Submitter : Mrs. Vivian M. Mahoney **Date:** 08/31/2007

Organization : Florida State Massage Therapy Association

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

08/30/07
Centers for CMS Dept of Health & Human Services
RE: CMS-1385-P
The proposed Therapy Rules were published on July 12, 2007 and seeks to amend the regulations related to 42 Code of Federal Regulations Section Parts 409, 410, 411, 413, 414, 415, 418, 423, 424, 482, 484, 483, and 491.

To Whom This Concerns:
I share comments of the Florida State Massage Therapy Association with CMS on its proposed rules to limit the number & type of providers of all physical medicine & rehabilitation services in hospitals, other facilities & health clinics. State Licensed Massage Therapists, many highly trained Lymphedema Therapists, are serving millions of survivors of cancer sufferers & of hereditary lymphedema & many other medical conditions.

CMS states it wants to develop a consistent definition for PT s & PTA s. CMS and that profession continue to attempt to redefine physical medicine as physical therapy. Physical medicine & rehabilitation medicine is a much broader term than physical therapy. Many types of providers are qualified by State Licensure & other qualifications & are often more capable of providing some services.

The Florida State Massage Therapy Association s nearly 5,000 members & the 24 Associations & Member Groups of the Coalition to Preserve Patient Access to Physical Medicine & Rehabilitation Services realize it s patients who will be most harmed if they do not receive specific services treating physicians determine medically necessary & by qualified providers of physician s choice.
IS A MONOPOLY BEING CREATED? CMS, in collaboration with a professional organization, is once again attempting to establish a monopoly for PT s and PTA s for the delivery of physical medicine & rehabilitation services provided in varied provider settings.

Physical Medicine is NOT just Physical Therapy & Physical Therapy is NOT the only Physical Medicine procedure or modality. Physical Therapists do NOT own Physical Medicine AMA CPT Codes nor do they own the term Physical Medicine. Physical Therapists as well as all other qualified practitioners use procedures & modalities within the general term Physical Medicine. Even the AMA CPT Code Book states that listed CPT Codes are not for any one specific provider group.

Q. Why is Medicare Part A changes buried in what is typically viewed as Medicare Part B sections of proposed rules?
Q. Is it CMS s goal to prevent any health professional other than a PT from providing physical medicine & rehabilitation services? If this is the case, under what statutory authority has CMS pursued this objective?

The Florida State Massage Therapy Association questions whether these proposed regulations are more focused on delivering reimbursement to a selected group of providers than on delivering quality services to Medicare beneficiaries.

It appears that CMS only consulted the physical therapist lobby. From what we can determine, CMS did not consult with physical medicine & rehab physicians, specialty rehab provider groups, hospitals or medical associations.

It is unreasonable to believe that the judgment of CMS employees is superior to the collective judgments of the state legislatures, health departments & regulatory agencies throughout the United States who make these determinations for individual states.

RECOMMENDATIONS: We urge CMS to: 1.Immediately withdraw all proposed changes related to Therapy Standards and Requirements (physical medicine & rehabilitation) in all facilities mentioned in this Federal Register publication. 2.Assemble a working group with representation of varied & state licensed or certified providers furnishing physical medicine & rehab services to discuss proposed rules.

If more info is needed regarding this organization s concerns, please contact me: 865-436-3573 or vivianmadison@aol.com

Florida State Massage Therapy Assoc.
Vivian M. Mahoney,Insurance Consultant
1870 Aloma Avenue, Suite 260
Winter Park,FL 32789

CMS-1385-P-13517-Attach-1.DOC

08/30/07

Centers for CMS Dept of Health and Human Services

RE: CMS-1385-P

The proposed Therapy Rules were published on July 12, 2007 and seeks to amend the regulations related to 42 Code of Federal Regulations Section Parts 409, 410, 411, 413, 414, 415, 418, 423, 424, 482, 484, 483, and 491.

To Whom This Concerns:

I share comments of the Florida State Massage Therapy Association with CMS on its proposed rules to limit the number & type of providers of all **physical medicine & rehabilitation services** in hospitals, other facilities & health clinics. State Licensed Massage Therapists, many also highly trained Lymphedema Therapists, are serving millions of survivors of breast & other cancer sufferers of hereditary lymphedema & many other medical conditions.

CMS states it wants to develop a "consistent" definition for PT's & PTA's. CMS and that profession continue to attempt to redefine "physical medicine" as "physical therapy." **Physical medicine & rehabilitation medicine is a much broader term than physical therapy.** Many types of providers are qualified by State Licensure & other qualifications & are often more capable of providing some services.

The Florida State Massage Therapy Association's nearly 5,000 members & the 24 Associations & Member Groups of the "Coalition to Preserve Patient Access to Physical Medicine & Rehabilitation Services" realize it's patients who will be most harmed if they do not receive specific services treating physicians determine medically necessary & by qualified providers of physician's choice.

IS A MONOPOLY BEING CREATED?
CMS, in collaboration with a professional organization, is once again attempting to establish a monopoly for PT's and PTA's for the delivery of physical medicine & rehabilitation services provided in varied provider settings.

"Physical Medicine" is NOT just "Physical Therapy" & Physical Therapy is NOT the only "Physical Medicine" procedure or modality. Physical Therapists do NOT own Physical Medicine AMA CPT Codes nor do they own the term "Physical Medicine." Physical Therapists as well as all other qualified practitioners use procedures & modalities within the general term "Physical Medicine." Even the AMA CPT Code Book states that listed CPT Codes are not for any one specific provider group.

Q. Why is Medicare Part A changes buried in what is typically viewed as Medicare Part B sections of proposed rules?

Q. Is it CMS's goal to prevent any health professional other than a PT from providing "physical medicine" & rehabilitation services? If this is the case, under what statutory authority has CMS pursued this objective?

The Florida State Massage Therapy Association questions whether these proposed regulations are more focused on delivering reimbursement to a selected group of providers than on delivering quality services to Medicare beneficiaries.

It appears that CMS only consulted the physical therapist lobby. From what we can determine, CMS did not consult with physical medicine & rehab physicians, specialty rehabilitation provider groups, hospitals or medical associations.

It is unreasonable to believe that the judgment of CMS employees is superior to the collective judgments of the state legislatures, health departments & regulatory agencies throughout the United States who make these determinations for individual states.

RECOMMENDATIONS:

We strongly urge CMS to:

1. Immediately withdraw all proposed changes related to Therapy Standards and Requirements (physical medicine & rehabilitation) in all facilities mentioned in this Federal Register publication.
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If more information is needed regarding this organization's concerns, contact me directly: 865-436-3573 or vivianmadison@aol.com

Florida State Massage Therapy Association
Vivian Madison-Mahoney, Insurance Consultant
1870 Aloma Avenue, Suite 260
Winter Park, Florida, 32789

Submitter : Ms. Laurie Kertz **Date:** 08/31/2007

Organization : Sports Center

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

As a physical therapist, I am alarmed by the increase in physician owned physieal therapy practices. Not only does this arrangement encourage physicians to refer their patients to physical therapy (PT) for financial gain, but it also encroaches on patients' freedom to choose the services they need.

In my experience in outpatient orthopedic practices in Austin and El Paso, Texas, patients follow their physician's advice to access PT at in-house/physician-owned locations without taking into consideration the level of expertise of the practitioners or the location of the practice. Frequently, patients will travel greater distances to access a physician for infrequent visits; however, when a patient needs PT, they may need to attend sessions twice a week for 4 weeks. If the convenience of accessing such care is compromised by the physician's location, patients often disregard the advice of their physicians, leading to future, more expensive health needs.

For example, someone with shoulder impingement who has minor pain-- and who does not address the health of their tendons and poor body mechanics leading to the impingement-- has a great likelihood of sustaining a rotator cuff tear (often requiring surgery) after months/years of repetitive overhead activities.

