**Submitter :** Dr. Mary Berry **Date:** 08/31/2007

**Organization :** Dr. Mary Berry

**Category :** Chiropractor

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

I am writing in STRONG OPPOSITION to the proposed rule dated July 12 calling for ELIMINATION OF REIMBURSEMENT by Medicare when an x-ray is taken by a non-treating provider and used by a chiropractor to determine a subluxation.

A patient may require an x-ray to identify a subluxation or to rule out any "red flags," or to also determine diagnosis and treatment options. By limiting a Doctor of Chiropractic from referring for an x-ray study, the costs of patient care increase due to the need for a duplicative referral for evaluation by another provider (e.g., orthopedist or rheumatologist, etc.) prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo x-rays and thus forgo needed treatment. It is the patient who will suffer as a result of this proposal.

I STRONGLY URGE YOU TO TABLE THIS PROPOSAL. These x-rays, when needed, are integral to the overall treatment plan of Medicare patients and, again, it is ultimately the patient who will suffer should this proposal become standing regulation.

Sincerely,
Dr. Mary Berry, DC

**Submitter :** **Dr. Blaine Brown** **Date: 08/31/2007**

**Organization :** **ASA**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

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.

Blaine W. Brown, MD

**Submitter :** Dr. John Swicegood **Date:** 08/31/2007

**Organization :** Adv. Interv. Pain

**Category :** Physician

**Issue Areas/Comments**

**Resource-Based PE RVUs**

Resource-Based PE RVUs

The proposed RVU cuts are extreme and will cause a cut back in services to my Medicare beneficiaries. I will not be able to continue to offer my services to Medicare beneficiaries.

**Submitter :** Mrs. Robert Phillips **Date:** 08/31/2007

**Organization :** Orthopaedic Specialists PA

**Category :** Individual

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

My husband received physical therapy via the doctor's office where he had surgery. He was aware of the physical therapy department available at the local hospital but choose to go to the doctor's office physical therapy program. The experience of having the therapist in direct contact with the physician made his care much easier than waiting to find out from the hospital physical therapy department about whether or not he could proceed to the next level of his therapy. The doctor and therapist communication is much better and all parties, especially the patient profits from this type of service. The convenience of going to one place for your total treatment is also a big plus for the patient (especially with gas prices like they are today). If there is conflict on what was to be done at physical therapy, the patient does not have to wait until the next visit; it is handled the same day within minutes of the conflict. The therapists at Orthopaedic Specialists communicated directly with the physician during my husbands therapy and everyone was kept 'on the same page' without delay. Please allow doctors to continue their physical therapy departsment in house. The patient needs this type of service. Thank You.

**Submitter :** **Dr. Fred Davis** **Date: 08/31/2007**

**Organization :** **Lahey Clinic**

**Category :** **Physician**

**Issue Areas/Comments**

**Payment For Procedures And Services Provided In ASCs**

Payment For Procedures And Services Provided In ASCs

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

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** Dr. Sana Ata **Date:** 08/31/2007

**Organization :** Lahey Clinic

**Category :** Physician

**Issue Areas/Comments**

**Payment For Procedures And Services Provided In ASCs**

Payment For Procedures And Services Provided In ASCs

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** Mr. Van Simpson **Date:** 08/31/2007

**Organization :** AANA

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**Background**

Background

Medicare currently under-reimburses CRNA services. This will put the availability of many anesthesia related services at risk for Medicare beneficiaries. Many of these Medicare beneficiaries live in rural areas predominantly served by CRNA's. The availabilty of anesthesia services will be put at risk if increased funding for services is not increased. I support such an increase. Thank you for your time and consideration. Van Simpson CRNA

**Submitter :** **Dr. Thomas Victors** **Date: 08/31/2007**

**Organization :** **Dr. Thomas Victors**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid 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 :** **Karen Shanahan** **Date: 08/31/2007**

**Organization :** **AthletiCo, LTD**

**Category :** **Other Health Care Provider**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Sir or Madam:

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

My name is Karen Shanahan, and I am an certified athletic trainer and physical therapy student. As an individual with first hand experience in the educational requirements for both professions, I have a unique perspective on this situation.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual 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,

Karen A. Shanahan, ATC, CSCS, SPT

**Submitter :** **Mrs. Sheila Smallwood** **Date: 08/31/2007**

**Organization :** **Mrs. Sheila Smallwood**

**Category :** **Nurse**

**Issue Areas/Comments**

**Impact**

Impact

Dear Sir or Madam:

My name is Sheila Smallwood and I am an RN in a hospital setting.
I have been an educator in a Health Science program and recognize the need for Ahletic Trainers given the shortage of Physical Therapist.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

Athletic tainers are qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. Their education, clinical experience, and national certification exam ensure that patients receive quality health care. State law and hospital medical professionals have deemed Athletic Trainers qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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

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

Sincerely,

Sheila Smallwood, RN, MSN.

**Submitter :**

**Date: 08/31/2007**

**Organization :**

**Category : Physical Therapist**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

See Attachment

CMS-1385-P-13561-Attach-1.DOC

CMS-1385-P-13561-Attach-2.DOC

135561

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

**Physician Self Referral Issues**

To Whom It May Concern:

My name is Jennifer L. Diehl and I would like to comment on the July 12 proposed 2008 physician fee schedule rule. I am concerned specifically with the issue regarding physician self-referral and "in office ancillary services" exception.

I have been a physical therapist practicing in the outpatient setting since 1999 and have seen much change in the profession over the years both for the good and for the bad. I am a true advocate for patient care and am concerned with the potential for fraud and abuse to occur for my patients with this new proposal.

I feel that the potential for fraud and abuse exists with the physicians' ability to refer Medicare beneficiaries as well as other clients to entities in which they have financial interests. I have personally seen this abusive self-referral happen locally within my residential/practicing area. Patients have come to me stating that they were told or encouraged to attend physical therapy at a local physicians office even though they wanted to come to the clinic I practice in. They stated the physician owned physical therapy clinic was further away and much busier (less one-on-one time by the PT), but they went to the physician owned practice as the physician encouraged his/her own clinic. These patient comments made no sense to me. I question why would the physician encourage a client to attend his/her practice if it was inconveniencing the client. What was the purpose of the patient/client attending the physician owned clinic if the patient was not benefiting from it? Was this simply a financial convenience for the physician?

