Submitter : Dr. GREGORY SKARULIS **Date:** 08/31/2007

Organization : MANATEE PATHOLOGY ASSOCIATES

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a board-certified pathologist and member of the College of American Pathologists. I practice in Bradenton,Florida and am the Medical Director for two hospitals Manatee Memorial Hospital and Lakewood Ranch Medical Ceneter. Our group consists of three pathologists with two more soon to be added. The current self-referral abuses in the billing and payment of pathology services is directly adversley affecting our ability to continue to practice and find qualified pathologists. I am aware of arrangements in my practice area that give physician groups a share of the revenues from pathology services ordered and performed for the group's patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self referrals and I support the revisions to close the loopholes that allow physicians to profit from patholgy services that pathologists have spent so much investment in time and education to achive and perfect.

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

In addition to providing hospital based pathology services our group provides independent pathology services to several outpatient facilities and physician's ofices. Earlier this year, we were approached by a small group of gastroenterologists for whom we provided significant anatomic pathology services. The gastroenterologists informed us that they had begun negotiations with a company called EndoSoft to institute, among other things, electronic medical records (EMR) for their office and soon-to-be-opened outpatient surgery/endoscopy center. On EndoSoft's recommendation, the gastroenterologists then offered us the opportunity to pay 85% of the installation costs and yearly maintenance fees for their EMR hardware and software, in return for our keeping their anatomic pathology business. Considering the financial impact ($50,000.00 initially, followed by $4,000.00 yearly) and the legal ramifications (our lawyer interpreted this practice as a "kick-back"), we chose to not participate in these proceedings. Since then, we receive no specimens from these physicians from their outpatient surgery/endoscopy center. The estimated loss to our practice is $70,000.00 annually. Last week, a separate gastroenterologist called me personally to warn me that word of this has spread and that we should be prepared for other gastroenterology groups, including his, to follow suit. All of this is due to their own lowering rate of reimbursement for procedures performed by them.

In closing how is a practicing Pathologist supposed to encourage young physicians to spend years of training and sacrifice to enter a specialty which is continually being eroded by governmental laws which allow other specialties to pick and choose how they can infringe on Pathologist's practices without proper training, experience,or responsibility. The future looks bleak for the practicing private pathologist if the government continues to refuse to acknowledge the high degree of training and responsibility which pathologists provide behind the scenes of medicine.

Sincerely,

Gregory J. Skarulis MD
Medical Director,Manatee Pathology Associates
Bradenton,Florida

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

Organization : Carthage College

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer for over ten years, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education (BA in Athletic Training and Master of Education), clinical experience, and national certification exam ensure that my patients receive quality health 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,
Laurie Jensen, M.Ed., LAT, ATC
Head Athletic Trainer
Carthage College

Submitter : Mr. Randy Wagner **Date:** 08/31/2007

Organization : Countrywide

Category : Other Health Care Professional

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

August 31, 2007

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nations 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 undervaluationa move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUCs recommendation.

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

Thank you for your consideration of this serious matter.

Sincerely,

Randy Wagner

Randy Wagner
Randy_Wagner@countrywide.com
Sales Manager
Circle of Excellence

Countrywide Home Loans
21600 Oxnard Street, Ste. 1900
Woodland Hills, CA 91367
(818) 343-3599 ext.236
(866) 849-8655 - Fax

Assistant: Vadim (Va-deem) Pogrebitsky
Vadim_Pogrebitsky@countrywide.com
(818) 343-3599 ext.251

"Don't worry about the world coming to an end today.
It's already tomorrow in Australia" -Charles Schulz

Submitter : Mrs. Ann Rymer **Date:** 08/31/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

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

Organization : Catawba College

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My Name is Travis Armstrong and I work as an assistant athletic trainer at Catawba College in Salisbury, North Carolina. I am currently working with the women s volleyball team and then baseball during the spring season. I received my B.S. in athletic training from Grand Canyon University in Phoenix, Arizona and my M.S. in Sports Health Care from A.T. Still University, The Arizona School of Health Sciences in Mesa, Arizona. I have been licensed to practice in the states of Arizona and North Carolina.

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

Submitter : Dr. Lloyd Angel **Date:** 08/31/2007

Organization : NYSCA

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

In the new Medicare proposal, chiropractors will no longer be allowed to ORDER x-rays. Logic being that x-rays are no longer needed to demonstrate subluxation. However chiropractors are required to rule out contraindications to spinal manipulation. certainly this requires at least ordering (if not actually taking) x-rays. It will be more costly to force chiropractors to refer to PCP's to then order the x-ray, or may result in more injury to the patient.

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

As a independent physical therapist I vehemently oppose referral for profit situations. The "incident to" loophole in the Stark laws allows physicians to own PT services and profit from referral. Your own data shows that the predominance of fraudulent billing practices in regards to PT are generated by these Physicain owned Practices (POPTS) I would not be so opposed to the POPTS if the playing field were level ie; PT's had direct access. Then a patient could choose to see a Physical Therapist without a physician referral. MD's cannot be the tollkeeper and own the bridge. In this day and age where there is tremendous competition for the health care dollar it is only natural that to capture more revenue MD's would elect to open PT clinics and refer to them. That is exactly what the Stark laws was suppossed to prohibit. Please close the "incident to" loophole that essentially renders the law useless.