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.
Please empower patients with unhindered access to choose PT services that will best support their health and prevent future health care costs.

With gratitude for your thoughtful consideration of this issue,
Laurie Kertz, PT

Submitter : **Dr. choying wu** **Date: 08/31/2007**

Organization : **citrus valley 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.

Submitter : **Mrs. Tanya Rice** **Date: 08/31/2007**

Organization : **Pfizer Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Hi, my name is Tanya Rice and I have been working in the medical field over the past ten years. I have worked as an athletic trainer(ATC)in a variety of medical settings from highschool, college, physical therapy as well as assisting orthopedic surgeons. Within these past years I have also continued my education by earning other certifications such as Emergency Medical Technician (EMT) and Orthopedic Technician (OTC). Currently I am managing a gym as well as working more specifically as an ATC at Pfizer Physical Therapy. My role as an ATC is to teach and provide the proper exercise regimine to our patients. In addition, I assist with the use of modalities when necessary. I in part do not take away from the role of the physical therapist nor has there been any indication that my job has threatened PT's. In fact, I was specifically hired due to my ATC certification. ATC's have been selected in the past to work in these institutions because of their education, knowledge and dedication to aide in the proper rehabilitation and overall well being of 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,

Tanya Rice- ATC, EMT, OTC

Submitter : **Mr. Daniel Vasquez** **Date: 08/31/2007**

Organization : **Illinois State University**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Daniel Vasquez. I am currently a graduate assistant, board certified athletic trainer at Illinois State University. I am pursuing an advanced master's degree in athletic training with a focus in orthopedic rehabilitation and manual therapy techniques. My previous employer was an outpatient orthopedic rehabilitation clinic where I worked in collaboration with a board certified physical therapist treating patients of various ages various injuries. While working in the private clinical setting, I am confident my patients received the best possible care available. My ongoing continuing education and clinical experience will allow me to provide a better standard of care to my patients.

Today, 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, and national certification exam ensure that my patients receive quality health 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,

Daniel Vasquez, ATC, LAT
Graduate Assistant Athletic Trainer
Illinois State University
Campus Box 7130
Normal, IL 61761

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 writing this comment to support the application of consistent Therapy Standards for all PT, OT and SLP plan of care policies in both Part A and Part B settings.

Sincerely,
Mary Beth Geiser PT, OCS

Submitter : Mr. Mike Sarjeant **Date:** 08/31/2007

Organization : Long Beach Fire Department

Category : Other

Issue Areas/Comments

Ambulance Services

Ambulance Services

See Attachement

CMS-1385-P-13523-Attach-1.PDF

LONG BEACH FIRE DEPARTMENT
925 Harbor Plaza Drive Suite #100
Long Beach, CA. 90802

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 Long Beach Fire Department provides emergency and non-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

Long 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.

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.

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.

Institute of Medicine Report on Hospital Emergency Department Overcrowding

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

Long Beach 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,

Mke Sarjeant
Battalion Chief, Operations Section
Long Beach Fire Department

Submitter : **Mr. Adam Greenfield** **Date: 08/31/2007**

Organization : **NATA / Emory Sports Medicine Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Hello, my name is Adam Greenfield. I am currently working as a Certified Athletic Trainer (ATC) / Physician Extender at the Emory Sports Medicine Center. We are a Sports Medicine Physician based clinic in Atlanta, Georgia. We have six Orthopaedic Sports Medicine, fellowship trained physicians and I am one of five full time certified athletic trainers and four ATC Fellows working in the clinic as orthopaedic athletic trainers / physician extenders, directly with our physicians and patients. It is daily we are tasked with overseeing the day-to-day health care needs of their patients.

I completed my undergraduate degree at the University of South Florida in Tampa, Florida and have been a certified athletic trainer for just over 4 years now and am licensed in both Florida and Georgia. I have worked in a variety of settings as an ATC, including outpatient physical therapy clinics, secondary school settings as well as communal outreach events. I was the Director of Sports Medicine for a physical therapy practice in Boca Raton, FL where I oversaw 5 local high schools and 5 certified athletic trainers and currently run my own athletic training company which provides certified athletic trainers for local sporting events, tournaments and camps within the State of Florida. Currently, I am working in a physician setting at the Emory Healthcare Orthopaedic & Spine Center.

In our practice, our physicians feel that ATC s are the ideal liaison in the orthopaedic clinical setting to see patients. They feel that certified athletic trainers have the education and knowledge with regard to musculoskeletal issues, to perform all skills necessary in physical medicine, patient education and rehabilitation, to treat their patients with the highest quality of 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 selection, 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, national certification exam and state licenses ensure that my patients will receive quality health care. I have been deemed qualified by state law, hospital medical professionals and orthopaedic physicians to perform these services and these proposed regulations attempt to thwart 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 feel free to contact me with any questions.

Sincerely,

Adam Greenfield ATC, LAT
Certified Athletic Trainer
Emory Sports Medicine Center
59 Executive Park Drive S
Suite 1000
Atlanta, Georgia 30329
Phone:404-778-6214
Fax:404-778-4324

Submitter : **Dr. Christina Diaz** **Date: 08/31/2007**

Organization : **Dr. Christina Diaz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medieaid Services
Attention: CMS-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. George Cheng** **Date: 08/31/2007**

Organization : **George Cheng MD 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 rccognized 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.

George Cheng

Submitter : **Date: 08/31/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician Self Referral

I am a physical therapist practicing in Tucson Arizona. I have been in practice for over 30 years. 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 would like to encourage and support you in your effort to remove PT services from permitted services under the in-office ancillary exception.

Physician self referral to any rehab services, including physical therapy, should be prohibited because it is no different than any other kickback scheme that a referring physician can participate in. If anything it is worse than an out and out kickback because the physician is in full control of the service, the referral, the finances and the unsuspecting patient. Physician ownership of physical therapy services or any other rehab services develops an unnecessary, voluntary conflict of interest which results in clouded physician judgment.

I am sure that you will hear many stories about over utilization of physical therapy/rehab services in physician owned settings. You will be told of many patients who were referred for physical therapy or other rehab services who really didn t need therapy at all. You will be told of the services provided in physician s offices that were authorized for continued care, by the referring/profiting physician without any real medical necessity or benefit. You will also hear of physical therapists in small private practices who were forced out of business because physician owned physical therapy services monopolized the market in their area. These reports are true.

I would like to highlight a different concern that physician self referral/profit for referral presents. That is the problem of the physician not selecting the best provider to meet a particular patient s needs if the physician cannot also make a profit by referring the patient to that provider.

In our area there is one physical therapist who is recognized as the best physical therapist around to treat patients with chronic pain. There is a physician, who belongs to an orthopedic group, who regularly sees this type of patient. Until about one year ago that physician sent most of her most challenging patients to this particular physical therapist. She would refer 2 to 4 patients per month on average. The physician and the patients all raved about how good this physical therapist was in dealing with this difficult patient type. The physician and the physical therapist worked well together for the benefit of the patient. There was no financial incentive for the physician s referrals to the physical therapist. The patient s best interest was all that counted.

That all changed, about a year ago. At that time the physician s group purchased the physical therapy department from the hospital. They set it up as a physician owned physical therapy service (POPTS). From that time on that physician sent no more of her patients to that physical therapist. Zero. From 2 to 4 patients a month to none. All patients were referred in house to a physical therapist with less experience and less expertise but who could provide a profit to the referring physician.

Was this change in referral pattern just a coincidence? Did the physician find a PT for hire who had equal or better skills than the physical therapist she used to refer to? Was the physician suddenly displeased with physical therapist she had been referring patients to for years? Was it no longer beneficial to refer a patient to a facility close and convenient to the patient s home rather than to the physician s owned physical therapy services which was miles, and several bus fares away?