More and more physician in the area are opening physical therapy clinics in their own building for what I believe to be for financial self interests. I question the supervision within these offices as well. Are the clients who are supposedly receiving "physical therapy" coming from a physical therapist or an unlicensed person?

Thank you for reviewing this letter. I hope that you will consider my above comments when considering this proposal. Ask yourself: Is the patient or the physician benefiting from this practice setting?

Sincerely,
Jennifer L. Diehl PT 08588

**Submitter :** Mr. William Stewart **Date:** 08/31/2007

**Organization :** Clemson University

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Sir or Madam:

My name is William Stewart and I am currently an assistant athletic trainer for Clemson University in Clemson, SC. I am responsible for the prevention, evaluation, treatment and rehabilitation of the Clemson University football team. I have been in my current position for 6 years and have been in this profession for 14 years. I finished my undergrasuate degree from Clemson University and my Master's degree from Middle Tennessee State University. I have been a Certified Athletic Trainer for 9 years and have worked at both the college and high school settings taking care of athletic related injuries.

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

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

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

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

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

Sincerely,

William R. Stewart, III, MS, ATC

**Submitter :** **Dr. Jennifer Zannini** **Date: 08/31/2007**

**Organization :** **Winchester Anesthesia Associates**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Ycar Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has 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,
Jennifer L Zannini, MD

**Submitter :** Mr. John Riesenberg **Date:** 08/31/2007

**Organization :** Mary Black Health System

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Sir or Madam:

I returned to school as a non traditional student at the age 50 to persue a degree as an Athletic Trainer, I have passed the national test and have been employed at two different locations, both were thru hospital settings, the NH setting was a 50/50 area where I worked as a aide in the morning, laundry, and paper work, afternoons in the High school setting as an Athletic trainer. My current employment in SC, has me working for the hospital but I work full time at the schools and I interact with the orthopedic doctors and therepists as a professional extention of our team. We have many athletes that have no insurance and they rely on my professional skills to return them to play after they have had surgery or have been injured. Athletic Trainers are making a difference and the positive response we are recieving from the community is a testement to our dedication and and professionalizm.

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

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

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

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

Sincerely,

John J. Riesenberg Jr., ATC

**Submitter :** Ms. Samuel Lecates **Date:** 08/31/2007

**Organization :** AANA

**Category :** Other Practitioner

**Issue Areas/Comments**

**GENERAL**

GENERAL

The medicare amount of payment for anesthesia for cataract surgery is too low. I believe an increase is in order

**Submitter :** **Dr. Mark Macri** **Date: 08/31/2007**

**Organization :** **APTA**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

August 31, 2007

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

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

Dear Mr. Weems;
I am a physical therapist in Ohio and I am writing in regard to the Physician Self-Referral Issues. I am requesting your consideration to eliminate physical therapy as a designated health service furnished under the in-office ancillary services exception. This exception facilitates an abusive referral arrangement and creates a captive referral base of physical therapy patients in the physician s office.
Thank you for your attention in this matter.

Sincerely;

Mark A. Macri, PT, DPT, MS, OCS

**Submitter :** Miss. Heather Carter **Date:** 08/31/2007

**Organization :** Palmer College of Chiropractic Florida

**Category :** Individual

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

Attention: CMS-1385-P
see attached.

CMS-1385-P-13567-Attach-1.DOC

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

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Sincerely,

Heather Carter
DC Student
Palmer College of Chiropractic Florida

**Submitter :** Mr. Devin Cashman **Date:** 08/31/2007

**Organization :** Regis College (MA)

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Devin Cashman, I currently work as a Certified Athletic Trainer at Regis College. I hold an undergraduate BS degree with a concentration in Athletic Training and a MS degree in Clinical Exercise Physiology. In my current role as a Certified Athletic Trainer I work with a variety of patients. The range of patients I provide treatment for include college athletes to elderly clergy members. I feel it is extremely important to allow these patients to recieve the best quaility of care possible from a varicty of health care providers including Certified Athletic Trainers.

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

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

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health 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,
Devin Cashman, MS, LATC
Head Athletic Trainer
Regis College
235 Wellesley St.
Weston, MA 02493

**Submitter :** Mr. Edward Doherty **Date:** 08/31/2007

**Organization :** Mr. Edward Doherty

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a licensed and nationally certified athletic trainer in my 22nd year of practice. I have been employed in a collegiate setting, high school setting, private practice setting and minority principal owner in a private practice setting that also treated Medicare patients. I have in excess of 600 hours in continuing education training with medical doctors, osteopathic physicians and physical therapists, beyond my Master s Degree, in the areas of manual therapy, lymphedema and exercise as it related to athletic and geriatric populations. While in private practice I have had elderly patients sent directly to me at the request of there attending physician because of my additional training, care, expertise and results.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules would create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, national certification exam, and on-going continuing education requirements ensure that my patients receive quality health care. State licensure law and hospital medical professionals have deemed Athletic Trainers qualified to perform these services and these proposed regulations attempt to circumvent those standards. Further, current acceptance of Physical Therapy Assistant s as qualified providers, with only two years of higher education and zero continuing education requirements, demonstrates a misrepresentation of information by an association with an agenda that may not be based on accessible and affordable health care for all Americans.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry, especially in rural areas. It would be irresponsible to further restrict their ability to receive qualified rehabilitation services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment 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,
Edward M. Doherty ATC

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

**Organization :**

**Category : Physical Therapist**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

August 28, 2007

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

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

PHYSICIAN SELF-REFERRAL ISSUES This is a comment regarding the July 12 proposed 2008 physician fee schedule rule specifically the issue surrounding physician self-referral and the in-ofice ancillary services exception.

