have such enrollments or, if they do, such enrollments will not be the basis of the Medicare coverage for the implantable devices that are at issue here.

Moreover, the physician-owned company neither needs nor will it have any such enrollment, and it therefore cannot be considered to be providing items in those categories. This is because implantable medical devices simply do not fall within the Stark law's definitions of DME, prosthetics, orthotics or prosthetic devices or supplies. Implanted medical devices do not fit within the applicable definitions and therefore are not covered in their own right by Medicare as DME (as defined by SSA Section 1861(n)) or as prosthetics, orthotics or prosthetic devices or

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[4] For the reasons set forth herein, Allez Spine also believes that CMS should not adopt the MedPAC proposal.

supplies (as defined by SSA Sections 1861(s)(8) and (9).) They are instead simply supplies that are used in connection with surgeries.[5]

* * * * *

Allez Spine very much appreciates CMS' review of the issues discussed herein that impact physician-owned medical device manufacturing and distribution companies. Please feel free to call me if you have any comments or questions regarding the discussion herein.

Very truly yours,

W. Bradley Tully

WBT/ng
cc: Ed Geehr

[5] CMS' discussion of implants at 66 Fed. Reg. 935, January 4, 2001, which could be read to suggest that implanted knee joints are prosthetics, should not be considered to be relevant here. The comment was based on the completely specious contention that artificial legs, which are prosthetics, contain knee joints, and that implanted knee joints are therefore also prosthetics. While that might make sense where a joint is provided as part of an artificial leg, it makes absolutely no sense in the context presented here, where the joint is implanted, and no artificial leg is being used.

Submitter : **Mrs. McKeown Jennifer** **Date: 08/30/2007**

Organization : **Mrs. McKeown Jennifer**

Category : **Individual**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Jennifer Sanders-McKeown

Submitter : **Miss. Ashley Kane** **Date: 08/30/2007**

Organization : **Emory Sports Medicine Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-13374-Attach-1.DOC

13374

EMORY HEALTHCARE

EMORY SPORTS MEDICINE CENTER

59 Executive Park South, suite 1000
Atlanta, Georgia 30329
Phone 404.778.7176
Fax 404.778.7266

Dear Sir or Madam:

Hello, my name is Ashley Kane I am currently the working at Emory Sports Medicine Center as clinical staff. We are a Sports Medicine Physician based clinic in Atlanta Georgia. We have six (6) orthopaedic sports medicine, fellowship trained, physicians and five (5) full time athletic trainers working in the clinic, as orthopaedic athletic trainers/physician extenders, directly with our physicians and patients. We also have an athletic training fellowship with four (4) AT graduates each year. I completed my undergraduate degree at University of the Pacific and my graduate studies at Ohio University and have been a Certified Athletic Trainer (ATC) for three (3) years now.

I have worked in a variety of settings as an ATC, including the head athletic trainer for a large high school, US Soccer Federation Youth National Teams, and US Ski Association Freestyle Team. Currently, I am working in a physician setting at Emory University and Hospital and since coming here have obtained my orthopaedic Technologist Certification (OTC through the NBCOT). All of our clinical ATC's and ATC Fellows have also obtained their OTC for multi-credentialing purposes.

In our practice, our physicians feel that ATC's are the ideal physician liaison in the clinic setting to see patients. Who better to see musculoskeletal patients than musculoskeletal specialist? Certified Athletic Trainers have the education and knowledge to perform all skills necessary, and are some of the most qualified, to use their skills in physical medicine, patient evaluation, and rehabilitation.

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,

Ashley Kane, MS, ATC/L, OTC, PES
Emory Sports Medicine Center
59 Executive Park South, suite 1000
Atlanta GA. 30329
ph: 404.778.7137
fx: 404.778.7266
Ashley.kane@emoryhealthcare.org

Feel Free to contact me with any questions or concerns

Submitter : **Dr. Kevin McKeown** **Date: 08/30/2007**

Organization : **AAI**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Leslie V. Norwalk, Esq.
Acting Administrator
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Attention: CMS-1385-P
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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.

Kevin McKeown, MD

Submitter : **Mr. Patrick Lamboni** **Date: 08/30/2007**

Organization : **Salisbury University/Maryland Athletic Trainers As**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Pat Lamboni, I am a NATABOC Certified Atheletic Trainer. I have been in the profession for 28 years and am extremely proud of the strides my profession has taken educationally, clinically and politically for Athletic Trainers. 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.Our profession has taken tremendous strides in our educational requirements to meet the need of the population of patients we treat. Our infusion into the health care industry has given physicians another means of providing care to those who can benefit from our services. It seems with 1385-P and with the recent passage of "services incidental to" provision, a monopoly is being casted by certain professional (PTs)over services that other professions, such as Athletic Trainers can provde. Pure and very simple it is an attempt to push out Athletic Traioners from an expanding industry, which physicians are using very successfully incorporating into their treatment regimes, in an attempt to protect their turf. This is creating a very tenuous and very dangerous state which may leave a rather significant part of the American population without choice for treating their injuries and conditions.

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.

In conclusion, pure and simple this is another attempt by PTs to monopolize the market of providing therapy services. Passing this provision will be detrimental to theprofession and careers of Athletic Trainers. But, even worse, it will limit the access of the American public to quality and readily available services, which is another "Blackeye" to CMS in caring for our citizens.

Sincerely,

Pat Lamboni, ATC

Submitter : **Ms. Barbara Hemphill** **Date: 08/30/2007**

Organization : **Salem State College - Athletic Training Students**

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Senior Athletic Training Student at Salem State College in Salem, Massachusetts.

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 a future athletic trainer, I will be qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam will ensure that my patients receive quality health care. State law and hospital medical professionals 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.

As an Athletic Training Student and future Certified Athletic Trainer, any decision to restrict the profession of Athletic Training will have a substantial impact on the careers of all Athletic Trainers, current and future. Please help to ensure that this outstanding profession can excel to match the way that we have all been educated and trained.

Sincerely,

Barbara Hemphill
Salem State College Athletic Training Student - Senior
Eastern Athletic Trainers Association Student Delegation President
Eastern Athletic Trainers Association Student Delegate - Massachusetts

Submitter : **Mr. Brian Vaught** **Date: 08/30/2007**

Organization : **St. Paul's School for Boys**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Brian J. Vaught, a certified athletic trainer, teacher and coach at St. Paul's School for Boys in Brooklandville, MD. In addition to providing comprehensive health care to our student athletes, I also teach 6th grade Health Science, 5th & 7th grade Physical Education and coach middle school and junior varsity level ice hockey. I received my bachelor of science degree in Health Sciences-Athletic Training from Slippery Rock University of Pennsylvania in 2002 and my master of science degree in Athletic Training from West Virginia University in 2004. In addition to being a proud NATABOC Certified Athletic Trainer, I am also a certified American Red Cross First Aid/CPR/AED instruetor as well as a certified National Academy of Sports Medicine Performance Enhancement Specialist.

I am writing today to voice my strong opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive the highest 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,

Mr. Brian J. Vaught MS, ATC, PES
Assistant Certified Athletic Trainer
St. Paul's School for Boys

Submitter : **Ms. Shelly DiCesaro** **Date: 08/30/2007**

Organization : **DiCesaro Spine and Sport**

Category : **Academic**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Dear Sir or Madam:

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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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,

Shelly DiCesaro,MS, ATC, CSCS (and/or other credentials)

Submitter : **Mr. Tony Pazzaglia** **Date: 08/30/2007**

Organization : **Terrapin Physical Therapy, Inc.**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Mr. Kerry Weems,Administrator Designate,
Subject: Medicare Program; Physician Self-Referral Issues

I am a physical therapist and owner of an independent physical therapy practice. I employ a small staff of 10, 3 of whom are also licenced physical therapists (PTs). Approximately 40% of my patients are Medicare beneficiaries and our practice is diligently committed to providing the best evidenced-based physical therapy treatment for common and potentially expensive musculoskeletal disorders. Our treatments are safe, effective and cost-effective, especially when compared to pharmaceutical management and surgical interventions.

An unfortunate trend in my community is the growing number of physician owned physical therapy services (POPTS) This trend is certain to increase cases of physical therapy overutilization and dilute the skill mix in services provided as it once did prior the the Stark loophole which allowed physicians to provide physical therapy as an ancillary service within thier office. This exception is defined so broadly that it facilitates the creation of abusive referral arrangements. POPTS practices limit patients freedom of choice. In my practice, I have treated patients who had to argue with thier physician to recieve treatment outside of his office. One Orthopaedic Surgeon who owns a physical therapy practice told a patient of mine, "If you don't go to my PT, I won't prescribe PT at all."

Additionally, POPTs practices encourage an environment where the physical therapist is not likely to tell the patient the truth if it is not in the M.D.s best interest. If the PT is employed by the M.D., his professional obligation to honestly educate the patient may be compromized by his desire to keep his job. If the M.D. is a surgeon or prescribes medication, thier will be a conflict of interest in that PTs treat many of the same conditions successfully without medication or surgery. Does the PT tell his patient, "I can help your arthritic knee without drugs or surgery as evidence shows" at the risk of termination from his Surgeon employer? Sadly, not in my town.

Lastly, POPTS groups dilute the number of licensed PTs with unlicenced, less qualified personel in order to be profitable. There exists a shortage of licenced PTs and they are in demand and therefore able to command a relatively high salary. Additionally, their exists a stigma where PTs working for M.D.s are considered to be practicing in an unethical mannor. The M.D.s, therefore have a difficult time profiting while meeting the needs of the patients with licenced personel and instead hire fewer PTs and fill in with unlicenced aides while the PTs sign the legal documentation. This is against CMS regulations and results in inferior physical therapy care. Please help to elose the in-office ancillary services exeption. Physical therapy should be performed by licensed physical therapists or licenced physical therapy assistants and not be physicians or PTs working for them.

Thank you for consideration of my comments.

Sincerely,

Tony Pazzaglia, Physical Therapist, Orthopaedic Clinical Specialist

Submitter : **Mr. Jason Vian** **Date: 08/30/2007**

Organization : **Mr. Jason Vian**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jason Vian and I am an Athletic Trainer. I presently work for OAA Orthopaedic Specialists in Pennsylvania. My educational background includes graduate degrees in athletic training and business administration. In addition, I have helped numerous people of all ages over the last 10 years working in many different settings. Presently, I work with Physical Therapists, and Physical Therapy Assistants on a day to day basis. We work in cooperation to take multiple viewpoints on a patient and create the best treatment for them.

Therefore, 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,

Jason Vian MS, MBA, ATC, CSCS

Submitter : Mrs. Jessica Elder **Date:** 08/30/2007

Organization : Cedar Crest Whole Health Medical Center

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a recent college graduate and newly certified athletic trainer. I now work at a small, rural family practice medical center. I also work with local high schools providing athletic training services. I am currently one of the few, if not the only, athletic trainer in the area. I have been able to provide this rural community with a service that they would not otherwise receive.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jessica Elder, ATC

Submitter : **Gautam Sreeram** **Date: 08/30/2007**

Organization : **Emory University**

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 an anesthesiologist at Emory University Hosptial in Atlanta, GA and am writing to express strong 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 scrvices, and that the Agency is taking steps to address this complicated issue.

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 time and consideration.

Gautam M. Sreeram M.D.
Assistant Professor in Anesthesiology
Emory University School of Medicine

Submitter : Mr. William Twohy **Date:** 08/30/2007

Organization : AANA

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Dear Administrator:
I write to support the Center for Medicare and Medicaid Services(CMS) proposal to boost the value of anesthesia work by 32%. Under the proposal CMS would increase the conversion factor(CF) by 15% in 2008 compared to 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.

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).

36,000 CRNAs provide some 27 million anesthetics in the U.S annually. We 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 are undervalued, and the proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Submitter : **Dr. Albert LaCasse** **Date: 08/30/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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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.

Albert LaCasse, MD

Submitter : Dr. Ferdinand Santos **Date:** 08/30/2007

Organization : Dr. Ferdinand Santos

Category : Physician

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

See attachment

CMS-1385-P-13386-Attach-1.DOC

13386

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.

Dr. Ferdinand Santos,
Springfield, Oh, 45502

Submitter : Mr. Bill Butch **Date:** 08/30/2007

Organization : Physical Rehabilitation Services, Inc.

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : **James Powell** **Date: 08/30/2007**

Organization : **James Powell**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am writing in regards to my support for the proposed increase in anesthesia payments under the 2008 Physician Fee Schedule. It is encouraging to see that CMS recognizes the underevaluation of anesthesia services and is willing to address the issue.

It is imperative that our patients continue to have access to expert anesthesia care, and that CMS ensures this by implementing the proposal in the Federal Register for the anesthesia conversion factor increase.

Thank you for your consideration.

Submitter : Mr. Edward Gilberti **Date:** 08/30/2007

Organization : Post University Athletic Trainer

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Certified and State Licensed Athletic Trainer. I live in Shelton, Connecticut and work at Post University in Waterbury, Connecticut. I have my Bachelor s in Science from Northeastern University in Boston, Massachusetts.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilitics proposed in 1385-P.

While I am concerned that these proposcd 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 rccommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Edward Gilberti ATC, LAT
Head Athletic Trainer
Post Universiry
800 Country Club Road
Waterbury, CT 06708

Submitter : **mark wilkes** **Date: 08/30/2007**

Organization : **mark wilkes**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

AS a member of the American Association of Nurse Anesthetists (AANA),I write to support the Centers for Medicare and Medicaid Services proposal to boost the value of anesthesia work by 32%. under the proposed rule medicare would increase the anesthesiaconversion factor by 15% in 2008 compared with current levels, this would help to ensure that CRNA's as medicare part B providers can continue to provide medicare beneficiaries with access to anesthesia services. if CMS's proposed change is not enacted and 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 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America's 36000 CRNA's provide over 27 million anesthetics in the U.S. annually in every setting and are the predominate providers in rural and under-served areas. Medicare patients and healthcare delivery in the U.S. depend on our services. the availability of anesthesia services depends in part on fair medicare payments 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, Mark Wilkes CRNA
804 cottonwood place
Liberty MO. 64068

Submitter : **Mr. Ying Hsin Lo** **Date: 08/30/2007**

Organization : **Northside Anesthesiology Consultant**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am currently a student at the University of Illinois and I am in the Athletic Training Program.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Lindsey Otte

Submitter : **Mr. Jacob Dinauer** **Date: 08/30/2007**

Organization : **Carthage College**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Certified Athletic Trainer and Professor at a NCAA DIII University in Wisconsin. I work daily to improve the health care of our athletes and the education of future certified athletic trainers. Besides my duties on the field providing emergency care, and assesment, I save our student athletes time and money by providing rehabiliation services. I also teach a full load teaching undergraduate athletic training students how to be successful professionals.

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,

Jacob Dinauer, MEd, ATC, LAT, EMT-I

Submitter : **Dr. Dana Crovo** **Date: 08/30/2007**

Organization : **Spectrum Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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,

Dana Crovo, MD
16 Hunts Point Road
Cape Elizabeth, Maine 04107

Submitter : **Dr. Nadeem Khan** **Date: 08/30/2007**

Organization : **Interventional Pain Specialists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am submitting my request CMS to reevaluate payment methodology.

Submitter : **Ms. Sharon Panske** **Date: 08/30/2007**

Organization : **The Richland Hospital, Inc**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Sharon Panske, I have a Bachelor's of Science degree inaddition I am a certified athletic trainer by the NATA, as well as a licensed athletic trainer by the State of Wisconsin. I am employed by The Richland Hospital, Inc and work in the Rehabilitation Services Department where I work in the Sports Medicine outreach program covering local high schools.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and 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,

Sharon Panske, ATC, LAT

Submitter : **Dr. Christine Chow** **Date: 08/30/2007**

Organization : **Dr. Christine Chow**

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:

This is a letter to illustrate my support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful and glad that CMS has recognized the gross undervaluation of anesthesia services in this country, and that the Agency is taking steps to address this long-standing and 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 problematic 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 truly 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 not only vital but 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.

I thank you for your time and consideration of this serious matter.

Sincerely,

Christine C. Chow, M.D.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern:

Beginning in the 1990s, there was a gradual increase in interest in orthopedic surgeons employing their own physical therapist, using the safe harbor loophole of the Stark Law. Over the past 10 years, we have seen a dramatic increase in the number of physical therapists employed in physician offices. This includes a family practitioner, a podiatry group of eight physicians, and the four largest orthopedic groups in Lancaster comprising a total of 31 orthopedic surgeons. At the present time, every major orthopedic practice in Lancaster employs its own physical therapy staff.