Submitter : Dr. Gary Mester **Date:** 08/31/2007

Organization : Dr. Gary Mester

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

If you are truly interested in cost containment? Then start reembursing chiropractic physicians for x-rays taken of Medicare patient. This would drasticly reduce any duplication of services, delay of services to patient.

Submitter : Mr. Paul Uhrig **Date:** 08/31/2007

Organization : SureScripts, LLC

Category : Private Industry

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

See attached Letter for Comments

CMS-1385-P-13664-Attach-1.PDF

#13664

August 30, 2007

VIA OVERNIGHT MAIL & ELECTRONIC FILING

Mr. Kerry Weems
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: CMS-1385-P

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

Dear Mr. Weems:

Thank you for the opportunity to comment on the proposed rule (the "Proposed Rule") relating to Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies; Revisions to Payment Policies for Ambulance Services for CY 2008. Our comments, however, will be limited to the portions of the Proposed Rule related to the *Proposed Elimination of Exemption for Computer-Generated Facsimiles.*

BACKGROUND

By way of introduction, SureScripts, LLC was founded in August of 2001 by the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association (NCPA), which together represent the interests of the 55,000 chain and independent pharmacies throughout the United States. SureScripts is committed to building relationships within the healthcare community and working collaboratively with key industry stakeholders and organizations to improve the safety, efficiency, and quality of healthcare by improving the overall prescribing process. At the core of this improvement effort is the Pharmacy Health Information Exchange™, a healthcare infrastructure that establishes electronic communications between pharmacists,

prescribers, and payers, and which enables the two-way electronic exchange of prescription and prescription related information.

SureScripts does not develop, sell, or endorse specific electronic prescribing software. Instead, SureScripts works with software companies that supply electronic health record (EHR) and electronic prescribing applications to physician practices and pharmacy technology vendors to connect their solutions to the Pharmacy Health Information Exchange, operated by SureScripts. Technology vendors cannot connect to the Pharmacy Health Information Exchange until they complete a comprehensive certification process. As part of its certification process, SureScripts establishes ground rules that safeguard the fairness of the prescribing process, including rules that, among other things, ensure patient choice of pharmacy and physician choice of therapy.

On a technical level, the certification process specifies the standard technical format for transmitting prescription information and tests each vendor's electronic connections to the network. The standards are based on the NCPDP SCRIPT Standards as mandated by the Medicare Modernization Act of 2003.

The certification rules also ensure that prescribing decisions are based on best medical practices, not on financial considerations or the interests of one particular entity. For instance, by prohibiting commercial messaging to physicians at the point of prescribing, SureScripts is helping to safeguard the fairness of the prescribing process and to prevent improper messaging activities.

Today, more than 95 percent of all pharmacies in the United States are certified on the Pharmacy Health Information Exchange. In addition, today most major, and many small to medium size, EHR and e-prescribing vendors in the United States are certified on the Pharmacy Health Information Exchange. This means that approximately 150,000 prescribers are using a software or application that has been certified on the Pharmacy Health Information Exchange for the exchange of prescriptions and prescription related information pursuant to the NCPDP SCRIPT Standards. As explained in greater detail below, however, not all of these prescribers are using their software or application to send prescriptions electronically using the NCPDP SCRIPT Standard (as defined in the MMA Final Rule) – many continue to use the software application to send computer generated faxes.

You can find more information about SureScripts at www.surescripts.com.

SureScripts Comment to "PROPOSED ELIMINATION OF EXEMPTION FOR COMPUTER-GENERATED FACSIMILES"

We support the desire of CMS to eliminate the exemption currently contained in Section 423.160(a)(3)(i) of the Final Rule (70 FR 67571) promulgated under the Medicare Modernization Act - Medicare Program; E-Prescribing and the Prescription Drug Program – that exemption provides that entities transmitting prescriptions or prescription related information by means of computer generated facsimile are exempt from the requirement to use the NCPDP SCRIPT Standard in transmitting such prescriptions or prescription-related information.

For all the reasons postulated by CMS at the time, we supported the exemption for computer-generated faxes when the MMA Final Rule was first promulgated in 2005. It has been our experience, however, that many in the industry point to Section 423.160(a)(3)(i) as support for them continuing to fax prescription information, and as a result they do not take steps to implement true electronic prescribing pursuant to the NCPDP SCRIPT Standards adopted by CMS. This loophole in the Final Rule has resulted in, and continues to result in, an adverse impact and slowdown in the adoption of electronic prescribing pursuant to CMS standards. We agree with CMS that the time has now come to address this loophole in the Final Rule that has slowed the adoption of e-prescribing; however, rather than eliminate the exemption in its entirety, we believe that the exemption should be narrowed in a manner that will produce significant and demonstrable results, but without unduly disrupting workflows related to the prescribing process and without becoming an undue economic burden for the industry.