The answers should be obvious. The physician was motivated by greed rather than patient needs and was unable to resist the temptation.

This is just one of many examples of what is wrong with allowing any type

Submitter : **Mr. Adam Greenfield** **Date: 08/31/2007**

Organization : **National Athletic Trainers Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13528-Attach-1.DOC

#13528

EMORY HEALTHCARE

EMORY SPORTS MEDICINE CENTER

#13528

59 Executive Park Drive South
Suite 1000
Atlanta, Georgia 30329
Phone: 404-778-6214
Cell: 954-592-4723
Fax: 404-778-4324

Dear Sir or Madam:

Hello, my name is Adam Greenfield. I am currently working as a Certified Athletic Trainer (ATC) / Physician Extender at the Emory Sports Medicine Center. We are a Sports Medicine Physician based clinic in Atlanta, Georgia. We have six Orthopaedic Sports Medicine, fellowship trained physicians and I am one of five full time certified athletic trainers and four ATC Fellows working in the clinic as orthopaedic athletic trainers / physician extenders, directly with our physicians and patients. It is daily we are tasked with overseeing the day-to-day health care needs of their patients.

I completed my undergraduate degree at the University of South Florida in Tampa, Florida and have been a certified athletic trainer for just over 4 years now and am licensed in both Florida and Georgia. I have worked in a variety of settings as an ATC, including outpatient physical therapy clinics, secondary school settings as well as communal outreach events. I was the Director of Sports Medicine for a physical therapy practice in Boca Raton, FL where I oversaw 5 local high schools and 5 certified athletic trainers and currently run my own athletic training company which provides certified athletic trainers for local sporting events, tournaments and camps within the State of Florida. Currently, I am working in a physician setting at the Emory Healthcare Orthopaedic & Spine Center.

In our practice, our physicians feel that ATC's are the ideal liaison in the orthopaedic clinical setting to see patients. They feel that certified athletic trainers have the education and knowledge with regard to musculoskeletal issues, to perform all skills necessary in physical medicine, patient education and rehabilitation, to treat their patients with the highest quality of 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 selection, 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, national certification exam and state licenses ensure that my patients will receive quality health care. I have been deemed qualified by state law, hospital medical professionals and orthopaedic physicians to perform these services and these proposed regulations attempt to thwart 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 feel free to contact me with any questions.

Sincerely,

Adam Greenfield ATC, LAT
Certified Athletic Trainer
Emory Sports Medicine Center
59 Executive Park South
Suite 1000
Atlanta GA. 30329
Phone: 404-778-6214
Cell: 954-592-4723
Fax: 404-778-4324
adam.greenfield@emoryhealthcare.org

Submitter : Mrs. Mary Beth Geiser **Date:** 08/31/2007

Organization : Wisconsin Phys Ther Assoc - Member

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

PHYSICIAN IN-OFFICE ANCILLARY SERVICES EXCEPTION

It is imperative that all physician loopholes related to this provision are closed. The present and loose definition allowed for "centralized building" creates an opportunity for physicians to have multiple centralized office locations. By allowing this exception physicians are able to create PT and OT practices and enables them to perform ancillary services to Medicare Beneficiaries, bill for "therapy services", and yet still not make a referral to the highest skill set specialist (specific for physical therapy services) who could best care for the rehabilitative needs of the Beneficiaries.

As a Board Certified Specialist in Orthopaedic Physical Therapy, I am very concerned about this loophole. I presently do not practice in a clinical setting where Physicians are "on site", "in the building" or functioning under the "in office ancillary services exception". It is troubling to me that beneficiaries nation-wide could be receiving advanced spinal manipulations by someone not qualificd to safely perform the needed treatments. I am also bothered that some physicians are billing (under this exception) for therapy services (performed on the same day of the office visit) that are not essential to determining the medical diagnosis. I believe that "policing" these unnecessary "therapy" treatments would positively impact the already financially stressed Medicare System.

I am in favor of much stricter guidelines and/or possibly the elimination of this provision for services specific to physical therapy (occupational therapy and SLP services). Eliminating the loop hole for therapy related service should strongly be considered and reconsideration of other services allowed in this provision should be closely monitored.

Sincerely,
Mary Beth Geiser PT, OCS
Board Certified Specialist, Orthopaedic Physical Therapy
American Board of Physical Therapy Specialties

Submitter : Mr. Allen Ling **Date:** 08/31/2007

Organization : Physical Therapy Innovations, Inc.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Remove physical therapy from the in-office ancillary services exception to the federal physician self-referral laws:

All of our 14 clinicians at our clinic at Physical Therapy Innovations believe that allowing physician practices to contract for services that they order and profit from creates an incentive for abuse in the Medicare system. In fact, we would recommend that Medicare should be concerned about over-utilization and program abuse when physicians are allowed to profit from ordering physical and occupational therapy services. Numerous studies in the recent past have provided a body of 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. The Government Accountability Office (GAO) has in two separate studies, detected considerable abuse when PT and OT services were furnished in physicians offices. With Physician owned Physical Therapy services, we have witnessed self-referral greed rise to the point where patients with shoulder surgery are told to drive 20 miles in heavy traffic to go to a therapy owned service by the physician, versus walking 2 minutes to our clinic. The physician stated that his physical therapist was better , despite the fact this therapist was previously employed by our office before hand!

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. We strongly support CMS for 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.

The clinicians at PT Innovations 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.

Submitter : **Dr. Kathleen Sullivan** **Date: 08/31/2007**

Organization : **California Anesthesia Associates**

Category : **Health Care Provider/Association**

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 support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I 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. Anmol Mahal **Date:** 08/31/2007

Organization : California Medical Association

Category : Health Care Professional or Association

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

see attachment

CMS-1385-P-13532-Attach-1.DOC

#13532

California Medical Association

Established 1856

August 31, 2007

Leslie Norwalk, Esq.
Acting Director
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P "GEOGRAPHIC PRACTICE COST INDICES (GPCIs)
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-1385-P Medicare Program;
Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008
"GEOGRAPHIC PRACTICE COST INDICES (GPCIs)"

Dear Ms. Norwalk:

On behalf of the California Medical Association, I am writing to provide comment on the proposed rules regarding the Medicare physician payment localities (72FR38122) and Geographic Practice Cost Indices (GPCIs). We appreciate the opportunity to provide our views on the three proposed California options.

I. Statement of the Problem

A. California

The intent of current Medicare law is to reimburse physicians according to the cost of providing services and to make adjustments for geographic differences in those costs. Since 1999, CMA has contended that the geographic boundaries of some Medicare physician payment localities in California and across the nation do not accurately address variations in the cost of operating a medical practice and therefore, Medicare is not paying physicians accurately pursuant to federal law. Shifts in demographics and economic conditions have created serious underpayment problems for physicians in 447 counties across the country.

In California there are several counties whose individual county geographic adjustment factors exceed the locality factor by 5% or more and should qualify for an update. Physicians in Santa Cruz are paid 10% less than they should be paid (according to Medicare's own geographic cost calculations) and these physicians are paid 21% less than physicians across the border in Santa Clara County with similar practice costs. Each of these California counties have become more urban and costly to practice medicine and

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despite Medicare's own data that shows their geographic practice costs rising, CMS has failed to update the locality groupings to more accurately pay these physicians.

The problem continues to compound because CMS has not updated the payment localities in nearly a decade and the last revision in 1997 was based on carrier-defined localities established more than 30 years ago in 1966. Further, the revisions were not uniformly applied in 1997. High cost counties are grouped with low cost counties resulting in a serious payment inaccuracies in these localities. These payment issues are addressed in detail in the CMA Medicare Geographic Payment Locality Report, January 2006.