As a physical therapist and private practice owner practicing for over 10 years, I am acutely aware and concerned of the negative impact that physician-owned physical therapy referrals can have. Having a financial interest in other services to which a physician refers a patient may cloud the physician s judgment as to the need for the referral, as well as the length of the treatment required. In addition, I have seen physician offices proliferating their physical therapy by setting up therapy in a vacant room in their office that they now call their physical therapy department and the patient receives so-called therapy from unlicensed personnel vs. a skilled, licensed physical therapist. I have also witnessed physician offices choosing their payor mix by keeping the patients that have good insurance/reimbursement and referring those patients with poor insurance/reimbursement to an outside therapy provider. This obviously creates a real conflict of interest. The patient is for the most part unaware that a potential conflict of interest exists. In addition, the consumer loses the opportunity to choose their physical therapist when they are told to go to the physician owned therapist for possibly economic rather than clinical reasons. Financial ties can increase utilization of services. A report by the OIG (Office of the Inspector General) that investigated in-office physician services found that from a sampling of physical therapy line items billed by physicians during the first 6 months of 2002, that 91% of PT billed by physicians and allowed by Medicare did not meet Medicare guidelines and this resulted in $136 million in improper payments. In addition, the study noted that services were rendered by unskilled and/or unlicensed personnel, placing the beneficiary at risk.

At a bare minimum, action should be taken to accomplish the Inspector General's suggestion that the requirements for physical therapy rendered in physician's offices, including licensure, should not differ with the requirements for physical therapy rendered in other settings, such as independently practicing physical therapists' offices and nursing homes.

These comments are intended to highlight the real and potential abuse of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

**Submitter :** Dr. Marc Huntoon **Date:** 08/31/2007

**Organization :** Dr. Marc Huntoon

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

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

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

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

**Submitter :** Dr. Jeffrey Heftler **Date:** 08/31/2007

**Organization :** Dr. Jeffrey Heftler

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

I feel that the cuts in the fee schedules are unfair. With malpractice and business expenses increasing, decreasing the physician. payment could be disasterous

**Submitter :** Dr. Bennett Rudorfer **Date:** 08/31/2007

**Organization :** FACC

**Category :** Physician

**Issue Areas/Comments**

**Resource-Based PE RVUs**

Resource-Based PE RVUs

I have added the MTWA HeartWave equipment to my practice in Crittenden County, AR. We have 2 devices, one in each office in West Memphis and one in Marion. The test is extremely valuable in the management of patients at risk for Sudden Cardiac Death, and who may possibly need an AICD. Although we run the offices full time, the assumption that the Microvolt T-Wave Alternans equipment is used 50% of the time is inaccurate. It is used much less than 50% of the time - - perhaps 15-25%, but I would have to check. It is a costly test to run because of the electrodes, the expertise needed to get a good study and the fixed equipment cost. The equipment sits mostly dormant. Bennett Rudorfer MD FACC.

**Submitter :** Dr. Quoc Dang **Date:** 08/31/2007

**Organization :** South County Anesthesia Associates

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

Pleasc help to support the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue. If you have had surgery or know a family member that has, you must realize the importance of the anesthesiologist during one' surgery. We not only help to reduce the patient's anxiety, pain and suffering, but more importantly watch and care for their life during any medical procedure they might undergo. Pleasc realize how important this service is and help reimburse it properly.

Thank you for your consideration of this serious matter.

Quoc Dang, MD-PhD

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

**Organization :**

**Category :** **Chiropractor**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I strongly oppose any legislation that denies medicare payment for radiographic procedures ordered by a chiropractor. Radiology is an integral part of the practice of chiropractic and is often necessary for delivering the appropriate level of care to seniors. Denial of payment for this service will result in sub-standard care and in increased cost as senior patients will need to seek duplicate evaluations from other providers in order to have this basic procedure reimbursed.

**Submitter :** Mrs. Kelli Manning **Date:** 08/31/2007

**Organization :** Appalachian Physical Therapy

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am trying to stress the importance it is to allow Certified Athletic Trainers the same practice standards as a Physical therapist. I work in a clinic with several physical therapists and see the same type of patients. There are several patients with Medicare with a simple ankle sprain that I could treat, but cannot because of a law that is unjust and unfair. I have the same schooling but because I am a certified athletic trainer and not a physical therapist I am restricted by a certain patient that I can see. If the CMS law is not changed I amafraid my profession is going to be in serious trouble as far as finding a job. It is hard enough already without an unjust law stopping us. Please reverse the changes and stop placing critical laws into pratice without all the facts.

**Submitter :** Mr. George Britt **Date:** 08/31/2007

**Organization :** Childrens Healthcare of Atlanta

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is George Britt and I am a Certified Athletic Trainer. I recieved a degree in Sports Medicine from Valdosta State University 1998. I currently work at Childrens Healthcare of Atlanta performing rehab on adolescent athletes during the day and then go to a high school in the afternoons. I specialized on back injuries and core stabilization in athletes and knee injuries. I have helped several professional, collegiate, highschool athletes get back to there sports and even the weekend warrior get back to there every day living routines. I have also educated many Physcians, Physical therapist, and other Athletic trainers at seminars on several sport related injuries, and new methods of rehabilitation, and core stability to help prevent further injuries in the future.

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

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual 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. However, Athletic Trainers have the same ability as physcial therapist and we specialize in sport related injuries. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. I Also have a Licensure in the state of Georgia as an Athletic Trainer that allows me to treat in the state.

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. Not only will this affect the outstanding care that patients recieve from there Athletic Trainers, but also will affect the 100,000+ highly educated, and certified Athletic Trainers Jobs.

Sincerely,

George F. Britt, ATC/L

**Submitter :** **Dr. Samuel Dickerson** **Date: 08/31/2007**

**Organization :** **ASA**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

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. 1 am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

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

Thank you for your consideration of this serious matter.