There are three aspects to this self referral pattern that appear to be most troubling. First and foremost is that the patient is unclear about their choices regarding rehabilitation. There have been many instances where patients who previously were seen at our office for rehabilitation, were later funneled to the physician s office for future rehab services. In many cases, the patient has reported to us that they were interested in returning to us for their treatment, but that the orthopedist suggested that it would be more convenient for them to participate in a rehabilitation program at their office. In several cases when the patient persisted, the referring physician was even more adamant that their own PT center was the best place for them to initiate and complete their rehabilitation. In a medical paradigm where the doctor knows best , it is at times very difficult for a patient to contradict the physician s wishes, and assert his own desire to have a choice in his rehabilitation care. Thus, the physician has a distinct advantage in referring his own patients to his ancillary care facility.

Secondly, we feel that the quality of the care provided at the physician-owned physical therapy offices is not on par with that of the independent PT practices. We have an inherent motivation to maximize our clinical and continuing education skills, our business practices, and our professional development. We serve various physicians and specialty groups throughout the county, we are driven to maximize patient outcomes, closely monitor our treatments and their effectiveness, and use evidence-based practice interventions and protocols in our paticnt care.

Lastly, this attention to quality helps us to focus on controlling costs and ovcr-utilization of our services. An OIG study several years ago regarding physician-owned physical therapy practices showed that there was both excessive frequency and duration of physical therapy treatments rendered in the POPTS practices compared to independent PT offices. We are under constant scrutiny from third party payers to practice efficiently, and our professional reputation is assessed daily by our treatment decisions. This makes us more focused on the clinical rather than the administrative side alone of our business, as we strive for the best patient outcomes in the shortest period of time.

There is no doubt that we have lost a significant number of referrals from our orthopedic consumers, and that the proliferation of ancillary physical therapy services within their own practices has resulted in decreased business in our independent professional practice. We are of the opinion that POPTS proliferation is not driven by patient convenience or improved quality of care, but simply an opportunity to take advantage of a loophole in the law which allows legal referral for profit.

We respectively request that you very carefully consider the facts presented to you by all of our colleagues who are in independent practice. By eliminating physical therapy services as an exemption to the in-office ancillary service federal physicians self referral laws, you will be taking a major step toward protecting the Physical Therapy profession and providing consumers with a choice in their care, improving the quality of their care, while reducing costs of outpatient rehabilitation.

Thank you

Submitter : Dr. Emilio Puentedura **Date:** 08/30/2007

Organization : Southwest Rehabilitation Associates

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I wish to strongly recommend that Physical Therapists and Physical Therapy Services be one of the services to be added to the Stark III physican self referral policy under CMS this coming Sept 31.

Submitter : Mrs. Kimberly O'Leary **Date:** 08/30/2007

Organization : Fitness Together

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My Name is Kimberly O'leary and I am a Licensed Athletic Trainer who was the former Head Ahtletic Trainer at Western New England College in Springfield MA. I am currently working as a per diem LATC and a Personal trainer at Fitness Together in Northampton MA. I have a masters degree from Springfield College and have worked as an ATC for the past 14 years.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kimberly O'Leary, Med, ATC

Submitter : **Veronica Phillips** **Date: 08/30/2007**

Organization : **Veronica Phillips**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

see attached

CMS-1385-P-13401-Attach-1.DOC

13401

August 30, 2007

Mr. Kerry N. Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

RE: Medicare Program, Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

Dear Administrator Designate:

I am writing to address Physician Self-Referral Issues and the delivery of physical therapy services. I am a recent graduate and have been practicing for the past several months. I have heard over the past few years the discussions about physician owned practices and am concerned for the quality of care my patients are receiving.

I recently worked in a clinic that saw a drastic decline in the number of referrals from an orthopedic group. This decline happened after the orthopedic group opened their own physical therapy practice. While we experienced a decreased in the number of overall referrals, we continued to receive the referrals of the family members and close friends of the surgeons. I was perplexed as to why the surgeons would not recommend our practice to anyone other than their loved ones.

I am concerned about the quality of care my patients are receiving from physician owned practices. If the quality of care is equal among private and physician owned practices, why are the family members not being referred to the "in- office ancillary services"? Patients seek treatment from the physical therapists at my facility because of the high quality of care we provide, not because their physician told them they had to come here. Unfortunately, not every patient knows they have the right to choose.

The "in-office ancillary services" has not benefited the people who matter the most, the patients. Instead the patients are receiving lower quality of care for the financial benefit of the physicians. Please consider the repeal of this exception and thank you for your consideration of my comments.

Sincerely,

Veronica L. Phillips, DPT
Physical Rehabilitation Services, Inc.
1033 Perry Highway
Pittsburgh, PA 15237

Submitter : **Miss. Jessica Peters** **Date: 08/30/2007**

Organization : **Wellington Orthopaedic**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I recently graduated from Miami University of Ohio with my Bachlors Degree in Athletic Training. Soon after graduation I begain working full time in a physical therapy clinic and also at a local high school.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certifieation exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jessica N. Peters, ATC

Submitter : **Dr. Deborah Bash** **Date: 08/30/2007**

Organization : **American Society of Plastic Surgeons**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter.

CMS-1385-P-13403-Attach-1.PDF

#13403

AMERICAN SOCIETY OF PLASTIC SURGEONS®

Executive Office
444 East Algonquin Road
Arlington Heights, IL 60005-4664
847-228-9900
Fax: 847-228-9131
www.plasticsurgery.org

August 30, 2007

Herb Kuhn
Deputy Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically

Re: Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Mr. Kuhn:

The American Society of Plastic Surgeons (ASPS) is the largest association of plastic surgeons in the world, representing surgeons certified by the American Board of Plastic Surgery. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer. ASPS promotes the highest quality patient care, professional, and ethical standards and supports the education, research and public service activities of plastic surgeons.

ASPS offers the following comments on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule for "Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008" that was published in the July 12, 2007 *Federal Register*. As requested in the proposed rule, the relevant "issue identifier" that precedes the section we are commenting on is used as a sub-heading throughout this letter to assist the Agency in reviewing these comments.

Resource-Based PE RVUs

In its calculation of the practice expense (PE) equipment costs, the Centers for Medicare & Medicaid Services (CMS) assumes equipment is in use 50 percent of the time a physician's office is open. In the

proposed rule, CMS acknowledges that it does not have sufficient empirical evidence to justify an alternative assumption and proposes no change at this time. As a long-standing participant on the RUC, we are aware that the RUC has previously commented that a 50% utilization rate for all equipment is not an accurate measure and further points out that CMS does not have any data to support the 50% value. Therefore, ASPS respectfully requests that CMS officials consider alternative utilization rates based on recommendations from the RUC and others provided during this comment period.

Physician Practice Information Survey

ASPS appreciates that CMS has expressed support of the Physician Practice Information Survey being conducted by the AMA, in conjunction with over 70 medical specialty societies and the Gallup organization. ASPS, a contributor to the survey process, looks forward to providing the data from this survey to CMS in the Spring of 2008 in hopes it an be used to update the practice expense per hour calculations for plastic surgery and other specialties in the 2009 Medicare Physician Payment Schedule.

Coding—Multiple Procedure Payment Reduction for Mohs Surgery

ASPS supports the CMS proposal to apply the multiple procedure payment reduction rules to the Mohs micrographic surgery codes. We believe it is fair and consistent with CMS multiple procedure payment policies already affecting a wide range of procedures with codes in the Surgery/Integumentary System section of CPT.

Impact

In this proposed rule, CMS announces that the Five-Year Review Work Adjuster will increase from negative 10.1% to negative 11.8%. **ASPS commented last year and reaffirms in this letter that we disagree with CMS's decision to create this adjuster and strongly urges CMS to apply any necessary adjustments to the conversion factor instead.** Continuing to use the work adjuster is undesirable, because it has the potential to inappropriately affect relativity among services in the RBRVS and creates confusion among the many non-Medicare payers that adopt the RBRVS payment system.

TRHCA—Section 101(b): PQRI

The proposed rule discusses in detail plans for implementing the second year of the Physician Quality Reporting Initiative (PQRI) and also discusses the criteria that must be met by organizations proposing quality measures. ASPS has concerns about relying on the National Quality Forum (NQF) as the final arbiter of physician measures at this time. We support the laudable work of the National Quality Forum and are members. However, we feel that leadership in the quality arena is still emerging, and no one organization is ready to lead the charge at this early juncture. As more transparent and streamlined processes are developed for the various quality leadership groups, we may be better equipped to identify one organization to support this role for the entire health care community.

CMS notes that it plans to evaluate and test mechanisms for registry-based quality data reporting to PQRI. ASPS is pleased that CMS is moving forward with allowing the use of registries for this purpose. The Society is actively engaged in performance measurement and quality improvement efforts. Specifically, ASPS is committed to measuring and improving the quality of patient care through its national web-based registry, Tracking Outcomes and Operations in Plastic Surgery (TOPS). The TOPS registry was launched in 2002 to provide valid procedural information on clinical outcomes and key components of perioperative care performed by board-certified plastic surgeons. The program is

currently undergoing a major redesign, and the updated version will include the opportunity for participants to report on relevant quality measures. In addition, we are awaiting release of the regulations pertaining to patient safety organizations to determine if TOPS is eligible. The Society is also an active participant in the Surgical Quality Alliance's collaborative data registry development initiative.

ASPS is also concerned about addressing gaps in providing quality care. ASPS has petitioned the Physician Consortium for Performance Improvement (PCPI) to allow plastic surgery to take the lead in developing evidence-based performance measures for chronic wounds of the lower extremity. The PCPI is in the early stages of convening a Chronic Wounds Work Group, and we look forward to sharing further information with CMS next year regarding the progress of this workgroup. It is our hope that we can develop a series of measures that will be useful for PQRI in 2009 and beyond.

TRHCA-Section 101(d): PAQI

The Tax Relief and Health Care Act of 2006 (TRHCA) requires the Secretary of the Department of Health and Human Services to establish a Physician Assistance and Quality Improvement Fund (PAQI) of $1.35 billion to be available for physician payment and quality improvement initiatives. Although physicians are facing a 10% payment rate cut on January 1, 2008, CMS has chosen to use the PAQI fund for quality purposes only rather than applying it to the conversion factor. **ASPS strongly believes these funds should be applied to the conversion factor to help reduce the negative update in order to provide a greater incentive for continued participation in the Medicare program.**

As always, we greatly appreciate your consideration of these comments. We will continue to carefully monitor future correspondence on these and other relevant health care issues.

Sincerely,

Deborah S. Bash, MD
Chair, ASPS Payment Policy Committee

Submitter : Dr. Penny Shepherd **Date:** 08/30/2007

Organization : Dr. Penny Shepherd

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Chiropractic is already has the least amount of parity within governement programs that provide health coverage. I am U.S. citizen by birth and a tax paying citizen at that yet the profession by which I earn my income is highly discriminated against by my government's agencies. It what I do is not good enought to be considered for reimbursement under the medicare program or the other government policies for that matter then my income should not be taxed to support these entities.

Submitter : Dr. Sandra Amundsen **Date:** 08/30/2007

Organization : Dr. Sandra Amundsen

Category : Physician

Issue Areas/Comments

Technical Corrections

Technical Corrections

The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxaiton, be eliminated. I am writing in strong opposition to this proposal.

While subluxation does not need to be detected by an X-ray, in some cases the patient clinically will require an X-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

By limiting a Doctor of Chiropractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider for duplicative evaluation prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and thus needed treatment. If treatment is delayed illnesses that could be life threatening may not be discovered. Simply put, it is the patient that will suffer as a result of this proposal.

I strongly urge you to table this proposal. These X-rays, if needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,
Sandra Amundsen, D.C.

Submitter : **Dr. john boudeman** **Date: 08/30/2007**

Organization : **Dr. john boudeman**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re CMS-1385-P
Anesthesia Coding

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposed increase for anesthesia services under the 2008 Physician Fee Schedule. I am happy to see CMS has seen how undervalued anesthesia services have been and proposed a change to rectify it.

When RBRVS was created anesthesia services were added as an afterthought and were severly undervalued. Today anesthesia services stands at $16.19 per unit. This amount does not cover the cost involved in caring for our nation's seniors. The situation is becoming very unstable and many anesthesiologists are leaving areas with high percentages of seniors in order to make a living. This creates access to care issues for these people.
In order to ensure expert medical care for these seniors, it is imperative CMS follow through with the proposal.

Thank you for your consideration

Submitter : **Ms. Vicky Graham** **Date: 08/30/2007**

Organization : **Wesleyan University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern:

I am a certified athletic trainer, board certified nationally for 23 years, and licensed to practice in the state of Connecticut. I am presently employed at Wesleyan University, where I provide health care for several hundred student-athletes.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services; which, as you know, is not the same as physical therapy. My education, clinical experience, and national board certification 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,

Vicky Graham, M.S., ATC, LAT
161 Cross Street
Middletown, CT 06459

Submitter : Mr. Alan Reid **Date:** 08/30/2007

Organization : North Hills Hosptial

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

My name is Alan Reid and I am employed as a Certified Athletic Trainer working for a hospital outpatient clinic. After receiving my undergraduate degree and national certification in 2003 I went on to receive my Masters of Science in Athletic Training that following year. My educational background has given me a firm foundation for quality patient care. Over my four years of professional experience I have worked side by side with many allied health care professionals, who have never questioned the quality of my rehabilitation service or my ability to perform physical medicine. With my current job, six months of the year are spent in the clinical setting and the other six months, working in minor league hockey. While in the clinical setting I find myself working side by side with Physical Therapist, Occupational Therapist, and Physical Therapist Assistants on a daily basis, therapists often come to me for advice and suggestions for their patient s treatment. There is no greater show of respect than other allied health care professionals asking for my ideas and advice when it comes to patient care.

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,
Alan Reid, MS, ATC, LAT

Submitter : Mrs. Tessy Pothen **Date:** 08/30/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Dear Administrator,

As 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%. Under CMS's proposed rule Medicare would increase the anesthesia conversion factor by 15% in 2008, compared with current levels. (72 FR 38122, 7/22/2007. If adopted, CMS's proposal would help to ensure that CRNAs (Certifies Registered Nurse Anesthetists) as Medicare part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in medicare payment is important for many reasons:

1.As AANA has previously stated to CMS,Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia & other healthcare services for Medicare beneficiaries.

2.This proposed rule reviews & adjusts anesthesia services for 2008.Most part B providers' services had been reviewed & adjusted in previous years,effective Jan.2007. However the value of anesthesia work was not adjusted by this process until this proposed rule.

3.CMS's proposed change in the relative value of anethesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS's proposed change is not enacted & if congress fails to reverse the 10% sustainable growth rate cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, & more than a third below 1992 payment levels.

America's 36000 CRNAs provide some 27 million anesthetics in the US annually, in every setting requiring anesthesia services, & are the predominant anesthesia providers to to rural & medically underserved America. Medicae patients & healthcare delivery in the US 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, & its proposal to increase the valuation of anesthesia work in a manner that boosts Mediacare anesthesia payment.

Sincerely,

Tessy Pothen, SRNA (student registered nurse anesthetist)
Nazareth school of Nurse Anesthesiology,
2601 Holme Ave, Philadelphia
PA.19152.

Submitter : **Craig Halls** **Date: 08/30/2007**

Organization : **Craig Halls**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Craig Halls. I'm a Licensed Athletic Trainer working at Aurora Health Care in Wisconsin.

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,

Craig Halls, ATC

Submitter : Dr. Leland Berkwits **Date:** 08/30/2007

Organization : Mountain Spine and Rehabilitation Specialists

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic.

Effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the 'all physicians' crosswalk. This did not relieve the continued underpayment of interventional pain services, the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians' ability to provide interventional pain services to Medicare beneficiaries. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries' access.

The current practice expense methodology does not accurately address expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. CMS should treat physiatrists, who list interventional pain or pain management as their primary Medicare specialty designation, as 'interventional pain physicians' for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur. RESOURCE-BASED PE RVUs: (I.) CMS SHOULD TREAT PHYSIATRISTS WHO HAVE LISTED INTEVENTIONAL PAIN OR PAIN MANAGEMENT AS THEIR SECONDARY SPECIALITY DESIGNATION ON THEIR MEDICARE ENROLLMENT FORMS AS INTERVENTIONAL PAIN PHYSICIAN FOR PURPOSES OF RATE-SETTING. Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to all physicians for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report or physiatry anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is physiatry or anesthesiology. (II.) CMS SHOULD INCORPORATE PRACTICE EXPENSES IN RULE-MAKING. I urge CMS to take the appropriate steps necessary to incorporate the updated practice expense data into payment methodology as soon as it becomes available. (III.) CMS SHOULD WORK WITH CONGRESS TO FIX THE SGR FORMULA SO THAT PATIENT ACCESS WILL BE PRESERVED. The sustainable growth rate ('SGR') formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Continuing reimbursement cuts are projected to total 40% by 2015 despite 20% projected increase in practice expenses over the same period. Because of this flawed formula, physicians and other practitioners disproportionately bear the cost of providing health care to Medicare beneficiaries. Accordingly, many physicians face clear financial hardship and will have to make painful choices as to whether they continue to care for Medicare beneficiaries.