B. Access To Care Problems in California's Underpaid GPCI Counties

Many seniors in these areas of California are experiencing problems accessing physicians. While physician shortages are a chronic problem across California, the underpaid GPCI counties have experienced substantial difficulty attracting and retaining physicians. As you are aware, California has one of the highest Medicare beneficiary populations in the country so these problems affect a greater number of seniors. The Medicare underpayment problem compounds for physicians because most of the private payers in California base their rates on Medicare.

o As mentioned above, no medical groups in Santa Cruz County are accepting new Medicare patients because of the low reimbursement.

o Sonoma County is experiencing a 30% primary care physician turn-over rate. Physicians are attracted to the quality of life in Sonoma County but after two years of practice are forced to leave because the reimbursements do not cover their high practice costs. Moreover, the largest number of physician group bankruptcies per capita have occurred in Sonoma County. The number of active physicians has declined by roughly 10% - 10.2% for specialist physicians and 9.2% for primary care specialties (not adjusted for population).

o Because of the low reimbursement rates and difficult practice environment, Sacramento County has experienced a nearly 20% decline in the number of physicians. More than a third of that loss occurred in the primary care specialties.

o 30% of physicians in San Diego County reported difficulty attracting new physicians to join their physician practices and medical groups. 33% reported to CMA that they planned to move out of state, retire early or change professions.

o A "slow water torture" is how a California board-certified internist recently described the practice of medicine in California when being interviewed by U.S. News and World Reports for its article, *Doctors Vanish from View*. This article details the phenomenon of California physicians limiting or leaving their practices altogether because of administrative hassles and declining reimbursements from insurers and the corresponding inability to devote themselves to the provision of continuous, quality patient care.

o The University of California Office of Health Affairs commissioned a report on California's physician workforce conducted by the University of Albany's Center for Health Workforce Studies. The report concludes that "growth in physician demand is likely to outpace growth in *(California)* physician supply by between 4.7% and 15.9%." The population of California is growing rapidly, which will place great strains on the health-care delivery system and the physician workforce.

o More than one quarter of the state's practicing physicians were over the age of 55 in 2000.

o Without appropriate access to physicians, patients seek care in California's emergency departments. California's ERs are already operating at critical capacity, and risk jeopardizing quality of care. Unfortunately, due to financial difficulties, more than 70 emergency departments have closed in the past decade.

o In a CMA Medicare survey more than 60% of California physician respondents said they cannot sustain future Medicare payment cuts and continue to accept new Medicare patients.

C. The Government Accountability Office (GAO) Report, June 2007

The Government Accountability Office (GAO) recently published a report entitled, "Medicare: Geographic Areas Used to Adjust Physician Payments for Variation in Practice Costs Should be Revised, June 2007" that substantiates the CMA concerns with the geographic payment problems around the country. The GAO was asked to examine how CMS has revised the localities; the extent to which they accurately reflect variations in physician's costs and alternative approaches to constructing the localities. The GAO reported the following:

> ***"...more than half of the current physician payment localities had at least one county within them with a large payment difference – that is, there was a payment difference of 5% or more between physicians' cost and Medicare's geographic adjustment for an area."***
>
> ***" Overall, there were 447 counties with large payment differences – representing 14% of all counties. These counties were located across the U.S., but a disproportionate number were located in five states. Specifically, 60% of counties with large payment differences were located in California, Georgia, Minnesota, Ohio and Virginia.***
>
> ***"...although substantial population growth has occurred in certain geographic areas, potentially leading to increased costs, CMS has not revised the payment localities to reflect these changes."***

These findings led the GAO to recommend 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..."

CMA strongly concurs with the GAO findings that the localities need to be revised using a uniform methodology and updated on a timely basis.

D. Past Petitions to Update Physician Payment Localities

As you know, CMA submitted a payment locality update proposal to CMS in 2004 during the public comment period on the CY 2005 Physician Fee Schedule rule. While the proposal was budget neutral on a statewide basis, CMS determined that it was not consistent with the law and did not adopt the plan. At CMS' suggestion, CMA re-submitted the budget neutral proposal to be implemented as a demonstration project. However, in 2005 CMS again responded that the approach was not feasible because it would not be subject to public comment through the normal rule-making process.

For the CY 2006 Physician Fee Schedule, CMS proposed to remove two counties, Santa Cruz and Sonoma, from the Rest of California, Locality 99. While the proposal would have provided payment accuracy for Santa Cruz and Sonoma and significantly helped physicians in those areas, it would have imposed a payment reduction on the counties remaining in Locality 99, including counties that also qualified for an increase. For this reason, CMA could not take a position on the proposal and provide the support that CMS required. Moreover, the proposal appeared to be a one-time only approach for helping only two counties. At the time, we believed there were 10 counties in California and nearly 200 across the country that qualified for an update. CMA asked CMS to adopt a long-term plan for updating the payment localities with a defined, uniform methodology that can be applied into the future on a periodic basis.

We appreciate CMS attempting to work with CMA over the years to address this problem but it remains unresolved and the payment discrepancies are getting much worse. It is time for CMS to act to keep payments current with geographically changing practice costs without imposing significant payment reductions on other physicians. We believe that any notable payment reductions that would be imposed on physicians are a direct result of CMS' unwillingness to update payment localities in over 10 years. Therefore, we believe it is paramount that CMS seek to minimize payment reductions to the fullest extent possible when considering locality revisions.

II. CMA Requests For GPCI Source Data Denied by CMS

CMA must express its great frustration that for the first time in eight years, CMS has refused to provide CMA the GPCI source data so that CMA could validate the CMS proposals and model alternatives to determine the impact on California physicians. This lack of data has completely crippled CMA's ability to comment appropriately on the three proposed California GPCI options in the 2008 physician payment rule. CMA would have preferred to model alternatives to the three proposed GPCI options to present

to CMS in the spirit of finding a mutually acceptable solution. However, without the information, CMA cannot develop alternatives and determine their true impact on California physicians. Without knowing the impact on payments, our physicians cannot vote on a proposal. The three proposed California options will have an enormous impact on physician payments in California. Therefore, we urge you to make the information available and transparent.

Information is Necessary to Verify CMS Calculations

There is a high probability that calculation errors are occurring that effect payments and may effect locality revisions. Errors are expected considering the nearly 20,000 figures (three GPCIs and three corresponding RVUs for each of the greater than 3000 counties) used to determine locality payments. Those errors could be minimized if the data used for the calculations were available to interested parties. Errors in GPCIs to the third decimal point can affect payment in millions of dollars to an area. For instance, in 2004, CMA found errors in the GAF calculations for Los Angeles County. The error would have imposed a half percent payment reduction on physicians in Los Angeles. The underpayment amount would have exceeded $50 million between 2005-2007. CMA contacted CMS and CMS immediately corrected the error. CMS working collaboratively with CMA, effectively and prospectively prevented that error from occurring.

Furthermore, there are many errors and typos in the current 2008 proposed options. In fact, in our efforts to replicate the methodology for Option #3, CMA discovered that CMS did not uniformly follow the methodology described in the rule. Therefore, proposed option #3 significantly misrepresents the true impact of the methodology on California physician payments in ten counties. Moreover, there would only be five payment localities instead of six.

Using HUD data provided to us by other entities, we believe that the proposed 9.2% reduction in payments to Santa Clara County are not the result of the most recent rent reductions but a correction of an error that CMS' contractor made in 2004. This kind of information should also be disclosed to all parties.

Because of the impact on physician payments, it is appropriate and essential that CMS make this information as transparent as possible. We urge CMS to make all data used to develop GPCIs and GAFs available to interested parties.