**Submitter :** Ms. Letha Lare **Date:** 08/31/2007

**Organization :** King's Daughters' Hospital and Health Services

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

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

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

**Submitter :** **Dr. Britt Smith** **Date: 08/31/2007**

**Organization :** **Soar Physical Therapy**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

I am a private practice physical therapist in Grand Junction, CO. A local orthopaedic physician group has added a PT service to their practice under provision allowed under Colorado Law as a 'provider network'. The impact on the local hospital (Community Hospital) outpatient services was profound in loss of clients. Our practice, also, has been impacted to a lesser degree, as we have a wider base of referral.
I am not privy to the workings of their PT operations, but allegations from patients, have included high billing rates and high volume care in the practice in a space in the basement of their office.
I have witnessed POPTS over my 26+ yr career in California and Colorado. The structure has nothing to do with 'best' practice or 'integrated systems' (as physicians usually claim), but rather that 'PT practices still make monies for the physician practice' (as a local office manager reported to another orthopaedist group after a national office managers meeting). The reality of the POPTS situation is a power & monies game in which PTs have little of either attributes to resist in the situation. Medicare is not in the business of making the world 'fair', but Medicare should look at the long history of POPTS and the legacy of over-bill charges, over-utilization of physical therapy services and under-serving the clients (where is the quality data?). Medicare should stop reimbursement for physician-ownership of ANY services. By the way, an office manager also reported to an orthopaedic group after one of their meeting 'MRIs are like printing money'. Should the US Mint be alarmed? No, but Medicare should be!!!
Thank you, Britt Smith PT, DPT, MS, OCS, FAAOMPT

**Submitter :** Dr. Micki Cuppett **Date:** 08/31/2007

**Organization :** University of South Florida College of Medicine

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**Therapy Standards and Requirements**

Therapy Standards and Requirements

See attached

CMS-1385-P-13581-Attach-1.PDF

1385-P

HEALTH

August 29, 2007

Dear Sir or Madam:

I have been a certified and licensed athletic trainer for 25 years and have worked in a number of practice settings including the clinic and hospital setting in rural areas. I now have the opportunity to teach future physicians and other health care professionals in the College of Medicine at the University of South Florida.

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

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

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. My colleagues and the University of South Florida have deemed me qualified to teach future physicians and other health professionals, including physical therapists, but the proposed regulations attempt to prohibit qualified and credentialed individuals like me from providing patient care utilizing these same skills.

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,

Micki Cuppett, Ed.D, ATC
Associate Professor, Dept of Orthopeadics and Sports Medicine
and
Director of Educational Design and Technology
Office of Educational Affairs

OFFICE OF THE DEAN, EDUCATIONAL AFFAIRS • COLLEGE OF MEDICINE
University of South Florida • 12901 Bruce B. Downs Blvd., MDC54 • Tampa, FL 33612-4799
(813) 974-7131 • FAX (813) 974-2976

**Submitter :** Dr. Wandana Joshi **Date:** 08/31/2007

**Organization :** Holyoke Medical Center

**Category :** Physician

**Issue Areas/Comments**

**Resource-Based PE RVUs**

Resource-Based PE RVUs

Thank you for considering the increase in anesthesia payments. As an anesthesiologist in Massachusetts were are having an extremely hard time recuiting physicians to provide anesthesia services because of low reimbursements.

**Submitter :** **Mr. Chris Poulin** **Date: 08/31/2007**

**Organization :** **Poulin Performance and Rehabilitation**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Therapy Standards and Requirements**

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Chris Poulin and I am a private practice physical therapy owner and certified athletic trainer by trade. I have been practicing for 10 years and have worked in a variety of athletic training settings including the high school, university and clinical settings. I am also certified as a strength and conditioning professional.

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

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

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health 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. This change would have a profound affect on our practice as it is already beyound difficult to recruit, hire and train quality staff. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

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

Sincerely,

Chris Poulin, ATC,CSCS,PES
Owner, Poulin Performance and Rehabilitation

**Submitter :** **Ms. Lisa Hughes** **Date: 08/31/2007**

**Organization :** **Cancer Research and Prevention Foundation**

**Category :** **Health Care Professional or Association**

**Issue Areas/Comments**

**Drug Compendia**

Drug Compendia

The Cancer Research and Prevention Foundation is concerned with the process set forth in Docket CMS- 1385-P Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies, with respect to Medicare Drug Compendia.

The number of compendia originally authorized for use in Medicare Part B has declined. Publishers of additional comprehensive and respected compendia within the oncology community have requested CMS approval and have not received any timely determination from CMS in response to their request.

While we are encouraged by CMS' efforts to create a process for accepting new compendia, CRPF is concerned that the process outlined is too lengthy, and at a minimum a 225 process with two windows of unspecified time that could lengthen the process even further. The process also leaves open questions such as the length of time it will take the agency to compile a complete list of requests, how soon the public comment period will begin after the compilation of requests, and when the change will become effective. Additionally, the criteria outlined do not take into account the way oncologists treat patients, relying less on drug compendia and more heavily on published treatment guidelines, clinical trial results and peer consultation.

Ultimately, the lack of authorized compendia and slow process for adding new compendia will have a significant negative impact on cancer patients in the Medicare program. Medicare beneficiaries deserve access to state of the art cancer care and expedited coverage policies that are not left at the discretion of local carriers to narrow coverage. Under the current state of affairs, and for the lengthy window of time created by the process, Medicare patients diagnosed and treated for cancer will be subject to inconsistent coverage policies, and slow and narrow coverage policies.

CRPF urges CMS to adopt a more patient friendly, streamlined process with an inherent sensitivity to the unique treatment processes within cancer under both Part B and Part D of the Medicare program that allows timely changes to keep pace with treatment standards and broad access to the most effective, cutting edge therapeutic and chemopreventive agents for beneficiaries.

Thank you for your consideration of our comments.

Sincerely,

Lisa Hughes
Senior Director, Policy and Advocacy

**Submitter :** Dr. Clifton Jr. Mereday **Date:** 08/31/2007

**Organization :** Dr. Clifton Jr. Mereday

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

These proposed changes can provide much needed assistance for care givers who routinely see malpractice charges increase while payment for services rendered are cut.

**Submitter :** Mrs. Gaetana DiLeo-Deiso **Date:** 08/31/2007

**Organization :** Staples High School

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**Therapy Standards and Requirements**

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Gaetana and I am the Head Athletic trainer at Staples high School in Westport, CT. It is my 4th year there and love helping athletes return to the playing field.

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

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

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

Gaetana DiLeo-Deiso ATC, LAT

**Submitter :** **Dr. Linda Levy** **Date: 08/31/2007**

**Organization :** **Plymouth State University**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Dear Sir/Madam,

I am the undergraduate Athletic Training Program Director at Plymouth State University in Plymouth, NH. As such, I teach undergraduate and graduate athletic training students about our profession as well as the numerous skills and competencies required to work as a Certified Athletic Trainer. CMS-1385-P is the type of bill that will allow our students to work in settings where they are able to apply all of those skills.