Submitter : **Mr. Martin Matney** **Date: 08/30/2007**

Organization : **Polarzone NW**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer and Physical Therapist Assistant employed in a physical therapy practice as well as a therapeutic modality manufacturing facility. I have a Bachelor of Science Drgree in Biology and a Master's of Business Administraion and have been employed in the healthcare field for over 27 years. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

Whilc 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,

Martin M. Matney, MBA, ATC, PTA

Submitter : **Date: 08/30/2007**

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.

Joel D. Fine, M.D.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

Subject: Physician Self-Referral Issues
Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule.

Dear Mr. Weems:

I am a physical therapist and have been in private practice for over six years.
I am writing in regards to the practice of physician owned physical therapy that has rapidly expanded in our area and most areas of the country. As you know, as do many others that physician owned physical therapy presents as an abusive situation most of the time. In our area private practice has historically provided the best trained clinicians and quality of care compared to other forms of physical therapy. As practice owners if we don t provide the best care our business does not survive. Presently, we still provide the best care but our business struggles due to physician owned physical therapy. Physicians that in the past have routinely referred to us do not any more because they own physical therapy and they will profit from referring to it.

Our clinic is known in the area as providing high quality specialized services that no one else does in our area. Our staff is trained in orthopedic manual therapy through residency approved programs. I am the only PT in my area with this type of training. I regularly see patients that have gone to physician owned physical therapy for months with no improvement. Only when they directly confront their physician about coming to our clinic do they finally agree, reluctantly. The patient will typically improve in less than 2 weeks to at least 80%. Most of the time the patient is very angry for spending a lot of time and money on ineffective PT, when they could have come to see us and been better much quicker and cheaper.

Just think of how many patients keep going to physician owned PT and never get better, but only keep going back because the physician makes a profit from it.

When this situation of physician owned PT is explained to the patient they cannot believe that it is legal. The patient thinks, of course they will refer more patients for more visits because they can profit from it.

Not surprising, physicians try to hide their real reason for owning the PT practice, profit, by stating they have better communication with the PT if it is in house. Our clinic provides optimal communication to physicians. This has never been an issue in any private practice I have ever seen.

I urge to you remove the in office exception to physical therapy services. Physicians can no longer own pharmacies, why should they own PT. Health care should be about what is best for the patient not what is best for the physicians pocket book.

Submitter : Mrs. Gayle Lehne **Date:** 08/30/2007

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,

Gayle Lehne, CRNA,MSN

R. R. # 4 Box 149B

Mount Sterling, Illinois 62353

Submitter : Dr. Ernest Marsolais **Date:** 08/30/2007

Organization : University Hospitals of Cleveland

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13416-Attach-1.PDF

13416

University Hospitals
Case Medical Center

CASE
CASE WESTERN RESERVE UNIVERSITY

E. Byron Marsolais, MD, PhD
Spine & Rehabilitation
Division of Pain Medicine
Department of Anesthesiology

August 30, 2007
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

Initially, RBRVS created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, 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 forcing anesthesiologists to avoid 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. 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 necessary expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely yours,

E B. Marsolais

E. B. Marsolais, M.D., Ph.D.
Professor of Orthopaedic Surgery, Biomedical Engineering and Anesthesiology
Case Western Reserve University, byron.marsolais@uhhs.com

EBM/lm

Submitter : Dr. Lawrence Yore **Date:** 08/30/2007

Organization : Advanced Urology of South Florida

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-13417-Attach-1.DOC

13417

ADVANCED UROLOGY OF SOUTH FLORIDA

PALM COURT PLAZA
5130 Linton Boulevard, Suite F-6
Delray Beach, FL 33484

561-496-4444
FAX 561-496-2001

Lawrence M. Yore, M.D., F.A.C.S.
Diplomate, American Board of Urology
Fellowship in Urologic Oncology
Fellow, American College of Surgeons

Edward M. Scheckowitz, M.D., F.A.C.S.
Diplomate, American Board of Urology
Fellow, American College of Surgeons

Emanuel E. Gottenger, M.D.
Diplomate, American Board of Urology
Fellowship in Urologic Oncology/Laparoscopy

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P

Dear Mr. Kuhn:

I am a urologist who has practiced in South Florida for over 17 years. I am part of a three-man urology group, which provides services to a large elderly Medicare community. I am fellowship trained in urologic oncology and thus the majority of my patients have bladder, prostate or kidney cancer. I am writing to comment on the proposed changes to the physician fee schedule rules that were published on July 12, 2007 that concern the Stark self-referral rule and the reassignment and purchased diagnostic test rules.

The changes proposed in these rules will have a serious impact on the way my group practices medicine, compromising our ability to provide the best medical care to our patients. With respect to the in-office ancillary services exception, the definition should not be limited in any way. It is important to patient care for urologists to have the ability to provide pathology services in their own offices. It is equally important to allow urologists to work with radiation oncologists in a variety of ways to provide high quality radiation therapy to patients.

The proposed changes to the reassignment and purchased diagnostic test rules will make it difficult, if not impossible for me to provide prostate ultrasound, kidney ultrasound and pathology services. This in turn will result in elderly patients having to travel to obtain these services and will also result in delays in diagnosis and treatment.

The proposed "under arrangement" rule will prohibit the provision of joint ventures, which can make expensive new technologies readily available in our community. An example would be proton therapy for prostate cancer, which is only available in a handful of centers in the United States and is not available in South Florida.

The sweeping changes to the Stark regulations and the reassignment and purchased diagnostic test rules go far beyond what is necessary to protect the Medicare program from fraud and abuse. The rules should be revised to only prohibit those specific arrangements that are not beneficial to patient care.

Thank you,

Lawrence M. Yore M.D., F.A.C.S.

Submitter : **Ms. Joni Kalis** **Date: 08/30/2007**

Organization : **Kalis Contracting and Arizona Board of PT**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

August 30, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-1850

Re: CMS-1385-P
THERAPY STANDARDS AND REQUIREMENTS

Dear Sir or Madam:

As the President of the Arizona State Board of Physical Therapy, I submit the following comments on the proposed rules changing the definition of physical therapist in Section 484, Title 42 of the Code of Federal Regulations. The proposed rules are part of the 2008 Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 2008, found in Volume 72 of the Federal Register, published on July 12, 2007.

Under subsection (i)(B) and (ii)(B) of the proposed definition of physical therapist an applicant would need to have [p]assed the National Examination approved by the American Physical Therapy Association. I strongly suggest that CMS rely on state licensure and that the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of physical therapist be deleted from the final rule.

We, along with all of the other state boards of physical therapy examiners, have already adopted a national qualifying exam for physical therapists, the National Physical Therapy Examination (NPTE). The Federation of State Boards of Physical Therapy (FSBPT) develops and administers the NPTE in close collaboration with the state boards. Working together, we have developed a national passing score. The FSBPT has done an outstanding job of meeting our needs. Likewise, the NPTE has been a valuable tool in screening physical therapist applicants. Through the NPTE, we have been able to successfully filter applicants. We protect the public not only by our statutory authority to regulate physical therapists and physical therapist assistants, but also by ensuring that all physical therapists meet a minimum standard of competence for licensure via the FSBPT s licensing exam.

CMS should not usurp the states function of licensing physical therapists and other professionals. Health care professional credentialing and licensing is a classically state function. Licensing and credentialing are the domain of the states. CMS proposal would inappropriately transform a state function into a federal function. There is no justification for this action, and CMS should prevent it by removing the proposed rule.

CMS respects states' rights and state licensure for other health care professions, and it should continue to do so with respect to physical therapists. For example, CMS' regulations define a physician as a doctor of medicine & legally authorized to practice medicine and surgery by the State in which such function or action is performed. 42 C.F.R. ? 484.4 (2006). Likewise, a registered nurse is defined as [a] graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing. 42 C.F.R. ? 484.4. Establishing requirements that are different than what the states require for licensing PTs would be inconsistent with not only the rights of the states, but also CMS own standards.

Moreover, the federal government should not impose an additional burden on the states, particularly since its stated desire for a national examination already satisfied and its other stated goals would not be better met by the burden it proposes to impose. The proposed unfunded mandate could result in the development of a second exam, which would create confusion and more work for the states, without benefit. Our resources are already limited and stretched.

In the preamble to the proposed regulations, CMS says that it is seeking uniformity. The fact of the matter is that uniformity and consistency across the nation and across provider settings already exists. State licensing requirements apply to physica

CMS-1385-P-13418-Attach-1.DOC

CMS-1385-P-13418-Attach-2.DOC

13418

#13418-Attachment #1

August 30, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-1850

Re: CMS-1385-P
THERAPY STANDARDS AND REQUIREMENTS

Dear Sir or Madam:

As the President of the Arizona State Board of Physical Therapy, I submit the following comments on the proposed rules changing the definition of "physical therapist" in Section 484, Title 42 of the Code of Federal Regulations. The proposed rules are part of the 2008 Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 2008, found in Volume 72 of the Federal Register, published on July 12, 2007.

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In the preamble to the proposed regulations, CMS says that it is seeking uniformity. The fact of the matter is that uniformity and consistency across the nation and across provider settings already exists. State licensing requirements apply to physical therapists without regard to where they practice. All states accept CAPTE accreditation. **All states already accept the Federation's NPTE and have adopted the same passing score. No federal regulation is required.**

In fact, the proposed regulations would likely defeat CMS' own goal of uniformity. If, for example, the APTA were to approve a different exam than the NPTE, which the regulations would permit it to do, physical therapists, patients, including Medicare and Medicaid beneficiaries and recipients, and others could face substantial confusion and interruption of service. As a state board of physical therapy examiners, we would continue to have authority to select an exam of our choice for licensing purposes. However, under the proposed rule, a physical therapist would have to pass a second exam approved by the APTA to qualify for Medicare reimbursement. Thus, patients might be forced to change physical therapists as they become Medicare or Medicaid eligible, and the current uniformity and continuity of standards across the country would be lost. Thus, the proposed rules undermine CMS' ambition for uniformity of standards.

CMS and the federal government should not empower an advocacy group, like the APTA, to establish an examination or any qualifications for professionals to provide healthcare services to patients. The APTA's mission is to advocate and promote the profession. As a licensing body, our mission is to ensure that physical therapists are qualified to provide physical therapy services and are authorized to do the work for which they are trained. **The FSBPT, the organization to which we look for the national licensing exam, was created to eliminate, protect against and prevent the inherent conflict of interest that the APTA would have if it were to have authority over the examination and credentialing processes.** Even the APTA recognized this conflict of interest problem two decades ago when it created the Federation of State Boards of Physical Therapy. CMS must not allow this conflict of interest to become a rule.

In summary, I strongly urge CMS rely on the national licensure exam that that is already in place for physical therapists. The APTA does not currently have nor should it administer an examination to physical therapists because of the huge cost and conflict of interest this involves. I urge CMS to remove the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist" be deleted from the final rule

I appreciate the opportunity to comment on the proposed rules regarding physical therapist and physical therapy assistant qualification requirements.

Respectfully yours,

Joni Kalis, P.T., M.S.
Practicing Physical Therapist and
President, Arizona State Board of Physical Therapy

#13418-Attachment #2

August 30, 2007

Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-1850

Re: CMS-1385-P
THERAPY STANDARDS AND REQUIREMENTS

Dear Sir or Madam:

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Moreover, the federal government should not impose an additional burden on the states, particularly since its stated desire for a national examination already satisfied and its other stated goals would not be better met by the burden it proposes to impose. The proposed unfunded mandate could result in the development of a second exam, which would create confusion and more work for the states, without benefit. Our resources are already limited and stretched.

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Respectfully yours,

Joni Kalis, P.T., M.S.
Practicing Physical Therapist and
President, Arizona State Board of Physical Therapy

Submitter : **Dr. Michael Oliver** **Date: 08/30/2007**

Organization : **Apex Physical Therapy, PLLC**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 30, 2007
Mr. Kerry N. Weems
Administrator Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule
Dear Mr. Weems:
I am an independent physical therapist in the Spokane area of Washington State, and I wish to comment of the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception. These comments are intended to highlight the abusive nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.
I have been an employee of a private, outpatient physical therapy clinic. During this time, our clinic has had a good working relationship with the local physicians and referral source; however, in the past several years, these local physicians have begun their own physical therapy clinics and have forced their patients to utilize only those services.
Examples of abusive arrangements our clinic has noted include patients who are encouraged strongly by their physician or health care provider to attend physical therapy only at the physician s physical therapy clinic. A frustrated Medicare patient told me that he was encouraged strongly to attend physical therapy at the physician s owned clinic which was approximately a 30 minute drive from his home. Unfortunately, there are eleven independent physical therapy clinics within five to fifteen minutes from this patient s home. The patient refused to drive 30 minutes and the physician s staff reluctantly gave this patient our clinic s name.
Another patient seen by the same physician group was instructed that further testing, to include x-rays, was being delayed because our clinic documentation was not readily available. She was also told that had she attended physical therapy at the physician s physical therapy clinic the delay would not have occurred. This statement was misleading, because all clinical documentation was available to the physician and was located in the patient s chart which was located in the exam room.
Many patients do not know that they have a choice as to the physical therapy clinic that they attend. Patients who already have a history or a relationship established with a certain clinic have been told that the physician would prefer that they discontinue that relationship and attend therapy at the physician s physical therapy clinic. The inability to attend physical therapy at a clinic of the patient s choosing is poor care and is abusive.
I do feel the in-office ancillary services is defined so broadly in the regulations that it facilitates the creation of abusive referral arrangements. Because of Medicare s referral requirements, these local physicians have a captive referral base of physical therapy patients in their offices.
I would like to thank you for your consideration into this matter. I hope that these issues can be resolved in the Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule.
Sincerely,

Michael S. Oliver, PT, DPT
Apex Physical Therapy, PLLC
1951 1st St.
Chency, WA 99004

Submitter : **Dr. Kieu Luu** **Date: 08/30/2007**

Organization : **Duke Univ Med Ctr**

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 strong 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, a huge payment disparity for anesthesia care was created, 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 matter.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Certified Athletic Trainers have the knowledge and education to evaluate and rehabilitate patients with medicare insurance. Our training and education gives use the knowledge to work with patients of every age. We are able to treat the young eged people through their elder years. By getting insurance companies to recognize Certified Athletic Trainers as health care professionals, we can help physical therapy clinics see more patients. We can help give all patients in need of physical therapy a high level of care and another individual how can see them for their therapy needs.

Submitter : **Mrs. Malinda McNew** **Date: 08/30/2007**

Organization : **Trinity Rehabilitation**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Malinda McNew and I m a licensed Athletic Trainer in Arkansas. I work for an out-patient physical therapy clinic. I received a Master of Science degree with an emphasis in athletic training. I am trained to provide the highest standard of care to all populations.

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,
Malinda McNew, ATC, LAT

Submitter : **Dr. Samuel Tirer** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

Ambulance Services

Ambulance Services

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

Samuel Tirer MD

Submitter : Mrs. Lisa Gallagher **Date:** 08/30/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attatchment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Mr. Eric Dell **Date:** 08/30/2007

Organization : Cedaron Medical, Inc.

Category : Private Industry

Issue Areas/Comments

TRHCS--Section 101(b): PQRI

TRHCS--Section 101(b): PQRI

Herb Kuhn
Acting Deputy Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018; Baltimore, MD 21244-8018

CMS-1385-P: Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008
We understand that the Secretary was required by Congress to address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry. These comments are in response to the proposed five options.

We believe that the data for the provider should be society driven. It is very important that each society control the database that Medicare is requiring. Only each society has the interest in and can ensure individual professional member s accountability as noted in the preliminary: quality data relevant to PQRI measures could be reported from the registries, on behalf of eligible professionals&claims (would be used) to capture the payment information at the NPI/Tax ID level.

None of the five options contains any data elements or methods that are different from the capabilities of our CONNECT products. CONNECT versions already contain the PQRI measure for Balance and Falls, and the analytic functionalities can calculate ratios. Our services should perform equal to or superior to all existing platforms.