Information is Necessary to Model Potential Alternative Solutions

It is also important to establish the long-standing history of collaboration between CMA and CMS to share county GPCI and RVU data. Every year, CMS either performed the calculations or made the county GPCI, county RVU, and most recent HUD data available to CMA almost immediately upon CMA's request.

In 1999, (after the 1997 payment locality revision), CMA began contacting CMS to advocate for more appropriate payment locality groupings. From 1999 to 2003, CMA submitted requests to CMS staff to model different CMA-proposed solutions so that

CMA could determine the impact on California physicians. At CMA's request, CMS staff routinely performed geographic adjustment factor calculations. As CMA intensified its efforts to find a solution, this process became extremely burdensome and time-consuming for CMS staff. Therefore, in 2003 CMS began sharing all of the county GPCI and county RVU data with CMA so that CMA could make the necessary calculations to develop potential solutions. Using the CMS data in 2004, CMA developed a proposal that was budget neutral on a statewide basis. Because CMA had the appropriate data, physicians in California could determine the impact upon their practice. This proposal had the support of the vast majority of physicians within the CMA. CMA used the most recent data again in 2005 and 2006 to develop a major white paper that outlined several alternatives for updating the payment localities on a national basis.

The CMA is extremely frustrated that CMS refused to share the county GPCI data and the county RVU data for the first time in nearly a decade. After multiple requests, CMA was forced to file an expedited request for this data under the Freedom of Information Act. CMS never responded to any of our repeated requests. Therefore, we cannot provide alternative approaches to CMS that may have been more acceptable to our physician members.

III. Errors and Discrepancies

Before commenting on the three options, we would like to comment on discrepancies in the tables and text of Options 1-3.

In Column 3 of Table 7 Option 1 (72FR38140), the "New CY 2009 GAF, no locality change" for the Rest of California Locality and Counties is listed at 1.017. We calculate (from the 2009 GPCI's listed in Addendum E) the CY 2009 Rest of California Locality GAF is 1.012. Therefore, the "New CY 2009 GAF, with locality change" in column 4 of the same table for Rest of California is incorrectly listed as 1.012. This error is also present in Table 8, Option 2. We estimate that the correct Rest of California GAF for CY2009 with Option 1 or 2 Locality change is 1.006-1.007.

TABLE 7--OPTION 1--Apply 5 Percent Threshold To Remove Counties From Their Current Payment Localities, California Impact---(revised by CMA)

Locality Name	County Name	New CY 2009 GAF, no locality change	New CY 2009 GAF, with locality change	Percent change, due to locality change
Santa Cruz	Santa Cruz	**1.012**	1.100	**8.70%**
Monterey	Monterey	**1.012**	1.080	**6.72%**
Sonoma	Sonoma	**1.012**	1.076	**6.32%**
Marin	Marin	1.112	1.173	**5.49%**
Napa/Solano	Solano	1.112	1.066	**-4.14%**
Napa/Solano	Napa	1.112	1.066	**-4.14%**
Rest of California	Rest of California	**1.012**	**1.006-1.007**	0.49%

CMA has the capability to calculate locality GAFs from GPCI data, assess the impact of locality revision, and calculate payment accuracy that is not provided in the proposal. However, without the new GPCI and RVU data for California Counties, we cannot perform the calculations necessary to accurately evaluate the impact of Option 1 and 2.

In addition, we observed that the NEW CY 2009 GAF with locality change for the single counties listed in Table 7 (column 4) and Table 8 (column 3) differ from the Current county GAF (column 3) in Table 9, Option 3 for the same counties.

County GAF differences Table 7, 8 & 9

Locality Name	County Name	Table 7 & 8 New CY 2009 GAF, with locality change	Table 9 County 2009 GAF
Santa Cruz	Santa Cruz	1.100	1.098
Monterey	Monterey	1.080	1.077
Sonoma	Sonoma	1.076	1.074
Marin	Marin	1.173	1.170

These discrepancies lead us to question the accuracy of the impact of the three options listed in Tables 7, 8, and 9 and the accuracy of the locality configurations.

A significant discrepancy is present in Option 3. The text describes methodology similar to the County-based GAF range option studied in the GAO report (GAO-07-466) applying a "top-down" approach. After counties are sorted by descending GAFs, all counties within a 5% range of the highest GAF County are combined in the same locality. The process is repeated with the next highest GAF County outside of the 5% range, until all counties are assigned a locality. In Table 9, Option 3 (72FR38141-2) San Mateo County (GAF 1.204) is listed as the highest GAF County. 5% of GAF 1.204 is .062. Therefore, applying the methodology according to the text, Santa Clara County (GAF 1.148 or .058 difference) should be included in Locality 1. However, the table lists Santa Clara County as the highest GAF County in Locality 2 rather than the lowest GAF County in Locality 1. The methodology used to create the new localities listed in Table 9 appears to use a 0.05 GAF difference rather than a 5% difference. The methodology described in the text is not the methodology that was applied in the calculations.

Option 3--.05 vs 5% difference			
County	County 2009 GAF	.05 difference	5% difference
		CMS Published	CMS Corrected
San Mateo	1.204		**1.1438**
San Francisco	1.201	**Locality 1**	**=5% floor**
Marin	1.17		
Santa Clara	1.148	**error**	
Contra Costa	1.134		**1.0773**
Alameda	1.129		**=5% floor**
Orange	1.128	**Locality 2**	
Ventura	1.121		
Los Angeles	1.112		
Santa Cruz	1.098	**error**	
Napa	1.077		**1.0232**
Monterey	1.077		**=5% floor**
Sonoma	1.074	**Locality 3**	
Santa Barbara	1.053		
San Diego	1.053		
Solano	1.051		
[illegible]	[illegible]		
[illegible]	[illegible]		
[illegible]	[illegible]		
[illegible]	[illegible]		
[illegible]	[illegible]		
[illegible]	[illegible]		
[illegible]	[illegible]		
San Joaquin	1.006	**error**	
Yolo	0.995	**error**	
Stanislaus	0.979	**error**	
Mono	0.977	**error**	
Nevada	0.975		**0.9263**
Kern	0.973		**=5% floor**
San Benito	0.971		
Sierra	0.967		
Amador	0.967		
Fresno	0.963		
Mendocino	0.960		
Madera	0.960	**Locality 5**	
Tuolumne	0.959		

Alpine	0.957	
Mariposa	0.956	
Tulare	0.950	
Butte	0.950	
Calaveras	0.949	
Merced	0.949	
Humboldt	0.947	
Lake	0.947	
Imperial	0.945	
Plumas	0.945	error
Lassen	0.944	error
Sutter	0.942	error
Yuba	0.942	error
Colusa	0.940	error
Del Norte	0.940	error
Modoc	0.938	error
Shasta	0.937	error
Kings	0.935	error
Inyo	0.935	error
Siskiyou	0.934	error
Trinity	0.933	error
Tehama	0.932	error
Glenn	0.930	error

Santa Cruz County (GAF 1.098 in Table 9, GAF 1.100 in Table 7 & 8) appears to be within both the 5% and 0.05 thresholds of Locality 2 (Santa Clara County GAF 1.148 used for comparison), but is listed, instead, as the highest GAF County in Locality 3. Imperial and Plumas Counties have Current County GAFs listed as 0.945, yet Imperial is listed in Proposed Medicare Locality 5 and Plumas County is listed in Locality 6. We do not believe this is due to rounding effects. Including County GAFs to four digits might elucidate these apparent discrepancies.

Please also see the more detailed discussion below (V. Specific Comments on the General GPCI Update (72FR38136)) related to San Benito County. Based on the work of the GAO, we believe that CMS used the wrong MSA data for San Benito County. San Benito County is in the San Jose MSA, not the California Non Metropoitan Area. Applying the correct MSA data to San Benito County would move San Benito to Locality 2 and increase payments by 9.8% -- an appropriate classification given the dramatically rising costs in that community.