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

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

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

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

Sincerely,

Linda S. Levy, EdD, ATC
Athletic Training Program Director
Plymouth State University

**Submitter :** **Capt. Christopher Kuennen** **Date: 08/31/2007**

**Organization :** **USAF/NC**

**Category :** **Other Practitioner**

**Issue Areas/Comments**

**Background**

Background

Dear Sirs,

I am writing to give my support to the proposed boost to the value of anesthesia work by 32%. As you know anesthesia has been historically compensated at a less than fair market value. Anesthesia is so much more than rendering a patient insensate. It involves internal medicine, cardiology, pulmonology, critical care and life support. Without anesthesia surgery doesn t occur.

Without a payment boost and facing a shortage of providers; no longer will the specialty attract the best and brightest. A further shortfall in the number of anesthetists will impede the delivery of healthcare across the spectrum and patients receiving Medicare will be the hardest hit.

I am asking you to counteract the decline in Medicare payment for anesthetists. Please enact the proposed change to increase payment, to better reflect the true market value of our services.

Sincerely,

Capt. Chris Kuennen CRNA, USAF/NC
59th MSGS/MCOA
Wilford Hall Medical Center
(210) 679 0441 H (210) 292 5554 W
Christopher.kuennen@lackland.af.mil

**Submitter :** Mr. Michael Eldridge **Date:** 08/31/2007

**Organization :** Mr. Michael Eldridge

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Dear Sir or Madam:

I am currently a Licensed Athletic Trainer for a local high school, contracted by a Physical Therapy Clinic. I have been practicing Athletic Training for about ten years and love helping the "physically active" with their injuries. I have helped save the parents at the high school where I am employed, time and money. This is done by the timely "on-site" care which I provide. Sometimes eliminating the need for the athlete going to the local Emergency Room for a diagnosed "contusion". I can even help the injured athlete by quickly and properly protecting an injury, so the athlete can then return to play safely.

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

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper 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,

Michael Eldridge, L/ATC

**Submitter :** Mrs. Valerie DeVine **Date:** 08/31/2007

**Organization :** Berks Cardiologists, Ltd.

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

The utilization rate of nuclear and ultrasound imaging equipment for cardiology is well below 50%, and increasing the rate to 70% is not substantiated. Bundling 93325 into Doppler Echo Codes is not appropriate. The code 93325 results in additional physician work and is not typically performed with other echo codes. The estimated 9.9% cut will be extremely onerous for private practice cardiology. The age of the general population continues to increase and the lifespan lengthens - cardiology will not be able to sustain services to the Medicare population with reimbursements continuing to decline. Physicians have not received cost of living increases for years yet the cost of providing care continues to rise. A permanent solution to the flawed sustainable growth rate must be attained.

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

**Organization :** **Anesthesia Medical Consultants, PC**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** **Dr. Minzhi Chen** **Date: 08/31/2007**

**Organization :** **Allegheny General Hospital**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Leslie V. Norwalk, Esq
Acting administrator
Center for Medicare and Medicaid services
P.O. Box 8018
Baltimore, MD 21244-8018

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Anesthesia Coding ( Part of 5 year review)

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Thank you for your consideration of this serious matter.

Sincerely,

Minzhi Chen, MD

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

**Organization :** **Purdue University**

**Category :** **Physical Therapist**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Sir or Madam:

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

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

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

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

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

Sincerely,

Jeffery L Stein MS, ATC, DPT

**Submitter :** **Mr. David Price** **Date: 08/31/2007**

**Organization :** **Mr. David Price**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Background**

Background

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

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

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

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

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

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

Sincerely,

David L. Price SRNA
1175 Pineville Road Apt 107
Chattanooga, TN 37405

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

**Organization :**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

**Organization :**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attached

CMS-1385-P-13596-Attach-1.DOC

Dear Mr. Kuhn:

I am a radiation oncologist who practices within a group practice in both the hospital and outpatient setting. I am writing to comment on the proposed changes to the physician fee schedule rules that were published on July 12, 2007 that concern the Stark self-referral rule and the reassignment and purchased diagnostic test rules.

I am compelled to comment on the proposed changes through recent experiences in dealing with referring physicians and the "call for action " that has been sent out through the AUA urging their members to comment on how the changes will negatively impact their practices. I have included a copy of the "sample letter" as I would like the opportunity to discuss several salient points and provide arguments as to the erroneous nature of their support for the status quo.

The proposed changes will not have a negative or serious effect on the way urology is practiced. The argument in support of "joint ventures" with regard to ancillary services such as diagnostic testing, radiation therapy and pathology services generally centers around "improved access to care." First and foremost with respect to radiation therapy services there are no access issues. This issue has been examined and I urge you to consult the various radiation societies such as the American College of Radiation Oncology (ACRO) and the American Society of Therapeutic Radiation Oncology (ASTRO) with regards to the number and distribution of external beam radiation centers.

You will no doubt find that very few patients are not within a reasonable distance of a radiation oncology facility. As an example, in my state of New Jersey no patient is greater than 25 miles from an existing center. Moreover I would challenge the position that patients do not have access to radiation services and ask these providers to supply their location and I would look forward to assisting your evaluation of such a claim. In reality the radiation oncology centers whom urology has financial interests are generally in metro areas with many other centers in close proximity.

The interest by urology in external beam services is a relatively new phenomenon although the use of external beam radiation therapy in the treatment of patients with prostate cancer is not. Intensity modulated radiation therapy (IMRT), which is a sophisticated form of external beam radiation has become the new standard of care with

respect to external beam therapy for patients with localized prostate cancer. As a new technology IMRT has a favorable reimbursement profile from the technical component. (It should be noted that despite the increased complexity of IMRT, there is no financial benefit over three-dimensional conformal therapy from the professional side of reimbursement). Since this is the only variable that has changed, one must assume that the recent interest in radiation oncology facility ownership by urology is largely if not solely due to a potential financial benefit in referring patients for IMRT

The practice of radiation oncology and the recommendation for the delivery of radiation therapy should remain an independent and objective decision between physician and patient based on best practices and patient preference. This relationship has the potential to be negatively impacted when urology has a financial interest in a radiation oncology practice. In a typical scenario patients are referred by urology for a radiation oncology opinion and/or services. The radiation oncologist therefore does not control the referral and can offer an objective opinion. When urology has a financial interest in an IMRT center there will be significant pressure to recommend IMRT as opposed to other local therapies such as surgery or permanent seed implants.