Available technologies make Options 1, 2 and 5 sub-optimal methods for Medicare. Options 1, 2 and 5 pose challenges of the following nature: maintaining two separate data architectures, each requiring their own interfaces; data abstraction from two very distinct sets of data; data aggregation of disparate data elements into a singe dataset. These processes will lead to increased costs to both CMS and the provider, create delays, increase the complexity of accuracy and validity checks, and increase the potential for errors. However, if Medicare decides to pursue Options 1, 2 or 5 we are capable of eliminating the above-described challenges.

CMS should combine Options 3 and 4 into one plan and implement these Options together. A combination of Option 3 and Option 4 is the best direction for CMS as it gives CMS the best of both worlds, clinical data as well as procedures performed (CPT) and ICD codes.

CONNECT can provide a solution that is a combination of both Option 3 and Option 4 as well as collect all other information required. The combination would provide CMS with a unique data rich solution in a very short period of time. Also, if Medicare wanted a new query to resolve a new question, on an ad-hoc basis, an answer could be retrieved quickly, potentially from previously collected data. This process would not include any re-programming or re-design efforts.

We read an implicit either/or limitation in this proposal which is unnecessary in light of current technology. For example, There is an assumption that the registry is able to submit either: (1) the ICD-9, HCPCS, and CPT category II codes and exclusion as stated in the measures specifications; or (2) supply the clinical information needed for CMS to make those judgments (eligibility and quality of care). CONNECT offers both data streams of coding and clinical data, which removes the need for two data collection systems. A CONNECT solution would not require a series of linkage algorithms to attempt to connect the registry data with the matching claims. We already have the functionality for performing the necessary calculations to be able to submit completed numerator/denominators for both reporting and performance rates.

CONNECT as the do all solution is available today for members whose clinics use our technology as their patient charting platform. This issue makes a clear case for complete electronic health record systems to be at the center of the quality reporting initiatives, across the board for all healthcare service lines.

Submitter : **Dr. Robert Murray III** **Date: 08/30/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Reviciw)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Robert F Murray III, MD

Submitter : **Mr. Chuck Walker** **Date: 08/30/2007**

Organization : **St. Clare Hospital and Health Services**

Category : **Hospital**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an Athletic Trainer in Wisconsin. I work in a rural hospital out-patient rehab clinic. I have worked very hard over the last 12 years providing effective and efficient healthcare to my patients. My work has proven both beneficial and economical to these patients and they have been quite thankful and relieved to recieve it. I hold a B.S. in Athletic Training and an M.A. in Education. These degrees and my professional experience are part of what make me an excellent clinician to the patients for whom I care. Also, athletic trainers are well-qualified professionals who, through legitimate research, have demonstrative positive clinical outcomes for their patients. Just as important, these outcomes were achieved at affordable costs.

Athletic Trainers are certainly a group of individuals who would help improve healthcare for all individuals. Our extensive knowledge involving physical medicine and rehabilitation in conjunction with our economical presence in the allied health field can only prove to be extremely beneficial to all.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

Chuck Walker, MA, ATC, LAT,

Submitter : **Dr. Meena Desai** **Date: 08/30/2007**

Organization : **Dr. Meena Desai**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Re: CMS-1385-P

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Dear Ms. Norwalk:

I wish 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. I am in Pennsylvania which has one of the lowest rates and highest costs.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Edward O'Brien** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

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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Thank you for your consideration of this serious matter.

Submitter : **Ms. Kathleen Thornton** **Date: 08/30/2007**

Organization : **Southcoast Hospital Group**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Kathleen P Thornton and I am a Certified Athletic Trainer in the state of Massachusetts. I work for Southcoast Hospitals Group in both the hospital and High school setting. I am both licensed by the state of Massachusetts and certified by a national certifying agency.

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. I feel these changes will restrict my legal rights to practice my trade.

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,

Kathleen P Thornton MS, ATC, LAT, CSCS, PES

Submitter : Mrs. ANGELA BIRCHFIELD **Date:** 08/30/2007

Organization : ORTHOPAEDIC SPECIALISTS OF TEXAS

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

As a athletic trainer, I am very qualified to perform physical rehabilitation services based on my education, clinical experience and certification exam by the state and national level. The patients in the CMS heathcare system, deserve to receive the highest quality of care as do any patient with healthcare needs. However, with the proposed regulations these patients will not be getting the highest quality of care due to the shortages in the therapy workforce. Also, with the proposed CMS regulations it is very typical that other insurance companies follow suit to the Medicare rules and regulations, therefore not allowing athletic trainers to perform any physical rehabiliation services to any patient in any type of healthcare facility. Thus more healthcare workforce shortages are taking place. I request that CMS withdraw these changes so that athletic trainers can go about providing quality care on a day to day basis to the needs of their patients.

Submitter : **Dr. Jeffrey Forbes** **Date: 08/30/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Sincerely,

Jeffrey A. Forbes, MD
Valley Anesthesia, P.C.
Salem, VA
jforbz@cox.net

Submitter : **Mrs. Lori Johannessen** **Date: 08/30/2007**

Organization : **Southcoast Hospitals Group**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Lori Johannessen. I am certified and licensed athletic trainer in the state of Massachusetts. Iwork in both a hospital and high school 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.

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Sincerely,

Lori K Johannessen, ATC (and/or other credentials)

Submitter : Mr. David Salem **Date:** 08/30/2007

Organization : Salem & Green, a Professional Corporation

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-13434-Attach-1.PDF

13134

SALEM & GREEN
A Professional Corporation
ATTORNEYS

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dsalem@salemgreen.com

August 31, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

VIA FEDERAL EXPRESS

Re: CMS—1385–P PHYSICIAN SELF-REFERRAL PROVISIONS

Dear Mr. Norwalk:

Thank you for the opportunity to comment on the proposed regulations published at 72 FR 38122. These comments *are* confined to the proposals discussed under the caption *"M. Physician Self-Referral Provisions"*.

1. Changes to Reassignment and Physician Self-Referral Rules Relating to Diagnostic Tests (Anti-Markup Provision).

Under the proposal, marking up the PC or the TC of certain diagnostic tests "performed by an outside supplier" for a billing physician or medical group would be prohibited, regardless of whether the billing physician or medical group purchased the test/interpretation or was reassigned the right to bill for the test/interpretation.

We support the proposal to treat reassigned tests and interpretations in the same fashion as purchased tests and interpretations for purposes of 42 CFR 414.50. As there is seldom a business difference between purchasing a test or interpretation and contracting for the right to bill for a test or interpretation by reassignment, the Medicare reimbursement rules should extend the same treatment to reassignment and purchasing under 42 CFR 414.50 and associated regulations, including the definition of 'Entity' at 42 CFR 411.351.

However, we have serious concerns with other aspects of the proposed revision to 42 CFR 414.50. At the outset, we note that many suppliers who do not fit the common

understanding of "medical group" are required to enroll on Form 855B as a "Clinic/Group Practice". In California, suppliers required to so enroll include medical foundations. Did CMS intend to impose the anti-markup prohibition of proposed 42 CFR §414.50 on all suppliers enrolled in Medicare Part B as a type of "Clinic/Group Practice"?

We believe that the proposal to define an outside supplier as anyone other than "a full-time employee of the billing physician or medical group" will have serious unintended consequences. In many contexts, the anti-markup rule cannot be reasonably imposed if a markup is deemed to occur whenever a part-time employee or independent contractor is importantly involved in rendering a service. We note the following:

1. *Mandating Full-Time Employment.* Part-time employment and independent contractor relationships are often necessary and appropriate to accommodate a variety of needs. Many supplier staff members are not able to work full time. Forcing suppliers and their staff into full-time employment relationships will impose needless costs and will require forgoing efficiencies that are available through more flexible supplier-staff relationships.

2. *Part-Time Employment-Supplier's Net Charge Calculation.* What would constitute the "supplier's net charge" to the billing medical group if the interpreting physician was a part-time employee of the medical group? Does CMS expect a common law employee of a medical group to deliver an invoice for the interpretation? While medical groups may pay independent contractors separately for each discrete service, employees are generally reimbursed on a different basis. There is no rational basis for determining what portion of the employing medical group's total compensation costs for a part-time employee is the employee's "net charge" for a given service the employee renders.

3. *Defining Full-Time Employment.* When is a given staff member a full-time employee? Is forty hours per week of service required? Thirty-two hours per week? Wouldn't CMS strongly prefer to avoid regulating the working hours of supplier personnel?

4. *Technical Component.* In the TC context, the services of any given employee may be no more than one of many inputs necessary to deliver the technical service. Would the rule create an "outside supplier" whenever one of the employees involved in the delivery of a technical service does not work for the clinic/ group practice on a full-time basis?

5. *Proposed Outside Supplier Definition and the Corporate Practice of Medicine.* In states prohibiting the corporate practice of medicine, many suppliers enrolled as a clinic/group practice will be unable to directly employ the radiologist or other physician who performs a test interpretation. For example, consider the California medical foundation. Under California Health & Safety Code Section 1206(l), a medical foundation is a tax exempt charitable organization that provides medical research, health education and patient care to its patients through a group of at least 40 physicians representing at least ten medical specialties. Typically, the medical foundation contracts with a California professional corporation, the principal corporate entity entitled to practice medicine in California. The contract is usually long term, often running for five years, and provides that the practitioners employed by the professional corporation provide physician services exclusively to the foundation's patients. The professional corporation's practitioners provide physician and other practitioner services at the foundation's clinics, in hospitals, in skilled nursing facilities, and in other foundation-approved practice settings. The professional receipts generated by these practitioner services are treated as revenues of the foundation. The foundation pays the professional corporation for the practitioners' services, and the professional corporation in turn pays its employee and independent contractor practitioners.

Under the broadly accepted view of California's corporate practice of medicine prohibition, a medical foundation may not directly employ a physician. However, the overall relationship between a medical foundation, the professional corporation and its physicians leaves no doubt that the medical foundation is the genuine supplier of both the technical component and the professional component of the diagnostic tests produced in foundation clinics through the use of the foundation's equipment, employees, and contracting physicians. The medical foundation has all or most of the risk associated with the business of generating each test, maintains a unified identity as a non-profit healthcare organization, and functions as a single integrated entity that includes its contracting physicians or medical group. The medical foundation could be the employer of its physicians but for the corporate practice of medicine prohibition. To function as viable and integrated components of California's healthcare delivery system, a medical foundation must be able to provide and bill for the services that it renders.

In the medical foundation context, there is no reasonable way to determine a discrete "net charge" to the foundation for the services of the interpreting physician. The foundation is never invoiced or billed for interpretive services, and there is no reasonable basis for constructing an artificial deemed "net charge". If the entire professional component of an imaging service is deemed

the net charge to the foundation, and if the foundation pays the full professional component to the interpreting physician or to the professional corporation that employs the interpreting physician, the payment would arguably result in above fair market value compensation to the physician or employer. The medical foundation absorbs all of the expenses associated with the practice expense component of the PC. If the physician or employer billed the foundation for only the work RVU component of the PC, the foundation may have no way to recover the practice expensed component (or the malpractice component) of the service, which the foundation clearly provides. Neither the practice expense component nor the malpractice expense component can be billed to Medicare independently of the balance of the professional service.

In short, the economics at the heart of the medical foundation relationship are not appreciably different from those found in other integrated health care settings involving direct employment relationships. Reimbursement rules that define an outside supplier based on the presence or absence of an employment relationship, rather than on the overall unity of a medical foundation's clinic practice, would seriously and needlessly weaken an important component of California's health care delivery system. In any case, the need for generating entirely artificial invoices among the constituents of a medical foundation would greatly complicate and needlessly burden the medical foundation in question.

Finally, we question whether abusive markups are particularly correlated with all contracts between suppliers and their staff other than full-time employment. Should CMS determine that further controls on what it believes to be markups are needed, we suggest that CMS impose the new restrictions only on services furnished under the in-office ancillary services exception. Under this proposal, CMS would use its authority under Social Security Act Section 1877(b)(2) to deny the availability of the in-office ancillary services exception to the PC or TC of certain diagnostic tests which CMS defines to have been performed by an outside supplier. We are unaware of reports of abuses involving diagnostic test markups except in the context of services allegedly protected by the in-office ancillary services exception.

Accordingly, we ask CMS to withdraw proposed 42 CFR 414.50. At a minimum, we ask CMS to:

A. Clarify that 42 CFR 414.50 applies only to physicians and medical groups, and not to suppliers who are neither physicians nor medical groups but who must enroll in Part B as a "Clinic/Group Practice"; and

B. Abandon the proposed definition of an outside supplier for purposes of proposed 42 CFR §414.50.

2. Service Furnished Under Arrangements

We support CMS's proposal to revise the definition of 'Entity' in 42 CFR 411.351 to include the person "that has performed the DHS". This proposal will contribute importantly to closing the perceived under arrangements loophole that has been inappropriately used to circumvent the prohibition imposed by Section 1877(a) of the Social Security Act. We caution that further guidance may be necessary to better define who "performs" DHS in fact patterns where billing entities acquire inputs from multiple sources to deliver DHS.

Sincerely yours,

David S. Salem

DSS:gmf

Submitter : **Ms. Dana Dunn** **Date: 08/30/2007**

Organization : **Beacon Orthopedics and Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Licensed, Certified Athletic Trainer in the state of Ohio. I work for Beacon Orthopedics and Sports Medicine Physical Therapy. I have nine years of experience treating a wide variety of patients with orthopedics injuries. I received a BS Degree in Athletic Training and Sports Medicine and a Master's Degree in Exercise Science and Health Promotion.

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,

Dana Dunn, MS, ATC/L

Submitter : **Date: 08/30/2007**

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:

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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.

Submitter : Dr. Roderick Jones **Date:** 08/30/2007

Organization : American Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

It is my request that you abolish the recommended changes in CMS 1385-P. I have been in practice just over 15 yrs and some of my most memorable and appreciative cases were individuals that I never even treated. In fact, several had ranted and raved how I saved their life when I spotted an Abdominal Aortic Aneurysm on their radiographs. Others claim that they have been "everywhere" searching for an answer to their troubles. In a unique aspect chiropractors look not only for pathology but also review soft tissues, biomechanics, degenerative conditions and how they relate to one another as well as vertebral subluxations. X-rays play a vital role in a competent chiropractor's practice. This is a huge quality of care issue for all patients nonetheless those that are weak, elderly or handicapped with disabilities. This select population is even more vulnerable to adversities than the average JOE that walks into your offiee. I realize that you are all busy people, I will not ramble, however, if you are still not comfortable with making your decision I would be glad to offer more information and practical clinical examples that apply everyday in a real office. I may be contacted at (727)525-5500 ext. 229
Sincerely,
Roderick C. Jones, D.C.

Submitter : Dr. William Carney **Date:** 08/30/2007

Organization : William P. Carney, MD

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir/Madam:

I am writing in reference to your request for comments regarding in-office physical therapy and proposed Stark Regulation changes. I am a board certified orthopedic surgeon, in practice for ten years, and employ on-site physical therapy staff to care for my patients who require therapy.

What follows are comments regarding:
1. The patients' benefits of on-site physical therapy,
2. The prevalence of therapy centers already owned by therapists,
3. The apparent lack of potential restrictions on chiropractors who also own and operate in-office centers, and
4. The economic consequences to existing centers.

Please review and consider these comments as you consider changes in the Stark Regulations, as I believe they represent the sentiments of many of my colleagues.

"Doctor, why do my insurance premiums continue to rise each year but I get less benefits??" I hear this question every day. Restricting on-site therapy will hopefully not wind up being yet another answer to this common question. Providing on-site PT is extraordinarily beneficial to patient care. The therapist I employ frequently asks me very specific clinical questions regarding patient care. Also my patients often address their specific needs to me directly, while doing therapy. Having the facility on-site allows me to address the patients' and therapists' concerns and questions immediately. Patients are very comforted in knowing that their doctor is RIGHT THERE. They are very reassured in knowing that their doctor and therapist are working together, as a team. The whole experience becomes much more personal for the patient and I think this is very important in the healing process; whether the patient is recovering from a major surgery, or being treated for a non-surgical condition (that can be just as painful). On-site therapy is very important to me as a means of providing the best possible care.If restricted, the real loser is the PATIENT.

Most of the PT centers in NJ are ALREADY owned by businesses and physical therapists! Physical therapists can continue to own and operate therapy centers under the current laws. Does restricting in-office therapy therefore give the therapists an unfair economic advantage, or perhaps even a MONOPOLY?

Chiropractors also own, operate , and self-refer to their own therapy centers. Is CMS considering restrictions on chiropractors also? If only medical doctors are being targeted, this seems prejudicial.

My last comment involves economic consequences. What happens to the therapists, clerical staff, and medical billers currently employed by in-office facilities? Do they all loose their jobs, health insurance, and incomes? Does the physician owner also get punished , with large financial losses from physical therapy purchased equipment, computers and billing software? Will anyone reimburse me for my equipment if my center is no longer financially viable? At the very least, I believe existing centers should be grandfathered in.