We urge CMS to correct these errors and discrepancies and reissue the proposals for public comment so that physicians may comment on the correct application of the methodologies described in Options #1-3.

IV. Specific Comments on Options 1-3

To assist CMS in the evaluation of Options #1-3, CMA provides the following specific comments on each option.

Option 1 & 2

CMA has extensively studied payment localities and advocated that the 5% iterative methodology be applied (as described in GAO-07-466 County-based iterative option and Option 1 5%i (61FR34618)). Unlike the GAO and HCFA application, however, we advocate the methodology be applied to existing localities. The iterative methodology compares the highest GAF County to the weighted average (GAF) of the remaining counties of the locality. The 5% (non iterative) methodology proposed in Option 1 and 2 compares the highest GAF County to its Locality GAF. The highest GAF County is, therefore, included in the calculation of the Locality GAF to which it is being compared. As described by HCFA in 1996 (61FR34618) the 5% iterative methodology is preferred because mid sized areas in large states and large areas in small states with considerably higher input prices have difficulty meeting the threshold (see description p34618 Federal Register July 2, 1996).

For example, San Diego County in Rest of California Locality has considerably higher input prices than the Rest of California (72FR38141-2). San Diego County contributes about 20% to the calculation of the Rest of California's GAF. As San Diego County's GAF increases to the threshold, the Rest of California's GAF also increases disproportionately, raising the payment error for all counties. San Diego County is not included in Option 1 or 2, we believe, because the 5% iterative methodology was not applied. If the same methodology is applied more broadly in other states, areas exist where a county is so heavily weighted in the locality average that the threshold can never be met, unless they are compared separately (refer to CMS US County GPCI data).

CMA strongly prefers the 5% iterative methodology to the non-iterative methodology applied in Option 1 and Option 2 of the CMS Locality proposal. Our comparison of the three options shows greater payment accuracy with the 5% iterative option. Administration could be simplified by consolidating single county localities with similar GAF's or Metropolitan Statistical Areas (MSA's) into Localities. Furthermore, there is greater payment accuracy than the 5% iterative county-based option reported by the GAO because the methodology is applied to existing localities rather than states. Such an application creates less disruption among existing localities with high payment accuracy.

We are also troubled that the methodology consolidating counties in Option 2 (after the threshold is applied) is not clearly stated. Combining the Counties into one locality has less payment accuracy than Option 1. The three Counties are not geographically contiguous and reside in separate MSAs. It is not clear how such a consolidation would occur on a more broad application. CMS should clearly define the methodology (threshold) used to consolidate counties with similar cost structures into one new locality. We oppose an arbitrary consolidation of counties for administrative simplification at the expense of payment accuracy.

CMA cannot support Options 1 and 2 for the reasons listed above but most notably because the iterative methodology was not employed. An iterative methodology would recognize and corrects the underpayment problems in many additional counties.

Moreover, an iterative methodology in Options 1 and 2 would impose the least disruption on counties in California that are not experiencing problems and that have high payment accuracy. However, we are also concerned with the proposed payment reductions, particularly the 4.3% payment reductions in Napa and Solano Counties. In general, we refer you to the GAO report findings on the county-based iterative approaches. Most important, CMA is seeking a long term solution to the problem. Options 1 and 2 only update three counties on a one-time basis. The non-iterative methodology is flawed and is silent on future updates. We urge CMS to adopt a methodology that can uniformly be applied and updated every three years.

Option 3

Option 3 provides the greatest payment accuracy overall. In California, it creates fewer payment areas which is less burdensome for CMS. However, it creates payment error in localities that have high payment accuracy. Six of the nine payment areas in California have 100% payment accuracy (costs, as measured by county GAF, are the same as locality payment). Option 3 creates payment errors in these six localities. Option 3 creates localities with counties that are not geographically contiguous. The locality border difference is higher in Option 3 than the 5% iterative county-based methodology as reported by GAO. However, improving payment accuracy overall could reduce problematic boundary differences.

In addition, counties of the same MSA (and similar cost indices) are assigned different localities. Methodology used to create Option 3 would be difficult to apply for future revision without potentially disrupting all payment localities. While an MSA approach is attractive because the source cost indices are similar, CMA is also compelled by the GAO findings that it creates unacceptable ranges and higher overpayments within localities in other states.

Our greatest concern with Option 3 is the negative impact to low cost rural "Rest of California" – Locality 99 counties. These counties would receive 4.9% to 7.3% payment reductions in an environment of rising costs, no payment updates for five years and a 9.9% conversion factor reduction. Moreover, these rural counties have historically suffered from physician shortages and access problems. In our opinion, such a payment reduction would unquestionably affect access to care for Medicare beneficiaries in these areas.

V. Specific Comments on the General GPCI Update (72FR38136)

In past years, budget neutrality adjusting factors were described in the proposed update (69FR47504). Changes observed in the physician work GPCI update for 2009 were due to minor changes in utilization and budget neutrality factors (72FR38138). However, these factors were not specified in the proposed 2008 rule. In the interest of transparency, we recommend that this adjustment factor be published. We also recommend that all data used to calculate GPCIs be available to interested parties.

San Benito County

It is reported that "the geographic adjustment factors (GAF's) for more than 90 percent of counties are developed using proxies based on larger geographic areas" (72FR38139). Using the same census data as CMS, the GAO was able to calculate individual work and practice expense GPCIs for 1091 counties that were part of a metropolitan statistical area (MSA)(GAO-07-466 p46). This represents a third of all counties. We noted a significant discrepancy in the GAF for San Benito County, California between the GAF reported by GAO and GAF published by CMS (GAO San Benito GAF-1.081 on p.54, CMS San Benito GAF-.971 p.38142) that could not be explained by differences in rent indices and Malpractice GPCIs. We believe this might be explained by an error in MSA derived census data by CMS. We believe the wrong MSA data was applied to San Benito County by CMS. San Benito County resides in the San Jose MSA not the California Non Metropolitan Area as suggested by the CMS GAF.

If the correct San Jose MSA data is applied, we believe San Benito would more appropriately be placed in Locality 2 under CMS proposed Option #3 and receive a 9.8% payment increase instead of the proposed -4.9% reduction. This MSA application is of major importance to San Benito County which is experiencing an exodus of physicians from the County. We request that this be reviewed along with the accuracy of the Census data used to develop the Work and PE GPCIs for all California Counties, like San Benito, where the County data is derived from MSA data.

Santa Clara County

We are extremely troubled by the 2009 Practice Expense (PE) GPCI for Santa Clara County. Since the PE GPCI is derived from wage census data and rent indices, and the wage census data has not changed since the last revision, the difference between the 2007 and 2009 PE GPCI can only be accounted for by changes in the rent indices. Santa Clara County had a 29% reduction in HUD FMR rent indices between 2004 and 2007 (the years used to determine 2006 and 2009 PE GPCIs). San Francisco County and San Mateo County had a 27% reduction in HUD rent indices between 2004 and 2007. Yet Santa Clara County's 2009 PE GPCI fell 16% while San Francisco and San Mateo County's 2009 PE GPCI only fell by 7%. We have been told that the Santa Clara County 2009 PE GPCI has been recalculated and is accurate (personal communication with CMS). We can only conclude, therefore, that an error was made in the calculation of the 2007 PE GPCI for Santa Clara County that has been corrected with the 2009 revision.

We urge CMS to investigate the Santa Clara calculation because Santa Clara physicians are facing a disproportionate payment reduction of 9.2% versus a 4.3% reduction for the neighboring bay area counties. Moreover, if the 2009 Santa Clara GAF represents a correction of an earlier mistake, it should be fully disclosed to the public. A 30% reduction in rent should not equate to a nearly 10% payment decrease.