Radiation oncology is a highly technical field in which a typical center treats a wide variety of patients with various diseases. The proliferation of such "specialty" radiation centers fostered by the current regulations results in the duplication of extremely expensive technology and offers no significant benefit to patients and may actually restrict patient choice. Moreover it will cause an increase in expenditures to CMS

The decision with regard to the most appropriate therapy for patients with localized prostate cancer must remain independent of financial incentives. The proposed changes with restrictions on the in office ancillary exemption and leasing arrangements will have a positive effect on patient choice and will also positively affect the financial bottom line in many areas of patient care.

Respectfully

AUA Call to Action!

**Sweeping Changes Proposed to Medicare Self-referral and Reassignment Rules Could Negatively Impact Urology Practices**

Do you currently provide lab tests, imaging services or radiation therapy services in your office to Medicare patients, including diagnostic lab, IMRT or CT? Do you provide any services to Medicare patients under arrangement with a hospital or with equipment vendors, including TUMT, lasers, cyber knife and cryosurgery?

If so, you should be aware of proposals in the 2008 Medicare physician fee schedule rule relating to the physician self-referral (or Stark), reassignment and anti-markup rules. If finalized, the proposals, which were published in the *Federal Register* on July 12, 2007, could limit your ability to provide these services to Medicare patients and/or cause you to face significant new regulatory compliance hurdles beginning January 1, 2008.

**CMS Needs to Hear from Practicing Urologists**

The AUA Health Policy Council is working in conjunction with outside legal counsel to craft comments that will represent the interests of AUA members affected by these proposals—but CMS also needs to hear from you about how these proposals could affect access and quality of services for the Medicare beneficiaries that you treat.

If you are affected by these proposals and would like to send comments to CMS, please use this **sample letter** to aid in drafting your own personalized letter to CMS. Your letter will have more influence if you describe your individual circumstances and cite the impacts on patient quality of care and patient access in your area of the country.

To submit comments to CMS electronically, click here (note that you can submit your letter as an attachment).

Please send a copy of your comments to the AUA, attention Robin Hudson, Sr. Manager for Quality Initiatives & Health Policy via fax at 410-689-3862 or mail at 1000 Corporate Blvd.; Linthicum, MD; 21090. If you need more information or have any questions, contact Ms. Hudson at 410-689-3762 or rhudson@auanet.org.

The deadline for comments to CMS regarding these proposed rules is 5 p.m. eastern on Friday, August 31, 2007.

Thank you!

**Submitter :** Dr. Bryan HOff **Date:** 08/31/2007

**Organization :** Summit Urology

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

"see Attachment"

CMS-1385-P-13597-Attach-1.DOC

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

**August 27, 2007**

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

**Dear Mr. Kuhn:**

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

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

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

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

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

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

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

**Thanks you for your consideration.**

**Sincerely,**

**Bryan Hoff, M. D.**

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

**Submitter :** Mrs. Kristen Mason **Date:** 08/31/2007

**Organization :** Rehabilitation Centers of Charleston

**Category :** Physical Therapist

**Issue Areas/Comments**

**Therapy Standards and Requirements**

Therapy Standards and Requirements

To whom it May Concern:
My name is Kristen Mason, and I am a Physical Therapist in Moncks Corner, SC. I urge you to stop reductions in reimbursements for physical therapy services. In our practice, we are currently treating a large number of Medicare patients, who are greatly benefiting from our services. However, if reimbursement for physical therapy services in outpatient physical therapy practices is reduced, the number of physical therapists who can adequately provide quality of care for the patients is reduced. As the Baby Boomer generation ages, we understand the number of recipients of Medicare benefits increases. However, as this generation ages, the need for physical therapy services also increases. This generation is more active than any previous generation, and although this active and healthy lifestyle has many benefits, as people age, their bodies are often times not able to withstand the demands placed upon it. As physical therapists, we are well educated and well equipped to treat the movement dysfunctions patients may develop. But we are also health educators and promoters. It is our job to not only treat those who are currently experiencing a movement dysfunction, but to educate others how to prevent such problems and lead a healthier lifestyle.
A reduction in reimbursement places a great hardship upon us as physical therapists in the field that we so dearly love. As a new graduate, I have dreamed for the past 6+ years of one day doing the job I know I was meant to do. Reductions in reimbursement significantly challenge my job opportunities and job security.
I urge you to stop reductions in reimbursement for Medicare patients and consider the implications if you were to implement the changes. Bottom line, reductions in reimbursement means fewer physical therapists to treat more patients in a patient population that is only going to continue to grow. If it were you, or your mother or father, wouldn t you want them to receive the greatest quality of care?
Sincerely,
Kristen D. Mason, PT, MSRS

**Submitter :** Mr. michael flynn **Date:** 08/31/2007

**Organization :** West Bloomfield Township Fire Department

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**Ambulance Services**

Ambulance Services

Beneficiary Signature
The proposed rule for a "signed contemporaneous statement", made by an ambulance employee during the trip to the receiving facility.
Would have a negative impact on our fire department ambulance operation.
We believe it is impractical to pursue these signatures, first from our patients who are often unable to sign due to their current medical condition. And also very frequently our pts. are residents of nursing homes and our crews have no opportunity to be in contact with any family members.
Thank You for the opportunity to comment on this Proposed Rule ,and that it would negatively impact our operation.

**Submitter :** Dr. David Zucker **Date:** 08/31/2007

**Organization :** Anesthesiology Consultants of Toledo

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

David Zucker, M.D.