I believe my sentiments represent many orthopedic surgeons' feelings and thoughts. As you can see, making changes in existing laws raises many questions and concerns for orthopedic surgeons who own and operate on-site centers. I hope the CMS will carefully consider the consequences of any proposed restrictions: to existing centers, to MDs being targeted over chiropractors, to handing therapists a virtual monopoly, but most importantly to the patient who asks " Doctor, why do my premiums continue to rise each year but I get less benefits??"

William Carney,MD
Ridgewood,NJ

Submitter : **Dr. David K Lenser** **Date: 08/30/2007**

Organization : **Dr. David K Lenser**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

David K Lenser

Submitter : **Robert Coon** **Date: 08/30/2007**

Organization : **Robert Coon**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Thank you for your consideration of this serious matter.

Robert M Coon

Submitter : Dr. VIJAY KANGOTRA **Date:** 08/30/2007

Organization : THOMAS JEFFERSON HOSPITAL

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Submitter : **Dr. Kerri Murphy** **Date: 08/30/2007**

Organization : **Dr. Kerri Murphy**

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,
Kerri L. Murphy, D.O.

Submitter : Mr. Michael Palm **Date:** 08/30/2007

Organization : AthletiCo

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Dear Sir or Madam:

My name is Michael Palm and I am an athletic trainer from Glendale Heights, Illinois. I have bee an athletic trainer for 6 years now. I have a bachelor degree in Athletic Training from Western Illinois University and a Master's Degree in Sports Medicine from The University of Pittsburgh. I also have a certification as a Certified Strength and Coditioning Specialist, which allows mc to used more advanced techniques in my rehabilitation protocols. Currently I work as an outreach athletic trainer for AthletiCo in the Chicagoland area in Illinois.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, l am more concerned that these proposed rules will crcate additional lack of access to quality health care for my patients.

As an athletic trainer, l 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 pertincnt 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 changcs related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Michael E. Palm, MS, ATC, CSCS

Submitter : **Jeff Cullen** **Date: 08/30/2007**

Organization : **Salem State College A.T. Student**

Category : **Individual**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Jeff Cullen and I am currently an Athletic Training student at Salem State College.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justifieation, 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,

Jeff Cullen
Athletic Training Student
Salem State College

Submitter : **Mrs. Claudette Maloney** **Date: 08/30/2007**

Organization : **AANA**

Category : **Nurse Practitioner**

Issue Areas/Comments

Background

Background

August 30, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dcar Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

This increase in Medicare payment is important for several reasons.

? First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
? Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
? Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Claudette Maloney, CRNA
8390 Phoenician Ct
Davie, FL 33328

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern:
Please see the attached document.

CMS-1385-P-13446-Attach-1.DOC

13416

Re: Removal of Physical Therapy Treatment from the In-Office Ancillary Services Exception.

From: (What should be the most relevant perspective,) "The Patient"

As a relatively active, intelligent person seeking proper guidance and professional input, I was enrolled in an exercise program at an outpatient physical therapy clinic owned by a physical therapist. This facility was recommended by a friend who experienced excellent results following knee surgery and subsequently participating in a step-down program. I was actually having some pain in my knee and mentioned it to my personal trainer at the facility during a training session. He immediately recruited one of the licensed physical therapists on staff to take a look. Following some questions and an impromptu consultation, he referred me for an orthopedic consultation. The P.T. had indicated my condition may require surgery, but a course of physical therapy may even prevent that from becoming necessary. He gave me the name of a physician he felt was "one of the best in the area when it comes to knees". I scheduled the consult.

The physical therapist was right. The doctor indicated surgery may be required, but physical therapy should be the first course of treatment. At that point I thought I would be going back to the physical therapy facility for treatment. Imagine my surprise when the doctor told me he would oversee my therapy in his office. I was confused. I even asked about therapy at the facility that referred me to him. He assured me I would be better served if he could keep a closer eye on my progress. Honestly, I pride myself on being an educated consumer, but I felt there were no options for me. I attended therapy at the doctor's office. It was busy. I only saw the doctor one time during therapy and that was at a scheduled appointment with him. It turns out, I was not even treated by a licensed physical therapist. I usually worked with an athletic trainer and sometimes an aide. My knee condition did not improve and after a second opinion, I proceeded with the surgery. It was performed by the original physician recommended by the physical therapist. Following surgery, a course of physical therapy was prescribed. As a result of my experience before surgery and my friend's exceptional rehab experience at the physical therapy facility, I expressed my interest in receiving treatment there. Again, my physician had concerns and felt my transition would be smoother under his supervision. I'm not a doctor or a therapist, I reluctantly acquiesced. Originally the doctor told me I would need to get into therapy almost immediately following surgery. When I attempted to schedule therapy, however, there were no available openings. Consequently, I did not get into therapy until 2 weeks following surgery. By the physical therapist's (on staff at the physician's office) own admission, or slip of the tongue, I should have gotten into therapy immediately and now I was having post-surgical problems as a direct result of waiting to get in.

You know the saying, "Fool me once, shame on you; Fool me twice, shame on me."

I stopped by the physical therapy facility where I had been training before surgery and found out I could have received therapy wherever I decided I wanted to go. All he had to

do was fill out a prescription. I unwittingly assumed the doctor would be acting in my best interest. I assumed from his strong "suggestions", this was not really my decision to make. I assumed many things and as a result, well, you probably know the saying about assuming too. I will not make that mistake again. I discontinued therapy at the physician's office, and began treatment at the physical therapy clinic immediately. Imagine my surprise again when I was treated or seen by a licensed physical therapist at every single visit. The treatment was more comprehensive, the care more hands-on and the facility was state of the art when in came to equipment. The environment felt more conducive to healing and they also focused on educating me about my condition and rehabilitation. I did have an interesting follow-up visit at the physician's office though.

During my 45 minute sentence in his waiting room, I read an interesting article about something called POPTS. Until then, I never even realized my orthopedic surgeon owned that part of the practice. He never mentioned that and, of course, I never asked. I wish I had been more informed from the very beginning.

Unfortunately, this is not an uncommon series of events for patients; It should be. Removing physical therapy services from the exceptions to the in-office ancillary services represents a powerful and viable solution.

You have, and perhaps even understand, the perspective of physical therapists as it relates to our concerns about the direction and livelihood of our profession. For me and my associates, those concerns pale in comparison to the rights and welfare of patients. As a health care professional (practicing P.T. for over 15 years), I fully recognize and appreciate people's vulnerability and trust when it comes to their physical rehabilitation. As a husband, father and patient, myself, I have been forced to trust my health care, and that of my family, to physicians. With my background and education, I feel, perhaps, more armed with knowledge than most. However, I want assurances there are no financial incentives for my health care providers to recommend or provide treatment for anything; therapy, medication, etc. In addition, I would like to know my insurance company and/or government has provisions to prevent such inherent conflicts of interest. I want the quality of my care and that of my loved ones in the hands of people who are truly concerned about *our* health, not *their* bottom line.

On my behalf and that of my associates, we thank you for a forum that affords us the opportunity to voice our concerns.

Submitter : Dr. Najeeb Siddique **Date:** 08/30/2007

Organization : Dr. Najeeb Siddique

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

Rc: 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.

Najeeb Siddique, M.D.

CMS-1385-P-13447-Attach-1.DOC

13441

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.

Najeeb Siddique, M.D.

Submitter : **Dr. Sigurdur Sigurdsson** **Date: 08/30/2007**

Organization : **Dr. Sigurdur Sigurdsson**

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.

Sigurdur S. Sigurdsson, MD

Submitter : Mr. Yoshikatsu Ushijima **Date:** 08/30/2007

Organization : Mr. Yoshikatsu Ushijima

Category : Academic

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am currently work as a personal therapist and athletic trainer of the professional athlete came from Japan. I am a National Athletic Trainers' Association(NATA) certified athletic trainer who also earned Master's of Science degree of Kinesiology in 2004.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Yoshikatsu Ushijima, ATC (and/or other credentials)

Submitter : Dr. Lyle Woerth **Date:** 08/30/2007

Organization : Lincoln Anesthesiology Group, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. Maria Leonova **Date:** 08/30/2007

Organization : Yale New Haven Medical Hospital

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Mr. David Jones** **Date: 08/30/2007**

Organization : **National Athletic Trainers' Association**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern,

My name is David Jones and I am a Certified Athletic Trainer in the state of Alabama. I hold two Master degress with one in Athletic Training and another in Health Care Administration. I am deeply concerned by this proposal as once again this is not in line with the current idealism of Consumer Driven Health Care and allowing consumer decide what health care provider they choose to deliver their health care needs. Competition has proven to drive costs downward. The limiting of reimbursement dollars to a very SELECT group of providers hurts the consumer but also increase cost due to you the provider.

I am voicing 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

Sincerly,

David Jones, MS, MSHA, ATC
100 Kentucky Oaks
Montgomery, AL 36117

Submitter : **Ms. Sheila Jackson** **Date: 08/30/2007**

Organization : **Department of Veterans Affairs**

Category : **Federal Government**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

RE: Docket #1385-P Therapy Standards and Requirements, Physician Self-Referral Provisions

BRIEF INTRO ABOUT SELF: I work for the Department of Veterans Affairs in Washington, DC. I am a registered Kinesiotherapist and Certified Driver rehab specialist who evaluates and trains the veterans and active duty service members from Walter Reed to drive again after a disability. I graduated from Norfolk State University. I have been in my profession for 27 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 acccss and workforce shortage to fill therapy positions is widely known throughout the health care industry. It is irresponsible for CMS to further restrict PMR services and specialized professionals.

It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to reccive 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,
Sheila J. Jackson, RKT

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I am an advocate AGAINST physician owned physical therapy services. They are constructed purely as revenue makers for physicians. I do not feel these type of businesses are in the best interest of the patient and have witnessed poor quality of care through these systems. They are detrimental toward the autonomy practice of the physical therapy profession. I ask that the stark laws be amended to end the practice of physician owned physical therapy services. Thank you.

Submitter : **Patrick Creedon** **Date: 08/30/2007**

Organization : **St. Francis Hospital**

Category : **Physician Assistant**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

August 30, 2007
Dear Sir or Madam:

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.
I am a Physician Assistant as well as a Certified Athletic Trainer and currently work in trauma surgery in a level 1 trauma center in Connecticut. I have a Bachelors degree, two Masters degrees and twenty years of patient care experience. I am appalled at this latest attempt to prevent Certified Athletic Trainers from working in this setting.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services. 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.
These proposed changes to the hospital Conditions of Participation will create additional lack of access to quality health care for my patients. The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. I believe that it would be irresponsible for CMS, which is supposed to be concerned with the health of Americans, 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,

Patrick J. Creedon MS ATC MHS PA-C
St. Francis Hospital and Medical Center
Department of Surgery
114 Woodland Street
Hartford, CT 06105

Submitter : Mr. Terry Beeck **Date:** 08/30/2007

Organization : Bellin Health

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To whom it may concern:

My name is Terry Beeck and I am a licensed Athletic Trainer in the State of Wisconsin. I have been employed at Bellin Health for the past 11 years. Some of my responsibilities at Bellin Health are to provide Physician Extender coverage and community athletic event coverage. I also work as an Athletic Trainer at a Division I University. I graduated from a curriculum program majoring in Athletic Training from Western Illinois University and have been practicing athletic training for 13 years.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Terry Beeck, LAT/ATC

Submitter : Mrs. Tracy O'Kane **Date:** 08/30/2007

Organization : Mrs. Tracy O'Kane

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attachment

CMS-1385-P-13457-Attach-1.DOC

August 30, 2007

Mr. Kerry N. Weems
Administrator - Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Dear Mr. Weems,

I am writing to you to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. I am a Physical Therapist who has been practicing in Baltimore County, MD since 2002. My experience as a Physical Therapist has been primarily in outpatient orthopedics, working for 2 of the largest outpatient rehabilitation companies in the United States. Prior to returning to graduate school in 1999 to obtain my Master's Degree in Physical Therapy, I practiced as a Certified Athletic Trainer in a physician owned physical therapy practice from 1995-1999. My comments are mostly related to the "incident to" rule, which allows physicians to bill for physical therapy performed by any nonphysician staff (and not limited to physical therapists), and the financial gain that is obtained from these services being provided by such individuals other than licensed Physical Therapists.

I think it is pretty clear that the potential for fraud and abuse exists any time that a physician(s) is/are given the opportunity to refer Medicare beneficiaries to entities in which they have a financial interest. This is clearly the case with physician-owned physical therapy services as the physicians have an inherent financial incentive to refer their patients to the practices in which they have invested and to overutilize those services for financial reasons.

In addition to the obvious issues of fraud and abuse associated with the ability to self-refer and overutilize physical therapy services for financial gain, I would like to specifically comment on the abuse associated with allowing individuals other than Physical Therapists to provide physical therapy services. The May 1, 2006 OIG report regarding "Physical Therapy billed by Physicians" mentions that physical therapy in physician owned practices is often rendered by podiatrists, chiropractors, massage therapists, and physical therapy aides, in addition to the appropriately trained physical therapists and physical therapist assistants. I have to ask the following question. Why, in any other setting is it not legal for anyone but a licensed Physical Therapist or Physical Therapist Assistant to provide physical therapy services, but somehow in a physician owned practice it is ok? What is the point of a 2-3 year Master's or Doctoral level degree in physical therapy and passing a national licensure examination, if it is ok for other such

individuals to administer these services? It somehow devalues what we do as a profession, and provides the general public with a much lower quality service just to increase financial gain.

Thank you for your consideration of my comments and thoughts surrounding this very important matter affecting the Physical Therapy profession.

Sincerely,

Tracy A. O'Kane, PT, MSPT
Facility Director/Physical Therapist
Litofsky, Brager, and O'Brien Physical Therapists

Submitter : **Mark Lau** **Date: 08/30/2007**

Organization : **Mark Lau**

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.

Mark Lau, M.D.

Submitter : **Mrs. Jennifer Dougherty** **Date: 08/30/2007**

Organization : **Athletic Advantage, LLC**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer and a Certified Massage Therapist working in a private practice clinical setting. I have a Bachelors degree in Athletic Training, a Masters degree in Human Services/ Healthcare Administration and a certificate in Massage Therapy. On a daily basis I provide physical rehabilitation/therapy services to 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. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jennifer D Dougherty, MA, ATC, CMT
Certified Athletic Trainer
Certified Massage Therapist

Submitter : **Dr. Jerry Prentiss** **Date: 08/30/2007**

Organization : **Dr. Jerry Prentiss**

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.

Jerry E. Prentiss, M.D.

Submitter : Mr. Kris Schwiderski **Date:** 08/30/2007

Organization : Passavant Memorial Area Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Kris Schwiderski. I am A Certified and Licensed Athletic Trainer in the State of Illinois. I work in the Rehabilitation Services Department at Passavant Memorial Area Hospital in Jacksonville, IL. I completed my Bachelors Degree at Illinois State University, Normal, IL. I became certified as an Athletic Trainer in 1990 and have been working in the field ever since. I also became a licensed Athletic Trainer in the state of Illinois during the same time frame. Yearly, I attend nationally recognized educational seminars to keep up with the latest information that is relevant to my profession. Within the last year, I have also attained additional certification as a Performance Enhancement Specialist through the National Academy of Sports Medicine to further assist me with working with the patient population that need sports medicine/rehabilitation services.

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 the 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,

Kris A. Schwiderski, ATC, LAT, PES

Submitter : **Dr. Stephanie Brian** **Date: 08/30/2007**

Organization : **Dr. Stephanie Brian**

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.

Stephanie Brian, MD

Submitter : Ms. Philip Buss **Date:** 08/30/2007

Organization : St. Luke's Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1385-P-13463-Attach-1.DOC

13463

August 30, 2007

Dear Sir or Madam,

Good Day. My name is Philip Buss and I currently serve as the Manager of Outpatient Services at St. Luke's Hospital in St. Louis, MO. For 17 years I have had the privilege of serving the needs of the community in both clinical and managerial roles. I find myself continually frustrated with the lack of respect that certain health care providers receive. I am writing today to voice my opposition to the therapy standards and requirements regarding the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

My concern regards the ommitance of certified athletic trainers from the provisions set forth in the proposed standards. Through the years I have been fortunate to manage a diverse and committed group of professionals consisting of physical therapists, occupational therapists, speech therapists, nurses, exercise physiologists and certified athletic trainers. I've found through years of experience and education that certified athletic trainers have the knowledge and educational background necessary to treat the physically active. It's interesting that the world's elite and professional athletes primary health care providers are athletic trainers yet the general population is sometimes restricted from receiving treatment from these qualified professionals due to bureaucratic regulations.