CMA believes that the CMS contractor has made errors over the past several years that CMS has not been made aware. CMA suggests that CMS provide closer oversight of the contractor making the GPCI calculations. Moreover, if the contractor is making adjustments in the 2008-2009 proposed rule to account for errors made in previous years, those errors should be disclosed to the public.

San Diego County

We observed that San Diego County's GAF listed in Table 9 (1.053) is .02 less than what we calculated their GAF to be from previous 2006 GPCIs (1.072). San Diego County's 2007 HUD FMR is higher than their 2004 HUD FMR (used to determine the rent indices for PE GPCI). Therefore, the 2009 PE GPCI for San Diego County should be no lower than the 2006 PE GPCI. The 2009 Work GPCI should not be significantly different than the 2006 Work GPCI. The Malpractice GPCI contributes less than 4% of the GAF calculation. The .02 drop in San Diego GAF cannot be explained by the Malpractice GPCI alone. Since the San Diego County GAF is important in determining locality configurations for all three proposed options and contributes to 20% of Rest of California GPCIs if none of the options are finalized, we request that San Diego County's cost indices be reviewed.

VI. HUD Data Problems

There is considerable volatility in the HUD FMR data (used to generate rent indices for the PE GPCI) which makes us question its validity as a proxy for office rents. We do not believe that Santa Clara physicians experienced a 29% reduction in office rent relative to the national average. The GAO recommended in its 2005 report on GPCIs that CMS "consider the feasibility of replacing the practice expense GPCIs current rent index with a commercial rent index; if using a commercial rent index is not feasible, consider a residential rent index directly based on ACS data"(GAO-05-119). If the HUD FMR data is still considered the best proxy for office rents, we recommend that it be modified to adjust for the volatility in rental units that physicians are not seeing in their practice overhead.

VII. CMA Position

The California Medical Association cannot support any of the three GPCI options as proposed by CMS at this time for the reasons stated above. Of most concern are the significant reductions on physicians practicing in rural areas of California. Unfortunately, because CMS refused to provide the source data to CMA, we were unable to craft amendments to these three options that would have made them more consistent with our policy.

Therefore, the CMA urges CMS to adopt a payment locality update option that is consistent with the following policy that was unanimously adopted by the CMA House of Delegates in the Fall of 2006.

Resolution 102-06: MEDICARE LOCALITY REVISION

RESOLVED: **That CMA apply the following principles in supporting revised Medicare Geographic Payment Localities:**
(1) methodology for revision is applied consistently;
(2) payment accuracy within the locality is improved;
(3) there is a mechanism for future revision of localities that is formula driven;
(4) implementation of the revision minimizes payment reduction in each payment locality; and
(5) evaluation of any revision is based on accurate data gathered by CMA which shows that the revision minimizes any negative effect on access to care in California.

We also want to emphasize that we agree with the GAO recommendations that CMS needs to adopt a methodology and update payment localities on a timely basis rather than only considering locality issues when concerns are raised by interested parties. Medicare should pay as accurately as possible and appropriately account for geographic variation in practice costs.

CMS also requested specific comments related to administrative burden. We do not believe that any of the proposed options impose an undue administrative burden on CMS or physicians. The goal of paying physicians accurately outweighs any one-time administrative cost concerns.

Finally, we would like to summarize our specific recommendations related to the discrepancies in the three California options and the General GPCI update:

1. The data used to develop the GPCIs and the GAFs should be transparent and made available to all interested parties.
2. CMS should correct the GAF errors listed in Options 1-3.
3. CMS should correct the GPCIs of San Benito, San Diego and all California Counties with indices derived from the wrong multi-county MSAs.
4. CMS should investigate the Santa Clara HUD indices discrepancies and provide an explanation for the disproportionate 9.2% payment reduction.
5. CMS should correctly apply the methodology described in Option #3.
6. CMS should consider alternative methods to develop indices for office rent.
7. CMA urges CMS to resubmit options for locality revision for public comment once the errors and discrepancies have been fixed.

The CMA appreciates the opportunity to comment. We appreciate CMS' attempt to resolve the payment locality problem in California. We hope CMS will continue to work to equitably improve payment accuracy in California without imposing unreasonable payment reductions on physicians practicing in California's already underserved rural areas.

Sincerely,

Anmol S. Mahal.

Anmol S. Mahal, MD
President

Submitter : Mr. Travis Laloli **Date:** 08/31/2007

Organization : Providence Health System

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Travis Laloli and I am a Certified and Licensed Athletic Trainer in Oregon. I Graduated with my degree from George Fox University, which is one of three accredited universities in the State of Oregon. I work for Providence Health Systems in Newberg, Oregon as a part-time aide at the outpatient rehab clinic and also a part-time Athletic Trainer at a local high school, through Providence.

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

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

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health 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,

Travis Laloli, ATC

Submitter : Dr. Hansen Le **Date:** 08/31/2007

Organization : EBAMG

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

H. Le

Submitter : **Dr. Elizabeth Yasik** **Date: 08/31/2007**

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

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.

Submitter : **Miss. Anastasia Buerger** **Date: 08/31/2007**

Organization : **CSU, Fullerton ATEP Athletic Training Student**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Kinesiology major with an emphasis in athletic training at CSU, Fullerton, and I am in an accredited Athletic Training Education Program. I am completing rigorous academic course work, clinical hours, and I will be sitting for the BOC exam to become certified. The education, clinical experience, and standards that I exceed before becoming a Certified Athletic Trainer reflect the integrity of the athletic training 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 a future athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health 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,

Anastasia Buerger, ATS, Therapeutic and Sports Massage Therapist

Submitter : Mrs. Mary Beth Geiser **Date:** 08/31/2007

Organization : Wisconsin Phys Ther Assoc - Member

Category : Physical Therapist

Issue Areas/Comments

CAP Issues

CAP Issues

I would like to express my concern with the present THERAPY CAP restrictions for all physical therapists practicing in a private practice setting. Although I truly understand the magnitude of this regulation, I still believe it is unfair and unjust. In the last recent years (of my 16 years in practice) I continue to hear stories of Beneficiaries forced to leave their rural towns, local communities and trusted physical therapist(s) solely to seek continuation of physical therapy services in a hospital setting... because of course, their THERAPY CAP had been exhausted.

I myself have worked in an OP hospital based setting the majority of my career (either on site or in satellite clinic) and have witnessed distraught beneficiaries experience this dilemma. Although the CAP does not affect me or my institution in a financially negative way, I still feel compelled to voice my comments against the CAP each time there is an open comment session.

I fully understand that the only way to repeal the CAP is through congressional action - for this I am saddened. Despite my personal efforts to contact my legislators on this issue and create change, it continues to burden Medicare Beneficiaries on a national scale.

Numerous times recently I have spoken with panicked elderly family members, friends and clients about the Medicare CAP. They are confused, scared and frustrated that ALL PT services regardless of clinical setting are subjected to the CAP. (I know this is not true, but they insist at times that it is&) They avoid therapy, discharge themselves prematurely and tell their own colleagues mis-information about the CAP on a regular basis. It is a confusing and frustrating situation for Medicare Beneficiaries everywhere.

Over and over again I educate any person who will listen to me, about the limitations and restrictions of the THERAPY CAP. I tell each of them stories about Beneficiaries that have a lesser quality of life b/c of this CAP. In reality it would be nice, if all Beneficiaries who have exhausted their CAP (but have deficits) continue on with physical therapy services in the hospital setting, however many do not. I can only hypothesize how many of these Beneficiaries end up costing Medicare additional money b/c they became sicker or weaker as a result of not receiving all the physical therapy that they should have gotten b/c of the CAP.