**Submitter :** Dr. Brian J. Logue **Date:** 08/31/2007

**Organization :** Summit Urology

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-1385-P-13601-Attach-1.DOC

13601

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

**August 27, 2007**

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

**Dear Mr. Kuhn:**

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

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

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

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

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*Treatment & Surgery*

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

**Thanks you for your consideration.**

**Sincerely,**

**Brian J. Logue, M. D.**

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

**Submitter :** Mrs. Debra Morris **Date:** 08/31/2007

**Organization :** Morris Law Office, LLC

**Category :** Individual

**Issue Areas/Comments**

**Therapy Standards and Requirements**

Therapy Standards and Requirements

Dear Sir or Madam,
I am an attorney, a certified Athletic Trainer since 1978; and a Georgia licensed Athletic Trainer since 1989. I am writing because I oppose your proposal for staffing provisions for rehabilitation in hospitals and their outpatient facilities in #1385. By considering your proposed rules, you are in effect, limiting access to patient care for your beneficiaries by denying clinical expertise for those who will most benefit from the skill and knowledge of an athletic trainer. Athletic trainers have been providing physical medicaine and rehabilitation services to active individuals, young and old, since BEFORE 1950. Their education, training and expertise focuses on the physically active population in our country. Physical therapists, physical therapist assistants and occupational therapists are not trained specifically to treat this segment of our population, which makes up a large portion of your beneficiary mix.
In essence, you are denying appropriate care to your beneficiaries while prohibiting a clinical expertise from practicing its craft and earning a living. You are eliminating jobs in the health care setting while reducing numbers of providers for your deserving beneficiaries...all contrary to the mission set by Congress for the Medicare/Medicaid programs.

Typically, matching a patient's diagnosis with the most qualified expertise results in more cost-effective care, i.e., fewer visits and thus, lower overall charges to beneficiaries and insurance carriers. By reducing the numbers of providers in the marketplace, your proposal will be limiting access and ultimately increasing charges for physical medicine and rehabilitation.

Several professionals, physicians AND clinicians, have been providing PHYSICAL MEDICINE AND REHABILITATION services for years; in both in- and outpatient settings. It appears you are targeting the elimination of athletic trainers while permitting all others to remain as providers. Surely this governmental agency does not have a bias. This hardly appears fair and most of all, effective, for your beneficiaries. Perhaps the healthcare setting has changed drastically over the years and CMS will find it beneficial to review this policy to the benefit of many settings and population groups.

I respectfully request that you either withdraw the proposed changes or add athletic trainers as providers in hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Debra L. Morris, JD,ATC,LAT

**Submitter :** **Dr. Paul Mazzoni** **Date: 08/31/2007**

**Organization :** **Cardiovascular Anesthesiologists, PC**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** Dr. NICOLAS ATHANASSIOU **Date:** 08/31/2007

**Organization :** ASA

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

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

When 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. Over the last several years, the advancement of quality of care of patients during Anesthesia and Surgery has been amazing. Through research in Physiology as well as with new technology the outcomes from anesthesia have been the best ever. Anesthesiology is extremely safe inspite of the patient population becoming sicker and older. Unfortunately the cost of anesthesia practices has gone up to accomplish these results. 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 sicker citizens, 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.

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Thank you for your eonsideration of this serious matter.

Nicolas Athanassiou, MD
Dept. of Cardiovascular Anesthesiology
The Methodist Hospital,
Houston, Texas

**Submitter :** Mr. John Miller **Date:** 08/31/2007

**Organization :** OrthoCarolina

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer with a BS in Health Education. I have been working in an outpatient clinical setting for the past 18 years. My past work experience has included the high school setting and working on an outreach basis to local school districts from hospital based clinics.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients. As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

John J. Miller ATC, LAT, CSCS

**Submitter :** Dr. Gregory Walker **Date:** 08/31/2007

**Organization :** Summit Urology

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment"

CMS-1385-P-13606-Attach-1.DOC

1606

SUMMIT UROLOGY
SPECIALISTS

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

**August 27, 2007**

**Herb Kuhn, Acting Deputy Administrator**
**Centers for Medicare & Medicaid Services**
**Department of Health & Human Services**
**Attn: CMS-1385-P**
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**I am writing to you regarding the proposed change in physician fee schedule rules that was published on July 12, 2007 regarding rules and how they will impact our practice.**

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

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

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

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SUMMIT UROLOGY
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*Treatment & Surgery*

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

**Thanks you for your consideration.**

**Sincerely,**

**Gregory Walker, M. D.**

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# Terry Rehabilitation & Testing

***Physical Rehabilitation and Functional Testing Services***

August 31, 2007

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

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

Dear Mr. Weems,

I am writing to comment on the July 12, 2008 proposed physician fee schedule rule addressing the in-office ancillary exception to the physician self-referral rule.

I am current a physical therapist in private practice, however, I was originally trained and served in the United States Army, where therapists were able to determine the correct application and utilization of physical therapy services based on years of experience, advanced rehabilitation training, the patient's daily status and the best published evidence regarding that patient's problems.

After leaving active duty, I went on to manage and treat patients in a practice that, while attached physically to an orthopedic surgery center, was owned and operated by physical therapists independently of the orthopedists in the office next door. While we cooperated on patient care daily, we were independent professionals, and as such were obligated to render independent professional opinions about the continuing care of our patients.

Those physicians did not want the burden, expense, or ethical conflicts inherently associated with owning and operating a physical therapy practice. They were correct in their decision, and were models of integrity and honesty. I eventually moved to Texas to open my own practice, and unfortunately, the atmosphere here is much different. In my estimation, approximately 80% of outpatient physical therapy visits in this suburb of 120,000 people are performed in clinics owned and operated by orthopedic surgeons, primary care physicians, podiatrists, chiropractors and pain management physicians. The following examples that I have encountered since are illustrative of referral-for-profit systems as they operate in Carrollton and other suburbs of Dallas, Texas.

<u>Self referral is rampant, and impacts those patients who are least able to defend themselves</u> – the elderly and those injured at work. Both patient populations are reluctant to exercise their right to go to

an independent professional therapist, because both groups are wary of what the negative opinion of their treating physician could mean to their overall care. My grandmother is a good example – she was recently too worried about what her physician might think, and therefore did not report to him that her treatment was not getting her better after three months. After my prodding she spoke to her physician, who then realized that she had a fractured hip (rather than the lumbar radiculopathy that they believed she had) and after three months had her hip replaced last week in Enid OK.