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 throughout the nation.

Athletic Trainers are qualified to perform physical medicine and rehabilitation services. Athletic Trainers education, clinical experience, and national certification exam ensure that patients receive quality health care. State law, leading medical professionals and the American Medical Association (AMA) have deemed athletic trainers qualified to perform these services. The proposed changes in 1385-P attempts to circumvent those standards.

There is a therapy workforce shortage and a lack of access to qualified rehabilitative services throughout the country. The ability to provide flexible staffing in hospitals and other rehabilitation facilities are needed to ensure that patients receive the best, most cost-effective treatment available.

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. I strongly support legislation and regulation that permits our country's physically active the ability to receive treatment from Certified Athletic Trainers.

Sincerely,

Philip G. Buss MBA, LAT
St. Luke's Hospital

Submitter : **Dr. Lawrence Caruso** **Date: 08/30/2007**

Organization : **University of Florida**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Aeting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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. Rachel Kidd** **Date: 08/30/2007**

Organization : **Center for Physical Therapy and Exercise**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Rachel Kidd. I am currently working in a physical therapy outpatient clinic and a local secondary school as a athletic trainer. I have a bachelors of science degree from Northeastern University in Boston, MA. I am a licensed and certified athletic trainer and a member of the National Athletic Trainer's Association. I am certified in CPR, First Aid and AED and certified as a instructor of these areas.
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 reccived 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 mc 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,

Rachel Kidd, ATC

Submitter : **Ms. Kathleen Hertz** **Date: 08/30/2007**

Organization : **Flexeon Rehabilitation**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I wish to respond on the July 12th proposed 2008 physician fee schedule rule, specifically the issue surrounding phyisicna self-referral and the "in-office ancillary services" exception. I would strongly urge the CMS to remove physical therapy as a designated health service permissable under the in-office ancillary exception of the federal phyisican self-referral laws. My name is Kathleen Hertz and I have been a physical therapist for 3 years. One year I worked in a hospital setting with inpatient acute care and outpatient neuro. I currently am working at an outpatient physical therapy owned facility. Since I have been practicing, I have observed abusive arrangements made for patients of all insurances espcially medicare by physician owned phyiscal therapy groups. For example, recently I had been working with a patient who came for care at Flexeon because it was located by her house. She was not improving as well as I had hoped with therapy especially with being diagnosed with a MCL sprain. She went back to the physician with my recommendation for possible signs of meniscal pathology. He yelled at her for not going to his clinic, stating that "I was not a physician and didn't know what I was talking about. She then decided due to his rude character to get a second opinion. The next MD determined that she indeed had a meniscal tear and appreciated my input. This is just one example of many instances of phyisicans caring about finacial incentives instead of good quality patient care that non-physican owned facilities provide. If we receive doctoral educations currently and as much education as a chiropractor would recieve than why can't we be autonomous practioners as well. Not submissive to phyisicians, but recognized and respected as health care providers trying to provided the best patient care possible in a teamwork manner. This program will take us a step backwards into being recogized as movement specialists. Thank you for listening.

Submitter : **Dr. Kenneth Lie** **Date: 08/30/2007**

Organization : **Dr. Kenneth Lie**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

Thanks Inadvance for taking the time to read my letter. 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.

13468

August 27, 2007

The Honorable Herbert Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Washington, DC 20201

Dear Acting Administrator Kuhn:

I appreciate this opportunity to offer comment on Section II.E.2 (P-122) of the 2008 Medicare Fee Schedule Proposed Rule. I wish to comment on the proposed rule regarding the explicit withdrawal of the Multiple Procedure Reduction Rule (MPRR) exemption for Mohs surgical procedures as this will have a significant negative impact on the healthcare of U.S. citizens and potentially add unnecessary cost to the delivery of healthcare in this country.

As you are probably aware, over a million Americans per year are diagnosed with skin cancer, and over the last ten years the rate of new skin cancer diagnoses is growing by what many would call epidemic proportions. Mohs micrographic surgery is a common way of treating some of these cancers and is considered the gold standard among treatments for skin cancer, allowing the physician to examine 100% of the cancer margin to insure complete removal of the cancer with loss of as little normal skin as possible. It also provides the patient with the highest cure rate of any treatment for skin cancer. Mohs surgery is an outpatient procedure that utilizes onsite laboratory analysis of excised tissue while the patient waits for the results.

This proposed change will negatively impact the care of our patients and could add significant cost to an already stressed healthcare budget. This planned change is a departure from a longstanding exemption agreed to by CMS and virtually all private insurance carriers since 1991. The change proposed would eliminate the exemption and decrease reimbursement by 50% for either the Mohs excision or for the associated repair, and for Mohs excision of any additional cancers treated on the same day; ***such a decrease in reimbursement would not cover the cost of providing the service*** and possibly lead to the collapse of our institution's ability to provide the most effective care for our skin cancer patients.

If this proposed change is enacted, we will no longer be able to provide the same kind of high-quality, cost-effective services for our patients in need. I predict that skin cancer

surgeons will be forced to change the way they deliver care in order to cover their costs of providing this service.

The Final Rule that CMS agreed upon in the 1992 Medicare Fee Schedule that Mohs Surgery for skin cancer removal and subsequent reconstruction of the resultant defect involve, "a series of surgeries which, while done on the same day, are done at different operative sessions and are clearly separate procedures...They will be paid separately with no multiple surgery reductions." This is still correct and holds true today. **Mohs surgery is not simply an excision of a skin cancer.** Rather it is composed of several processes including: 1 removal of the tumor by the surgeon 2. precise mapping of the removed tissue performed by the Mohs surgeon to accurately trace the roots of the tumor, 3. processing of microscope slides of the removed tissue performed by a Mohs histo-technologist in an on-site Mohs Laboratory and 4. the reading of the microscope slides by the Mohs surgeon and mapping of the tumor roots. Mohs surgeon serves the role of surgeon by removing the cancer *and* the role of pathologist. In this way, Mohs surgery is unique in that it includes the two components of surgery and pathology, both of which are entirely performed by the Mohs surgeon, with the pathology component comprising half of the service. By its very nature, the entire procedure of Mohs surgery (including the processing and interpretation of histology slides) must be completed before any consideration is given to the excision of additional tissue or repair of the resulting defect. RUC acknowledge that the intra-service work for 17311 to be 80% for the total physician work of the procedure including surgery and pathology. When Mohs surgery is performed on two different sites (two different cancers) for a patient on the same date there is no overlap in work, as each requires the components of excision and tissue processing/ interpretation. There is no separate pathology fee - thus part of the Mohs fee must also cover the costs to run the on-site laboratory. The proposed reduction would not cover such costs.

Once the tumor is fully extirpated, the patient is left with a skin defect that typically requires reconstruction. When this is performed on the same day as Mohs Surgery, there again is no overlap. There is an onsite waiting period (often one hour or more) required during Mohs for the pathology component of the procedure. If a repair is required, the patient must return to the operating room, be repositioned, re-anesthetized, and re-prepped before the separate reconstruction can begin. New instrumentation is used for the repair and thus there is zero overlap of work, practice expense, labor time, medical supplies or medical equipment between the Mohs procedure and a repair procedure. They are separate procedures. Thus it is inappropriate to subject 17311 and 17313 to the multiple procedure reduction rules for repairs performed on the same day as Mohs surgery or for Mohs excisions performed on a patient's different skin cancers performed on the same day.

As nearly 10% of skin cancer patients present with more than one skin cancer on the day of surgery, this proposed rule would negatively affect Medicare patients' access to timely and quality care. Application of the proposed rule to a second tumor treated on the same day will mean that the reimbursement for the second procedure does not cover the cost of providing the service. This will most affect the Medicare population as the incidence of skin caner peaks in this age group. It will also pose a significant risk to our immunosuppressed patients (organ transplant patients, patients undergoing chemotherapy, etc) who are not only at a higher risk of skin cancer but who are also at risk for metastases and possibly death from skin cancer.

I am concerned primarily about being able to continue to provide the most optimal, cost-effective care for my patients; if this unexpected change is allowed to take effect that will no longer be possible. I therefore, respectfully request reconsideration of the proposed rule.

Respectfully,

Steven Jay Goulder, M.D., F.A.A.D.
Chief, Dermatologic Surgery
Director, Skin Cancer Program
Loyola University Chicago

Submitter : Mr. Michael Karren **Date:** 08/30/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 30, 2007

As a member of the American Association of Nurse Anesthetists (AANA), I am writing to strongly support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. I am currently a student nurse anesthestist and am looking forward to thirty plus years in the anesthiesia profession. I have as much at stake in this proposal as anyone. 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 availability of anesthesia services, however, 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,

Michael Karren BSN, SRNA
1802 Riverchase Blvd.
Madison TN, 37115

Submitter : BRADLEY HAUGSTAD **Date:** 08/30/2007

Organization : BRADLEY HAUGSTAD

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Ms. Norwalk:
I am writing to support the proposed fee schedule increase for anesthesia payments. I am a community-based anesthesiologist working at the local hospital. I am one of three in my group to do cardiac anesthesia, primarily on medicare patients. My remaining six partners take care of the "other" anesthetics, primarily on younger privately insured patients. My income is falling and theirs is growing. Soon I may "give up" my 13 years of cardiac experience and try to reshape my practice with younger, healthier, and more highly compensated patient procedures. The hard, cold reality of the proposed fee schedule increase is that a 30% increase will go a long way towards restoring a little of the equality that has been lacking in years past. I very much wish to continue providing needed cardiac services for Kenosha, WI, but without a pay increase I simply will have to choose between providing financially for my family versus providing cardiac care for other families. Please approve the increase and eliminate my need to choose. Thank-you Brad Haugstad MD

Submitter : Mr. Ken Ferry **Date:** 08/30/2007

Organization : iCAD, Inc.

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13471-Attach-1.DOC

#13471

#13471

August 30, 2007

Herb Kuhn, Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS–1385–P
P.O. Box 8018
Baltimore, MD 21244–8018

Re: Proposed CY 2008 Physician Fee Schedule; CMS-1385-P
Section: IMPACT

Dear Mr. Kuhn:

On behalf of iCAD, Inc., I appreciate the opportunity to comment on the Proposed Notice published by CMS in the *Federal Register* of July 2, 2007 which describes proposed changes to payment for services to Medicare patients under the Physician Fee Schedule.

iCAD, Inc. is headquartered in Nashua, NH and manufactures mammography Computer-Aided Detection (CAD) systems used for the early identification of breast cancer. CAD systems incorporate advanced pattern recognition and image analysis capabilities to aid radiologists in the detection of abnormalities on mammography images. The use of CAD provides a targeted second review. The clinical efficacy of CAD in the early detection of breast cancer with mammography is well documented and based on strong peer-reviewed clinical evidence.

ICAD is extremely concerned about the impact of the proposed changes to the Medicare payments for Computer Aided Detection (CAD) systems used with mammography (Codes 77051 and 77052)[1]. This proposal:

- Continues the transition of the new calculated practice expense Relative Value Units (RVUs) that were originally published in the 2007 Final Physician Fee Schedule Rule.

[1] 77051Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic

77052Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography

98 Spit Brook Road, Suite 100 Nashua, NH 03062 USA
+1 866 280 2239 toll free +1 603 882 5200 phone +1 603 880 3843 fax
www.icadmed.com

- Reduces the conversion factor by 9.9% for 2008.

Should the conversion factor reduction be initiated and the practice expense calculation be applied as is, by 2010, CAD payments would not cover the cost of providing this important service. The impact to technical payments for codes 77051 and 77052 is projected to be a decrease of about 57% by 2010.

CAD systems for mammography are important diagnostic tools, which enhance the ability of mammography to detect breast cancer in its early stages. The use of CAD requires the purchase and maintenance of medical equipment that is operated by certified mammography technologists.

The 2007 Medicare PFS final rule altered the Practice Expense (PE) RVUs for CAD. The 2007 technical component reimbursement rate for CAD is $14; with PE cuts, this will be reduced to $7 in 2010 (based on the 2007 conversion factor).

With the addition of the proposed 9.9% cut to the conversion factor for 2008, CAD technical component reimbursement would be reduced to $12 in 2008 and $6 by 2010. Based on the published direct cost inputs for CPT codes 77051 and 77052, the payment amount of $6-$7 does not cover the average cost per procedure of providing CAD.

Under these circumstances, we are concerned that reductions of this magnitude will have an adverse impact on the overall quality of mammography services provided to patients at the very time that the federal government is seeking to improve quality through various quality-related initiatives. Moreover, efforts to increase the utilization of screening mammography (with CAD) may be slowed. Reports of mammogram units closing as a result of payment reductions and other cuts to medical imaging may also have a harsh impact on beneficiaries.

We ask that CMS impose a delay of at least one year in implementing the conversion factor reduction so the impact of the various changes in the physician fee schedule can be assessed. We urge you to reconsider the practice expense reduction for CAD and welcome the opportunity to work with you on clarifying the cost data.

We appreciate the opportunity to comment on this proposal.

Sincerely,

Ken Ferry
President and Chief Executive Officer

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www.icadmed.com

Submitter : Mr. charles leonard **Date:** 08/30/2007

Organization : American Association of Nurse Anesthetists

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P Please accept the proposals to increase the unit fee schedule increase for anesthesia provision by Certified Registered Nurse Anesthestists, (CRNAs), and anesthesiologists. The current reimbursement fees to anesthesia providers have been stagnant for years, have not kept up with the cost of living or inflation, and certainly do not reflect the quality of service, nor seek to aid in meeting the growing demand for anesthesia services in the USA.

Thank you very much,

Charles K. leonard, CRNA, MAE

Submitter : Mr. Scott Kepins **Date:** 08/30/2007

Organization : Marietta College ATS

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an athletic training student here at Marietta College. I work with the volleyball team as my internship and I am furthering my education, so I can become a full certified athletic trainer. I hope that after I graduate these new standards being applied do not affect my job ability.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the rehabilitations programs in hospitals and facilities
While I am concerned that these proposed changes to the hospital will hurt not only the hospital patients, but it will also put a lot of the athletic trainers out of jobs. I will soon be out of college and I myself will be looking for work, and without being able to work in a clinical setup it will affect my choice to continue with this profession.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy but serves the same purpose. My education, clinical experience, and national certification exam ensure that my patients receive quality health care, and even if I m not a physical therapist they will still receive the same care that PT s give their patients if not on a more personal level. State law and hospital medical professionals have deemed me qualified to perform these services and these new standards are going to limit my ability.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible and wrong for CMS, which is supposed to be concerned with the health of all Americans, especially the elderly, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities should in ensuring patients receive the best, most cost-effective treatment available and if you take away our job then not only will they have to pay more but they will also have to wait to be seen because there will be a shortage.
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 Kepins, ATS

Submitter : Dr. David Desertspring **Date:** 08/30/2007

Organization : Rockford Anesthesiologists Assoc, LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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.

David N. Desertspring, MD

Submitter : **Dr. Howard Lakritz** **Date: 08/30/2007**

Organization : **ACNJ**

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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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. Marvin Warren** **Date: 08/30/2007**

Organization : **Billings Anesthesiology, P.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie Norwalk
Acting Administrator
CMS
Atttention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re : CMS-1385-P

Dear Ms. Norwalk:

I am writing to express strong support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.

Please fully and immediately implement the RUC recommendation to increase the anesthesia conversion factor.

Thank you for studying this matter and considering corrective action.

Sincerely,

Marvin L. Warren, M.D.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician Self-Referral Issues.
I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception. My comments are intended to highlight the abusive nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.
I am a physical therapist who has been practicing in the New Orleans area for 22 years. I have seen this issue wax and wane with the economic fortunes of physicians. When their economic fortunes wane this issue waxes. The issue is now waxing in that numerous physician practices in the New Orleans area offer in-office physical therapy. Anecdotally patients are often discouraged from seeking physical therapy outside of the physician s office if that office offers physical therapy.
Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to over utilize those services for financial reasons. This result should not be surprising to any observer of human nature.
Additionally the in-office ancillary services exception is defined so broadly in the regulations that it facilitates the creation of abusive referral arrangements. Physician s will claim that this in-office service is for the convenience of their patients but due to the repetitive nature of physical therapy services, it is no more convenient for the patient to receive services in the physician s office than an independent physical therapy clinic.
I strongly urge CMS to remove physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws. I have not included my name because of fear of economic retaliation.
Thank you for allowing me the opportunity to express my belief on this important subject.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

This proposed change will negatively impact the care of our patients and could add significant cost to an already stressed healthcare budget. This planned change is a departure from a longstanding exemption agreed to by CMS and virtually all private insurance carriers since 1991. The change proposed would eliminate the exemption and decrease reimbursement by 50% for either the Mohs excision or for the associated repair, and for Mohs excision of any additional cancers treated on the same day; such a decrease in reimbursement would not cover the cost of providing the service.