As always, I am grateful to have this opportunity (again) to voice my concerns with the present regulations surrounding the THERAPY CAP.

Respectfully Submitted,
Mary Beth Geiser PT, OCS
Board Certified Specialist, Orthopaedic Physical Therapy
American Board of Physical Therapy Specialties

Submitter : **Date: 08/31/2007**

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
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 : **Date: 08/31/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Submitter : **Date: 08/31/2007**

Organization :

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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Submitter : **Date: 08/31/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Submitter : **Date: 08/31/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attached Word file.

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. Scott Parkhill** **Date: 08/31/2007**

Organization : **Dr. Scott Parkhill**

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

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: 08/31/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attachment. Thank you.

CMS-1385-P-13544-Attach-1.DOC

13544

To: CMS
RE: Physician self-referral

I have numerous episodes and situations that point to the abuse and overutilization of physician-owned Physical Therapy clinics. However, one particular episode, which occurred in the last week, shows, without a doubt, the desire of physicians to keep patients under their care for monetary gain.

I used to work for a hospital, managing one of its satellite outpatient orthopedic Physical Therapy clinics. I even was asked to oversee its Industrial Rehabilitation program. The clinic was adjacent to an office that had an orthopedic surgeon, Dr. J.D., who utilized it as a satellite office, seeing patients there once per week, for approximately 3 hours, then would leave. He entrusted numerous patients to my care, including all types of shoulder injuries/surgeries, except labral injuries, which he sent to Chicago, and knee injuries/surgeries. Pre and post-operative treatments were rendered, with an extremely large amount of independence, for a period of 3 to 4 years. Excellent outcomes were obtained, with commendations from the surgeon.

Shortly afterward, the hospital closed, and the physicians and employees went in a variety of directions.

I had ventured into the realm of independent private practice, and had been able to offer a wider array of services to clients, all the while achieving high level outcomes. A nurse case manager, S.K., referred a patient, A.K., for treatment of the shoulder. The diagnosis was general, "shoulder strain". After performing the initial evaluation, and performing subsequent treatments, the injury appeared to be more involved than originally thought. After expressing these findings to the case manager, specifically indicating the subscapularis and subacromial areas, she sought a second opinion regarding the shoulder. A couple of weeks went by, and I phoned the case manager, S.K., to find out the results of the second opinion. She indicated that A.K. ended up needing surgery, citing a repair of the subscapularis and decompression of the subacromial area. I again informed her that I was quite capable of taking care of the post-operative care for these procedures, as I had extensive experience with this from working with Dr. J.D., as well as with numerous nationally known surgeons from Chicago and Indianapolis. S.K. indicated that she was happy I could continue with the patient, as A.K. told her that she was quite happy with the care and attention and thoroughness of my office. S.K. then indicated that Dr. J.D. was actually the surgeon, and I told her that it should be all the easier to handle the patient's rehab and return to work. The case manager, S.K., then stated that she would recommend to the surgeon that she wanted the patient to maintain the continuity of care with me.

Several weeks passed by, which was normal, per the surgeon's protocol, before starting therapy. Upon follow-up with the surgeon, the case manager and patient expressed their desire to continue with the already well-established line of care with me. Per direct report from the case manager, she stated the surgeon told her that "due to the complexities of the surgery, he wants her to stay at his therapy." Per direct report from the patient, A.K., she stated "I asked him twice if I could come and see you, and he told me 'no', so I just shut up, because I was scared."

The follow-up with the surgeon apparently happened on 08/28/07. Despite both the case manager and patient specifically requesting a particular therapist, Dr. J.D. restricted the right of the patient to choose her provider of Physical Therapy. Instead, he elected to send her to his own clinic, from which he receives direct financial compensation. Clearly, he had sent

numerous patients to me while at the hospital, some with the exact same diagnosis. Though, now he has elected to direct patients, despite their clearly verbalized wishes, to his own clinic. He has eliminated the patient's freedom to choose, which is a right that continues to be restricted when a physician has a financial interest in the next level of care.

Other physicians have opted not to directly own their own Physical Therapy office, but rather own the billing service that the Physical Therapy clinic uses. The physicians billing office charges 8 to 10% of the money that is collected. The physicians send increased numbers of referrals to the Physical Therapy clinic. As the clinic gets busier, more money is billed for and collected. The physicians are then able to get higher dollar amounts back in their pockets, as they own the billing service. It appears that this is a technique which "flies under the radar" much more easily than owning the Physical Therapy clinic directly. However, this is just as restrictive as the directly owned clinic, as the physicians have a strong incentive to refer high volumes of their patients to the clinic for which they provide billing services.

In both of these cases, the freedom of choice is severely restricted, and promotes overutilization of Physical Therapy services, and any other services in which the physician has a financial interest. It is clear that Physical Therapy clinics should not be under physician control in any manner. The current structure leads to higher costs, increased episodes of care, and diminished focus on medical necessity of treatment. I strongly recommend removing Physical Therapy as an in-office exception for physician self-referral.

I would also be willing to cite specific names and references for the above mentioned episodes, if so requested.

Sincerely,

Kevin Elo, MPT, ATC/L, CSCS, CEAS
(219) 678-0366

Submitter : Mr. Wade Soenksen **Date:** 08/31/2007

Organization : University of Oregon Athletic Medicine

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-13545-Attach-1.DOC

13545

UNIVERSITY OF OREGON
College of Arts and Sciences

Dear Sir or Madam:

My name is Wade Soenksen, ATC and I work at the University of Oregon in the Department of Human Physiology. I am currently a graduate student in the accredited Post-Professional Athletic Training Master's 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,

Wade Soenksen, ATC
Post-Professional Graduate Athletic Training Program Graduate Teaching Fellow
541.346.5304
wsoenkse@uoregon.edu

DEPARTMENT OF HUMAN PHYSIOLOGY

1240 University of Oregon. Eugene OR 97403-1240

T (541) 346-4107 F (541) 346-2841

Submitter : Mr. Zubin Tantra **Date:** 08/31/2007

Organization : Lake County Physical Therapy LLC

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See Attachment

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

lease 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 : Dr. Harry M. Miller **Date:** 08/31/2007

Organization : Dr. Harry M. Miller

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Harry Miller, M.D.

Submitter : **Erica Baumgartner** **Date: 08/31/2007**

Organization : **HealthSouth**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Erica Baumgartner and I have been an athletic trainer for the past 9 years. I have a Bachelor's in athletic training and a Master's in Health Education. I have been working for HealthSouth the past year in a clinic and a high school as the primary healthcare provider for the high school athletes. Previously I worked in Virginia as a Health Specialist and athletic trainer at the high school 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.

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Sincerely,

Erica Baumgartner,MS, ATC

Submitter : **Dr. Tamim Wafa** **Date: 08/31/2007**

Organization : **Dr. Tamim Wafa**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-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 in Modesto Ca who mostly takes care of Medicare pts in a hospital setting. We have seen our incomes decrease substantially over the last few years and many of my colleagues have moved to out-patient practice with little or no medicare patients.

Often, most of my patients are the elderly having major cardiac, general or othropeadic procedures. They suffer from a variety of serious medical problems and the anesthetic process is challenging and difficult. A great deal of thought and effort has to go into making sure that our patients have the best outcome. However, we feel that our services are not respected or valued by CMS. This is why the best and brightest anesthesiologist no longer want to care for patients who need them the most.

Please ask yourself this question. Would you want the best and brightest to take care of your mom, dad or family member? If so, then please support the proposed CMS increase in anesthesia compensation.
Your decision will have a great impact on the care of our elderly.

Best Wishes
Tamim Wafa, M.D.

Submitter : **Dr. Christopher Ward** **Date: 08/31/2007**

Organization : **UPHS**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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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Christopher Ward, M.D.