Furthermore, in both cases (as in Texas in general) patients are not able to seek their own therapists – their physicians can and do deny outside prescriptions for therapy. A good example is a podiatrist that moved into my building three doors down from me. Without realizing that I was the therapist down the row, one of his representatives contacted me about performing contract therapy services in his office.

They explained that they saw patients incident to the podiatry visits (even though there are three therapist-run clinics within 250 feet) booking 5 patients per therapist every hour, and billing all patients for individual treatment. They stated that due to the incident rule, treating five patients simultaneously was not "traditional group therapy" and therefore allowed them to bill all patients for individual therapeutic exercise.

From the referral of this one podiatrist, who occupies the office only three days a week, they saw about 45 physical therapy visits each week with only 9 hours of labor provided by an occupational therapist. I'm not aware of any occupational therapists trained to treat feet and ankles (and this one also treats the knee or any other part of the body designated by the podiatrist) but this is their practice model, and it seems to be very profitable for them. One of my current home health patients (I am forced to perform home health contracting to keep my patient census up) was one of his patients. She reports to me that she attended his clinic for three months for electrical stimulation to her foot and knee, and was then told that her Part B benefits had been exhausted. She was told to wait until October (she's happy because it's just around the corner) and she can re-start her electrical stimulation treatments on her foot and knee.

"Incident to" treatments also provide incentives for therapists to seek to co-locate and work on a contract basis in the physician's office. Such an arrangement allows the orthopedic surgeon to charge rates above market rate to a therapist who wants the guaranteed income of working directly in that physician's office. While physicians may argue that such utilization is more convenient for the patient, I cannot think of a case where incident-to treatments are provided where another therapist is not as convenient, or even more convenient to the patient. For example, the podiatrist in the last example has one PT office within 50 feet, one within 150 feet, and another just across the street. All with adequate parking and available appointments. In the example of the orthopedist's office with contract PT services provided, there is space for lease in the same building within feet of the orthopedist's office. I am not privy to their arrangement, but I'm surprised that this therapy company would pass up cheap rent down the hall (that complex has a high vacancy rate) from the surgeon and co-locate in his office.

"Incident to" treatments provide incentives for physicians to drop lower paying insurers. Two local physician-owned rehabilitation clinics (each about 2 miles away) explained to me that their patients are not allowed to go to other therapy clinics – however, they would be happy to send us any patients that were not insured, or those patients insured by Medicaid or Aetna.

I have three questions that pose their own answers regarding this practice:

1. If the purpose of "incident to" treatment is to allow better coordination and quality of care, then why are certain insurers excluded?
2. If the purpose of "incident to" treatment is to allow patients more convenient access to care, then why are the hours of physician clinics restricted and their locations more difficult to get to – operating in large medical office buildings only during regular business hours – than therapist operated physical therapy clinics?
3. If the purpose of "incident to" treatment is to allow higher quality of care and better utilization, then why are patients in these practices seen in a group setting, billed for individual treatment, and then not notified that they can pursue treatment at the local hospital (across the street from the podiatrist's clinic) when their Part B benefits have been exhausted?

The "incident to" exception is meant specifically to allow physicians who have total control over the referral process to enrich themselves at the expense of their patients and the government.

Thank you for taking the time to read my comments.

Sincerely,

Guy Terry PT, OCS
Clinical Specialist in Orthopedic Physical Therapy
Owner, Terry Rehabilitation & Testing, Inc.
Carrollton, Texas

**Submitter :** Dr. Richard Whitten **Date:** 08/31/2007

**Organization :** Noridian Administrative Services

**Category :** Physician

**Issue Areas/Comments**

**Recalls and Replacement Devices**

Recalls and Replacement Devices

Colleagues:

As you point out in the NPRM, recalls raise issues both with regard to the additional costs of replacement devices and with regard to the additional physicians services and diagnostic tests that beneficiaries who have these devices often need. The proposed rule would reduce payments for hospital inpatients when hospitals use a recalled or replacement device at no cost or with partial credit but it does little to offset the additional costs both to beneficiaries and to the Program that result from physician services. As you point out, not only (are) extra visits to physicians offices or hospital outpatient departments& necessary, but additional diagnostic tests &also (are) needed to care for the beneficiaries who have the recalled devices. You have requested & public comments on this issue to inform our future review and analyses.

Under our current processes, the absorption of such expenses by the Medicare program and beneficiaries (who bear co-pays and deductibles) is a huge windfall to the manufacturers who otherwise would reasonably be expected to bear such costs resulting from faulty or potentially defective equipment. This is an inappropriate burden that should be changed. It is true that in the interests of assuring rapid, needed services to beneficiaries, Medicare may want to initially allow compensation for such services, but as in other situations where there is third-party liability, this should be done in a way to identify the potential long-term subrogation and recovery of such claims from responsible corporate entities who otherwise are able to avoid this responsibility. It is illogical to pursue other Medicare-secondary payers while allowing corporate entities with a fault to benefit at the expense of Medicare beneficiaries.

Thank you for this opportunity to comment.

Richard W. Whitten, MD, MBA, FACP
Contractor Medical Director, Medicare B for AK, HI & WA

**Submitter :** **Dr. Martin Porter** **Date: 08/31/2007**

**Organization :** **Western Arkansas Anesthesiology Associates**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Dear Ms. Norwalk,

I fully support the proposal to increase the conversion factor for anesthesia services under the 2008 Physician Fee Schedule. This increase should assist greatly in our ability to recruit and retain anesthesia providers in western Arkansas.

During the past decade, it has become increasingly difficult to retain anesthesia providers in our community. In the past year alone, we have lost 4 of our 11 anesthesiologists, resulting in a 36% decrease in physician anesthesia providers in our hospital. The departure of our providers was in part the result of the substantial losses our group experiences due to a large Medicare population. Medicare payment for anesthesia service in Arkansas currently stands at just $14.95 per unit, which falls far short of covering the costs of even our nurse anesthetists. Our group would be nonviable without a substantial subsidy from our hospital.

I applaud CMS for accepting the RUC recommendation to increase the anesthesia conversion factor in the proposed rule. It is imperative that the long-standing undervaluation of anesthesia services be corrected as proposed, as it is becoming increasingly difficult for the anesthesia providers who remain to adequately provide for our patients.

Thank you for your consideration of this matter.

Martin Porter, M.D.
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