If this proposed change is enacted, we will no longer be able to provide the same kind of high-quality, cost-effective services for our patients in need. I predict that skin cancer surgeons will be forced to change the way they deliver care in order to cover their costs of providing this service.

The Final Rule that CMS agreed upon in the 1992 Medicare Fee Schedule that Mohs Surgery for skin cancer removal and subsequent reconstruction of the resultant defect involve, a series of surgeries which, while done on the same day, are done at different operative sessions and are clearly separate procedures&They will be paid separately with no multiple surgery reductions. This is still correct and holds true today. Mohs surgery is not simply an excision of a skin cancer. The Mohs surgeon serves the role of surgeon by removing the cancer and the role of pathologist. In this way, Mohs surgery is unique in that it includes the two components of surgery and pathology, both of which are entirely performed by the Mohs surgeon, with the pathology component comprising half of the service. By its very nature, the entire procedure of Mohs surgery (including the processing and interpretation of histology slides) must be completed before any consideration is given to the excision of additional tissue or repair of the resulting defect. RUC acknowledge that the intra-service work for 17311 to be 80% for the total physician work of the procedure including surgery and pathology. When Mohs surgery is performed on two different sites (two different cancers) for a patient on the same date there is no overlap in work, as each requires the components of excision and tissue processing/ interpretation The proposed reduction would not cover such costs.

When repair of the resultant defect is performed on the same day as Mohs Surgery, there again is no overlap. There is an onsite waiting period (often one hour or more) required during Mohs for the pathology component of the procedure. If a repair is required, the patient must return to the operating room, be repositioned, re-anesthetized, and re-prepped before the separate reconstruction can begin. New instrumentation is used for the repair and thus there is zero overlap of work, practice expense, labor time, medical supplies or medical equipment between the Mohs procedure and a repair procedure. They are separate procedures. Thus it is inappropriate to subject 17311 and 17313 to the multiple procedure reduction rules for repairs performed on the same day as Mohs surgery or for Mohs excisions performed on a patient s different skin cancers performed on the same day.

As nearly 10% of skin cancer patients present with more than one skin cancer on the day of surgery, this proposed rule would negatively affect Medicare patients access to timely and quality care. Application of the proposed rule to a second tumor treated on the same day will mean that the reimbursement for the second procedure does not cover the cost of providing the service. This will most affect the Medicare population as the incidence of skin caner peaks in this age group. It will also pose a significant risk to our immunosuppressed patients (organ transplant patients, patients undergoing chemotherapy, etc) who are not only at a higher risk of skin cancer but who are also at risk for metastases and possibly death from skin cancer.

Submitter : Mr. Jared Vinc **Date:** 08/30/2007

Organization : Vibrant Care Rehabilitation/The Boeing Company

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer from Seattle, WA. I currently work with the Boeing Company as an athletic trainer. My current job is to provide the care and prevention of worksite injuries for the employees of Boeing in the Puget Sound area. I have both a Master s and Bachelor s degree in Athletic Training/Sports Medicine. I received both degrees from East Stroudsburg University of Pennsylvania. I am certified by the National Athletic Trainer s Association Board of Certification. I also hold state licensure from the Washington State Board of Health.

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,

Jared D. Vinc, MEd, ATC

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Background

Background

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 caleulated 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.

M. Katherine Yurick, MD

Submitter : **Dr. Richard Schlobohm** **Date: 08/30/2007**

Organization : **UCSF**

Category : **Physician**

Issue Areas/Comments

Codlng-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

As a retired Emeritus Professor, I fit into the potential group of patients affected by this decision and I applaude it. It will help significantly.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Richard M. Schlobohm, M.D.

Submitter : **Dr. Paul Scott** **Date: 08/30/2007**

Organization : **Urology Associates of Mobile, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Urology Associates of Mobile, P.A.
168 Mobile Infirmary Boulevard
Mobile, Alabama 36607

A. Greer Megginson, M.D.
G. Coleman Oswalt, M.D.
Charles F. White, Jr., M.D.
Dino N. Frangos, M.D.
S. Harbour Stephens, III, M.D.
Paul A. Scott, Sr., M.D.

August 30, 2007

Center for Medicare and Medicaid Services
Department of Health and Human Services
Baltimore, Maryland

Dear Ladies and Gentlemen,

My name is Dr. Paul A. Scott, Sr. I am a urologist practicing in Mobile, Alabama in a private group practice. This letter is in addendum to the letter offered by my partner Charles White, M.D., dated August 21, 2007 on behalf of the entire practice. We are involved in a joint venture partnership providing lithotripsy services within Mobile and Baldwin counties in Alabama; however, we also provide service to patients in numerous rural counties in both Alabama and Mississippi.

Prior to the formation of our partnership, lithotripsy services were controlled by a for-profit hospital who determined whether or not a patient was offered treatment. Since their unit was a fixed unit, this limited geographically where a patient could have his or her treatment.

The proposed new regulations regarding physician fee schedules cause great concern to urologists, and threaten access to care for many of our patients.

Particularly of concern, regarding under-arrangement contracting, by sharing the services of our mobile lithotripsy equipment among several hospitals, this actually lowers costs. By providing mobile lithotripsy services, this provides access to services that smaller rural hospitals cannot afford. When the physicians own the equipment, we are more likely to remain up-to-date with technological advances in equipment, which allows patients access to this state-of-the-art therapy. Regarding concerns of over-utilization, with treatment of urinary stones, there is an easily identifiable diagnosis of a stone, which doesn t lend itself to the abuses of diagnostic procedures. The same argument can be made for provision of laser services for treatment of benign prostatic hypertrophy. These are not subjective issues, but objective findings.

Concerning per-procedure fee prohibition, hospitals potentially will not be willing to accept the risk of purchasing expensive new equipment, or engaging in fixed monthly leases where exact volume of cases cannot be predicted. This may be particularly true in low-volume rural hospitals. This will limit access to care. In addition, historically, Congress has wished to preserve per procedure fees in Stark legislation, and the proposed regulations would contradict this intent.

In conclusion, therapeutic joint venture partnerships, like ours in Mobile, Alabama, have provided greatly increased access to care, while reducing costs. Over-utilization is not a concern as there is an identifiable diagnosis to be treated. I feel that it would be a mistake to institute regulations that would limit the quality services that partnerships like ours provide to our patients.

Thank you for your consideration of this critically important issue.

Sincerely,

Paul Anthony Scott, Sr., M.D.

Submitter : Dr. Burak Ilsin **Date:** 08/30/2007

Organization : ASA

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Date: 08/30/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician's claim that it is more convenient for patients -- this is not true as Physical Therapy is a repeat visit business. It is not like an xray which the patient receives while in the office as a one time occurence aiding in the Physican making a diagnosis.

Physician's claim it is less expensive for the patient's because they usually meet their deductible with other physician services -- the meeting of the deductible applies regardless of where the patient receives Physical Therapy

Physician's claim that they can assure better quality of care because they can supervise the Physical Therapy -- Physician's are busy treating their own caseload and they rarely, if ever, observe treatments. As far a "Quality of Care" -- this will decline because because this arrangement could potentially eliminate competition and remove alternatives for the patients.

Submitter : Dr. Kayode Soladoye **Date:** 08/30/2007

Organization : Trinity Rehabilitation Clinic, Inc

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir,

I am a physical therapist in private practice with 19 years experience. I am writing to implore the Centers for Medicare and Medicaid Services to completely close the loop holes in the regulations that allow physicians to refer physical therapy patients to their own clinics. It is really of concern that the Medicare program is gradually becoming insolvent and nothing has been done to curb this abusive behavior. It is not only the right thing to do, it is a good way to save hard earned tax payers dollars.

When physicians have the ability to refer to themselves under the guise of providing ancillary services in their office, the temptation to overprescribe that service is great because it yields financial benefits to them. Also, this arrangement is in no special way beneficial to the patients. Rather, it denies them the opportunity to have choices. The bottomline question is this; where are the checks and balances in this kind of arrangements?

Physical therapy is a profession on its own. Physicians do not possess physical therapy licenses and as such cannot really claim to supervise this service when provided in their office. We have done enough beating about the bush with all these ineffective Stark laws. In order to put an end to one of the biggest fraudulent drains on Medicare resources, physical therapy services should be removed from the list of services under the in-office ancillary exception.

Thank you.

Submitter : Dr. Robert Frantz **Date:** 08/30/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Increase ASA unit reimbursement. Remember many members are providing "unchargeable" 24/7 availability to the Medicare system. We need help!

Submitter : **Dr. Rosemarie Garcia** **Date: 08/30/2007**

Organization : **Dr. Rosemarie Garcia**

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.

Rosemarie E. Garcia, M.D.

Submitter : **Dr. William Swanson** **Date: 08/30/2007**

Organization : **Pioneer Valley Urology**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The proposed changes are not beneficial to medicare patients as they will eliminate our ability to provide reliable and timely pathology, minimally invasive treatments and other important services to medicare patients at a cost which is usually lower than that provided by the hospital. The propeosed "under arrangement" rule and prohibition of "per click" payments for space and equipment rentals will be a step backward in the availability of these important services to our elderly patients.

The sweeping changes to the Stark regulations and the reassignment and purchased diagnostic test rules go far beyond what is neccesary to protect the Medicare program from fraud and abuse. The rules should be revised to only prohibit those specific arrangments that are not beneficial to patient care.

Thank you.

William Swanson, MD
Pioneer Valley Urology

Submitter : **Mr. Charles Hart** **Date: 08/30/2007**

Organization : **UW Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am an athletic trainer and physical therapist, licensed in both professions in the state of Wisconsin. I work at the UW Health Sports Medicine Center doing physician extender work and also in the University of Wisconsin Department of Intercollegiate Athletics where I am the athletic trainer with our men s and women s track and cross country teams. I have also worked in outpatient orthopedic physical therapy settings, high schools and a small hospital in a rural area during my career. I have a Bachelor of Science degree in physical therapy from the University of Wisconsin and a Master of Arts in health education and exercise science from Michigan State University.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As a dual-credentialed professional, I am more than qualified to comment on the skills and abilities of athletic trainers. Athletic trainers are well-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 as an athletic trainer 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,

Charles Hart, MA, PT, LAT

UW Health Sports Medicine Center
621 Science Drive
Madison, WI 53711

Submitter : **Dr. Gregorio Garcia** **Date: 08/31/2007**

Organization : **Dr. Gregorio Garcia**

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.

Gregorio J. Garcia, M.D.

Submitter : **Dr. Thor Milland** **Date: 08/31/2007**

Organization : **Partners Healthcare**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Mr. Scott Kuzma **Date:** 08/31/2007

Organization : University of Wisconsin - La Crosse

Category : Other Health Care Provider

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer working at the University of Wisconsin - La Crosse as a clinical instructor for the undergraduate students in the athletic training program. As an educator, this issue is very important to me as it will impact the job opportunities of many of the students I work with daily.

I completed my undergraduate studies at UW-L and I returned to work there after working as an athletic trainer for the Kansas City Chiefs for a year. Having worked in a variety of settings, I realize the importance of this issue to the livelihood of many athletic trainers.

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 Kuzma, ATC

Submitter : **Dr. Angela Azar** **Date: 08/31/2007**

Organization : **Dr. Angela Azar**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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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. I am a cardiothoracic anesthesiologists and a significant number of my patients have Medicare. I enjoy providing care for this population and would like to continue my care for them.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Miriam Garcia** **Date: 08/31/2007**

Organization : **Mrs. Miriam Garcia**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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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.

Miriam Garcia, CRNA

Submitter : **Date: 08/31/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

These comments are in favor of eliminating the Physical Therapy from the "in house ancillary services" exception. Most of the arguments in favor of this practice seem to center on the following:
1. Patient access. This would be the only valid argument but this rarely the case. In situations where it is, this could easily be determined and exception could be made on this basis.
2. Patient convenience. Given the fact that Physical Therapy is a repeat visit service, this argument has no validity. The patient can return for a visit to any clinic or office. PT is unlike an xray or lab test which could be provided on the day of the physician visit and may aide in formulating a diagnosis. PT services do not aide in the formulation of a diagnosis.
3. Quality of care. Eventually this practice could potentially eliminate competition. This would reduce the quality of care and reduce the choices available to patients, thereby decreasing access to care. Addtionally, the argument continues that the Physicians can supervise the service and therefore assure better quality of care. As a practical matter, I have never seen this happen. The Physicians are to busy and involved in seeing patients and doing surgery to supervise Physcial Therapy sessions.
Additionally, Physical Therapist practice independantly in many other settings providing quality care without supervision. This includes in clinics certified by Medicare as Independant Practicing PT's. The reality is that there is one motivation for this practice. It is to increase the passive income of the referring Physicians. I have seen numerous studies which outline the problems with this arrangement. Some of these studies were performed by government agencies. Some of these problems are:
1. 96% percent of PT treatment providing incident to Physician services do not meet Medicare requirements.
2. Average number of visits per refcrral in settings where Physicians have a financial interest is approx 40% higher than when provided by Independant pracicing PT's.
3. Average charge per visit is similarly higher

Elimination of this practice will very likely result in:

1. Lower cast to the Medicare program
2. More appropriate utilizaiton of services
3. Less concern for ulterior motives
4. Greater access for patients
5. Improved quality of care.

Submitter : Kathleen Corpora **Date:** 08/31/2007

Organization : Coordinated Health

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

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,
Kathleen Corpora

Submitter : Dr. Kenneth Hollingsworth **Date:** 08/31/2007

Organization : Bay Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to support the recommendation to increase the Anesthesia reinbursement rate. For years we have been severely underpaid for our services taking care of our senior citizens. They are typically our sickest, most complicated patients. They require more of our time and expertise. The risks of complications and malpractice claims are greater. In addition, when I provide care with a CRNA that is employed by the hospital, I get only half of the already inadequate fee. I frequently receive $50-75 for a complicated ancsthetic. Plumbers and car mechanics are paid better than this. Most of the Anesthesiologists I know consider taking care of Medicare patients as charity work since tha payments are so low. I have seen these cases postponed and cancelled for trivial reasons in order to avoid them. Making the reimbursement fairer will improve their access to quality care. I hope you do the right thing and approve this recommendation.
Sincerely,
Kenneth Hollingsworth, MD

Submitter : Dr. Clinton La Grange **Date:** 08/31/2007

Organization : Dr. Clinton La Grange

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Dr. James Jarrett** **Date: 08/31/2007**

Organization : **Home**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Dr. John Szewczyk **Date:** 08/31/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Ms. Martha Godfrey **Date:** 08/31/2007

Organization : Portsmouth Orthopaedic Associates

Category : Other Practitioner

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I have been a certified athletic trainer for over 20 years and have been working in an outpatient orthopedic clinic for 18 years. I have a Master's Degree in my field, am nationally certified and I'm licensed by the Virginia Board of Medicine, who find me highly qualified to provide rehabilitative services.

I am writing to you to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rhabilitation 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 additonal 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 are not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. Sstate law and hospital medical professionals have deemed me qualified to perform thses services and these proposed regulations attempt to circemvent 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. Physicians and physical therapists hire athletic trainers because they know they're getting a highly qualified health care provider but don't have to pay them as much as a physical therapist.

Since the 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.

Please consider these questions: How will hundreds of quality health care providers losing their jobs help those people who need their services the most? How will hundreds of quality health care providers losing their jobs going to help an all ready dysfunctional health care system? Lets not mirror the VA hospitals by leaving hundreds of patients without access to quality health care.

Thank you for your consideration.

Sincerely,

Martha M. Godfrey, MS,VATL,ATC

Submitter : Dr. Paul Bowman **Date:** 08/31/2007

Organization : The Bowman Institute for Dermatologic Surgery

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

August 30, 2007

The Honorable Herbert Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Washington, DC 20201

Re: CMS 1385-P: 2008 Medicare Fee Schedule
Coding Multiple Procedure Payment Reduction for Mohs Surgery

Dear Administrator Kuhn,

I am deeply concerned about the proposed removal of the Mohs micrographic surgery codes from the MPRR exemption list scheduled to occur in January, 2008.

Mohs surgery has a higher cure rate for skin cancer than any other procedure, and has made a huge impact on the well-being of my patients. It is the single most effective procedure in treating skin cancer, but is also very labor-intensive for the physician, who acts as both surgeon and pathologist. It offers many advantages to patients: Besides having the highest cure rate compared to other types of excisions, it sacrifices minimal normal adjacent tissue, which often has significant functional and cosmetic impact for the patient. In addition, once the removal of the cancer is complete, the surgical defect can be repaired the same day, which is much more convenient for the patient than having to go to another doctor or return on a different day for reconstruction.

If the proposed MPRR change goes into effect, there will be a very stong incentive to not repair the defect on the same day. Many patients will probably be referred to other surgeons who would repair the defect the same day, but are not Mohs-trained, and would perform a traditional excision with the associated higher recurrence rate. This would truly be a great step backwards in our treatment of skin cancer.

As a fellowship-trained Mohs surgeon, my sole purpose is to eradicate skin cancers as efficiently as possible. If the MPRR change does occur, it will greatly hinder my ability to provide high-quality care to my patients. Over the country as a whole, I know that more patients would end up having traditional excisions and other obsolete treatments for skin cancer and suffer more recurrences, metastases, and even death (squamous cell skin cancer is the third leading cause of death of organ transplant patients one of the most important groups of patients requiring Mohs surgery for skin cancer). These substitute procedures would actually result in INCREASED COST due to the increased recurrence rates and use of operating rooms (where many surgeons perform traditional excisions and reconstructions such as flaps and grafts, in contrast to Mohs surgeons who primarily perform these procedures in the office) and general anesthesia (same reason).

I would like to add my voice to my 800 fellowship-trained colleagues, respectfully requesting that you re-examine this decision, and the impact it will have on all patients with skin cancer and our medical system.

Most Sincerely,

Paul H. Bowman, M.D.
Member, American College of Mohs Surgery

Submitter : **Mr. John Cole** **Date: 08/31/2007**

Organization : **Mr. John Cole**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)
Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

We are having severe difficulty in attracting skilled anesthesiologists to Santa Rosa, California due to the high cost of living and low reimbursement rates for anesthesia services. It is critical for the wellbeing of the community that we increase the anesthesia payments to improve the quality of our health care, particularly as the population of our community ages.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

John Cole
johndcole3@yahoo.com

Submitter : Dr. Steven Haddy **Date:** 08/31/2007

Organization : Keck School of Medicine, University of Southern Ca

Category : Physician

Issue Areas/Comments

Background

Background

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.
Steven Haddy, MD.
Associate Professor of Anesthesiology
Keck School of Medicine
University of Southern California

Submitter : Mr. Mitchell J Smelis **Date:** 08/31/2007

Organization : McLaren Regional Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer (ATC) working for McLaren Regional Medical Center as a part of their Sports Medicine Program. I have been working as an ATC for the past 10 years, providing coverage for the athletic department, through McLaren, at Fenton High School. I graduated from Centeral Michigan University with a Bachelors in Science Degree in May of 1997. I passed by National Athletic Trainers Association Board of Certification exam in April of 1997. The state of Michigan recently passed legislation requiring state licensure, which I greatly welcome.

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,

Mitchell J Smelis, ATC

Submitter : Dr. Dennisa Williams **Date:** 08/31/2007

Organization : Williams Anesthesia, D.O., P.C.

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 reetify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Dennis A. Williams, D.O

Submitter : Dr. Alex Pue **Date:** 08/31/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.
Alex Pue, MD

Submitter : Mr. Cesar Garza **Date:** 08/31/2007

Organization : Santa Ana Unified School District

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Cesar Garza. I am a certified athletic trainer. My education includes a B.S in kinesiology with a focus in athletic training and a minor in health promotion. In addition I have obtained a Master in Education with an emphasis in physical education. I am employed by the Santa Ana Unified School District as a full-time athletic trainer at Saddleback High School in Santa Ana, California.

I am writing today to voice my opposition to the therapy standards and requirements in regard to 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 recieve 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 a certified athletic trainer, I am qualified to perform physical medicine and rehablilitation 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 medicine 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 rual areas, to further restrict their ability to recieve those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients recieve the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justifications, 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 you withdrawal the proposed changes related to hospitals, rural clinics, and Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Cesar Garza MEd,ATC

Submitter : **John Chou** **Date: 08/31/2007**

Organization : **Palo Alto Medical Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : **Date: 08/31/2007**

Organization :

Category : **Drug Industry**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951..

Submitter : Dr. Joseph Dunn **Date:** 08/31/2007

Organization : Pain Consultants of Oregon

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment STOP_ASC_Cuts

CMS-1385-P-13511-Attach-1.DOC

CMS-1385-P-13511-Attach-2.TXT

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, "Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008" (the "Proposed Rule") published in the *Federal Register* on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.

There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the "all physicians" crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians' ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries' access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as "interventional pain physicians" for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to "all physicians" for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. Interventional pain is an inter-disciplinary practice that draws on various medical specialties of anesthesiology, neurology, medicine & rehabilitation, and psychiatry to diagnose and manage acute and chronic pain. Many interventional pain physicians received their medical training as anesthesiologists and, accordingly, clinically view themselves as anesthesiologists. While this may be appropriate from a clinically training perspective, their Medicare designation does not accurately reflect their actual physician practice and associated costs and expenses of providing interventional pain services.

This disconnect between the Medicare specialty and their practice expenses is made worse by the fact that anesthesiologists have the lowest practice expense of any specialty. Most anesthesiologists are hospital based and do not generally maintain an office for the purposes of rendering patient care. Interventional pain physicians are office based physicians who not only furnish evaluation and management (E/M) services but also perform a wide variety of interventional procedures such as nerve blocks, epidurals, intradiscal therapies, implant stimulators and infusion pumps, and therefore have practice expenses that are similar to other physicians who perform both E/M services and surgical procedures in their offices.

Furthermore, the utilization rates for interventional pain and pain management specialties are so low that they are excluded from Medicare rate-setting or have very minimal affect compared to the high utilization rates of anesthesiologists. CMS utilization files for calendar year 2007 overwhelming report anesthesiologists compared to interventional pain physicians and pain management physicians as being the primary specialty performing interventional pain procedures. The following table illustrates that anesthesiologists are reported as the primary specialty providing interventional pain services compared to interventional pain physicians

CPT Code	Anesthesiologists - 05	Interventional Pain Management Physicians

	(Non-Facility)	- 09 (Non-Facility)
64483 (Inj foramen epidural l/s)	59%	18%
64520 (N block, lumbar/thoracic)	68%	15%
64479 (Inj foramen epidural c/t)	58%	21%
62311 (Inject spine l/s (cd))	78%	8%

The high utilization rates of anesthesiologists (and their extremely low practice expenses) drive the payment rate for the interventional pain procedures, which does not accurately reflect the resource utilization associated with these services. This results in payment rates that are contrary to the intent of the Medicare system—physician payment reflects resources used in furnishing items and services to Medicare beneficiaries.

I urge CMS to make a modification to its practice expense methodology as it pertains to interventional pain services such that its methodology treats physicians who list anesthesiology as their primary specialty and list interventional pain as their secondary specialty designation as interventional pain physicians for rate-setting. This pool of physicians should be cross-walked to "all physicians" for practice expenses. This will result in a payment for interventional pain services that is more aligned with the resources and costs expended to provide these services to a complex patient population.

I urge CMS not to delay implementing our proposed recommendation to see if the updated practice expenses information from the Physician Practice Information Survey ("Physician Practice Survey") will alleviate the payment disparity. While I believe the Physician Practice Survey is critical to ensuring that physician services are appropriately paid, I do not believe that updated practice expense data will completely resolve the current underpayment for interventional pain services. The accurate practice expense information for interventional pain physicians will continue to be diluted by the high utilization rates and associated low practice expenses of anesthesiologists.

II. CMS Should Develop a National Policy on Compounded Medications Used in Spinal Drug Delivery Systems

We urge CMS to take immediate steps to develop a national policy as we fear that many physicians who are facing financial hardship will stop accepting new Medicare beneficiaries who need complex, compounded medications to alleviate their acute and chronic pain. Compounded drugs used by interventional pain physicians are substantially different from compounded inhalation drugs. Interventional pain physicians frequently use compounded medications to manage acute and chronic pain when a prescription for a customized compounded medication is required for a particular patient or when the prescription requires a medication in a form that is not commercially available. Physicians who use compounded medications order the medication from a compounding pharmacy. These medications typically require one or more drugs to be mixed or reconstituted by a compounding pharmacist outside of the physician office in concentrations that are not commercially available (*e.g.*, concentrations that are higher than what is commercially available or multi-drug therapy that is not commercially available).

The compounding pharmacy bills the physician a charge for the compounded fee and the physician is responsible for paying the pharmacy. The pharmacy charge includes the acquisition cost for the drug ingredients, compounding fees, and shipping and handling costs for delivery to the physician office. A significant cost to the physician is the compounding fees, not the cost of drug ingredient. The pharmacy compounding fees cover re-packaging costs, overhead costs associated with compliance with stringent statutes and regulations, and wages and salaries for specially trained and licensed compounding pharmacists bourn by the compounding pharmacies. The physician administers the compounded medication to the patient during an office visit and seeks payment for the compounded medication from his/her carrier. In many instances, the payment does not even cover the total out of pocket expenses incurred by the physician (*e.g.*, the pharmacy fee charged to the physician).

There is no uniform national payment policy for compounded drugs. Rather, carriers have discretion on how to pay for compounded drugs. This has lead to a variety of payment methodologies and inconsistent payment for the same combination of medications administered in different states. A physician located in Texas who provides a compounded medication consisting of 20 mg of Morphine, 6 of mg Bupivicaine and 4 of mg Baclofen may receive a payment of $200 while a physician located in Washington may be paid a fraction of that amount for the exact same compounded medication. In many instances, the payment to the physician fails to adequately cover the cost of the drug, such as the pharmacy compounded fees and shipping and handling. Furthermore, the claim submission and coding requirements vary significantly across the country and many physician experience long delays in payment.

We urge CMS to adopt a national compounded drug policy for drugs used in spinal delivery systems by interventional pain physicians. Medicare has the authority to develop a separate payment methodology for compounded drugs. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA") mandated CMS to pay providers 106% of the manufacturer's Average Sales Price ("ASP") for those drugs that are separately payable under Part B. The language makes clear that this pricing methodology applies only to the sale prices of manufacturers. Pharmacies that compound drugs are not manufacturers, and Congress never contemplated the application of ASP to specific drug compounds created by pharmacies. Accordingly, CMS has the discretion to develop a national payment policy.

We believe that an appropriate national payment policy must take into account all the pharmacy costs for which the physicians are charged: the cost of the drug ingredient, the compounding fee costs, and the shipping and handling costs. We stand ready to meet with CMS and its staff to discuss implementing a national payment policy.

III. CMS Should Incorporate the Updated Practice Expenses Data from Physician Practice Survey in Future Rule-Making

I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge

CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

IV CMS Should Work Collaboratively with Congress to Fix the SGR Formula so that Patient Access will be preserved.

The sustainable growth rate ("SGR") formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

Because of the flawed formula, physicians and other practitioners disproportionately bear the cost of providing health care to Medicare beneficiaries. Accordingly, many physicians face clear financial hardship and will have to make painful choices as to whether they should continue to practice medicine and/or care for Medicare beneficiaries.

CMS should work collaboratively with Congress to create a formula that bases updates on the true cost of providing healthcare services to Medicare beneficiaries.

***

Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

Joseph S Dunn, MD
Pain Consultants of Oregon
360 So Garden Way, Ste. 101
Eugene Oregon, 97401

Submitter : **Dr. John Stewart** **Date: 08/31/2007**

Organization : **Shasta Anesthesia Consultants**

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.

John Stewart, MD

Submitter : **Becky Clark** **Date: 08/31/2007**

Organization : **apex physical therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician Self-Referral Issues
August 30, 2007
Mr. Kerry N. Weems
Administrator Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule
Dear Mr. Weems:
I am an independent physical therapist in the Spokane area of Washington State, and I wish to comment of the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception. These comments are intended to highlight the abusive nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.
I have been a co-owner of a private, outpatient physical therapy clinic since 1998. During this time, our clinic has had a good working relationship with the local physicians and referral source; however, in the past 2 years, these local physicians have begun their own physical therapy clinics and have forced their patients to utilize only those services.
Some Rockwood Clinic physicians have told some of my patients that they can only go to Rockwood s Physical Therapy when those patients have insurances to go anywhere. Patients are not given a choice.
Examples of abusive arrangements our clinic has noted include patients who are encouraged strongly by their physician or health care provider to attend physical therapy only at the physician s physical therapy clinic. A frustrated Medicare patient told me that he was encouraged strongly to attend physical therapy at the physician s owned clinic which was approximately a 30 minute drive from his home. Unfortunately, there are eleven independent physical therapy clinics within five to fifteen minutes from this patient s home. The patient refused to drive 30 minutes and the physician s staff reluctantly gave this patient our clinic s name.
Another patient seen by the same physician group was instructed that further testing, to include x-rays, was being delayed because our clinic documentation was not readily available. She was also told that had she attended physical therapy at the physician s physical therapy clinic the delay would not have occurred. This statement was misleading, because all clinical documentation was available to the physician and was located in the patient s chart which was located in the exam room.
Many patients do not know that they have a choice as to the physical therapy clinic that they attend. Patients who already have a history or a relationship established with a certain clinic have been told that the physician would prefer that they discontinue that relationship and attend therapy at the physician s physical therapy clinic. The inability to attend physical therapy at a clinic of the patient s choosing is poor care and is abusive.
I do feel the in-office ancillary services is defined so broadly in the regulations that it facilitates the creation of abusive referral arrangements. Because of Medicare s referral requirements, these local physicians have a captive referral base of physical therapy patients in their offices.
I would like to thank you for your consideration into this matter. I hope that these issues can be resolved in the Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule.
Sincerely,
Becky Clark, PT
1111 E Westview Ct
Spokane, WA 99218

Submitter : Mrs. Mary Beth Geiser **Date:** 08/31/2007

Organization : Wisconsin Phy Ther Assoc - Member

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

To Whom It May Concern:

My name is Mary Beth Geiser and I am a licensed physical therapist practicing in Wisconsin. I am writing this letter to express my support for the proposed updates and revisions to the therapy standards, regulations and requirements listed in the July 12, 2007 Federal Register (Vol. 72 No. 133).

It is in the best interest of all Medicare Beneficiaries that these new proposed updates be adopted and become effective immediately in January 2008. Changes adopted in this proposal will help insure that all Beneficiaries are receiving services from qualified personnel as established from prior regulation (42 CFR 484.4). Presently there are loop holes and exceptions in the verbiage that discusses which provisions are required to bill and render services for physical therapy . Without these proposed changes, there continues to be the potential for confusion between policies/provision as well as increased injury to Medicare s Beneficiaries. There is also risk that abusive and fraudulent behaviors by unqualified personnel may continue to drain the Medicare system, especially if clarification on these revised definitions is not resolved.

It is imperative that all services billed to Medicare and rendered as physical therapy are provided exclusively by physical therapists (PTs) and physical therapist assistants (PTAs) in accordance with previously established regulations (42 CFR 484.4). Following these pre-established guidelines across most, if not all, practice settings will create a consistent quality of care that curbs fraudulent and abusive practices as well as provide Beneficiaries with optimal rehab outcomes from qualified PTs and PTAs.

I am also making a strong suggestion that CMS consider revising its present means to educate its Beneficiaries about these proposed and eventually permanent changes for physical therapy personnel requirements. Additional effort should also be made to help encourage Providers and Beneficiaries to report discrepancies in physical therapy services especially those not provided by qualified personnel. Finally, I feel that future efforts of CMS should also focus on improving the process and paperwork necessary to report and track conditions where fraudulent and abusive practice patterns exist.

I thank you for the opportunity to comment on this very important matter and encourage CMS to continue is public comment policy for other aspects of rehab medicine, specifically policies that impact and relate to the delivery of physical therapy services.

Sincerely,
Mary Beth Geiser PT, OCS
Board Certified Specialist in Orthopeadic Physical Therapy,
American Board of Physical Therapy Specialties

Submitter : Dr. PEDRO M. LOPEZ **Date:** 08/31/2007

Organization : UPLAND ANESTHESIA MEDICAL GROUP

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
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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

PEDRO M. LOPEZ MD

Submitter : Mrs. Mary Beth Geiser **Date:** 08/31/2007

Organization : Wisconsin Phys Ther Assoc - Member

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I am in favor of the proposed changes to the Outpatient Therapy Certification Requirements where a physician (or NPP, as appropriate) continues to review and certify the initial plan of care as soon as possible, and recertification for physical therapy services would now apply for a length of time based on the patient needs, but not to exceed 90 days(vs. the present policy of every 30 days)AND require additional recertification for every 90 consecutive days thereafter.
Sincerely,
Mary Beth Geiser PT, OCS
Board Certified Specialist, Orthopaedic Physical Therapy
American Board of Physical Therapy Specialties