In the Proposed Rule, CMS distinguishes between computer generated faxes, on the one hand, where the prescriber's/dispenser's software has the ability to generate NCPDP SCRIPT transactions, but the feature is not activated because the prescriber has not activated the feature on the software, as compared to, on the other hand, where the prescriber's/dispenser's software (such as word processing program) is used to create and send a fax that results in a paper prescription or response at the receiving end, but does not have true e-prescribing (electronic data interchange using the NCPDP SCRIPT standard) capabilities. *See Proposed Rule at pages 397-398.*

We believe that the exemption should be narrowed to eliminate the exemption for those prescribers/dispensers that fall with in the first category; namely those prescribers/dispensers who have software or an application that has the ability to generate NCPDP SCRIPT transactions, but the feature is not installed/activated because the prescriber/dispenser has not activated the feature on the software application or the prescriber/dispenser has not upgraded to the version of the software application that has true e-prescribing capabilities. We believe there are over 100,000 prescribers and 15,000 pharmacies who fall within this category. Those prescribers/dispensers can convert to

true electronic prescribing without significantly changing their workflow and without significant expense. With respect to workflow, their application works with minor modifications, whether the prescription related information is sent via computer generated fax or NCPDP SCRIPT e-prescribing – the prescriber/dispenser hits the send button, and the new prescription order is sent. How the application sends the prescription message happens in the "background" of the application, out of sight and out of view of the prescriber/dispenser. In fact many of those prescribers/dispensers do not even know or realize that the prescription message is being sent by computer generated fax when they hit the send button. If they were to activate the true e-prescribing feature or upgrade to the version of their software application that has true e-prescribing capabilities, their workflow would remain substantially the same. With respect to cost, we understand that the required upgrade is usually included in the costs associated with annual software maintenance that the prescriber/dispenser is already paying, so there should not be any, or if there is, only minimal, incremental cost to the prescriber/dispenser to turn on the e-prescribing feature or upgrade to the version of their software that has true e-prescribing capabilities. We believe that if the exemption for computer generated faxes were eliminated just for these prescribers/dispensers, the number of NCPDP SCRIPT transactions would increase significantly in a short period of time, thus creating the "tipping point" that CMS is seeking for the adoption and utilization of electronic prescribing.

We believe, however, that to eliminate the computer generated fax exemption for those prescribers/dispensers who fall within the second category; namely those prescribers/dispensers who use software (such as word processing program) to create and send a fax that results in a paper prescription or response at the receiving end, but does not have true e-prescribing (electronic data interchange using the NCPDP SCRIPT standard) capabilities, would create an undue burden on those prescriber/dispensers, and we are concerned that they would revert to issuing paper prescriptions – thus, eliminating the exemption for those prescribers/dispenser might have the unintended and paradoxical effect of discouraging true electronic prescribing. Accordingly, we recommend that the computer generated fax exemption continue to apply for those prescribers/dispensers until such time as CMS creates initiatives to further the adoption of electronic prescribing.

We also believe that, for those prescribers/dispensers who fall within the first category today or on the date that the Proposed Rule is promulgated in final form (the "Final Rule Date"), the suggested deadline (see below for discuss of the implementation date) provides ample time for those prescribers/dispensers to activate, or upgrade to, the version of their software application that has the ability to generate NCPDP SCRIPT transactions. There will be prescribers/dispensers, however, who fall within the second category on the Final Rule Date, but who would find themselves in the first category **after** the Final Rule Date because their software application becomes certified to generate

NCPDP SCRIPT transactions after the Final Rule Date. Those prescribers/dispensers should not be allowed to continue to rely on the computer generated fax exemption, but they would need sufficient time to install, activate, or upgrade to the version of their software application that has the ability to generate NCPDP SCRIPT transactions. We believe that twelve (12) months after their software application becomes certified to generate NCPDP SCRIPT transactions would be sufficient time to stop generating computer generated faxes and convert to true e-prescribing.

In addition, we believe that there are other specific circumstances in which computer generated faxes should still be permitted, as follows:

First, the regulations promulgated and enforced by the Drug Enforcement Agency prohibit the electronic transmission of prescriptions for controlled substances. This prohibition, in and of itself, is a tremendous barrier to the adoption of electronic prescribing by prescribers, and we certainly encourage the DEA to amend its regulations to permit prescribers to send prescriptions for controlled substances by electronic means. We believe that where a law or regulation prevents the transmission of an electronic prescription using the NCPDP SCRIPT Standard, prescribers/dispensers need the ability to use the most efficient alternative to deliver the message, including by computer generated fax. Accordingly, the exemption should apply in any circumstance in which a law or regulation would prohibit the delivery of prescription-related information using the NCPDP SCRIPT standard.

Second, there are times when there are communications failures impacting electronic prescribing, due to power outages, other temporary system failures, down time due to maintenance operations, or otherwise. These temporary outages could occur with respect to the prescriber EHR or e-prescribing system, the pharmacy management system, or networks and exchanges. We believe that these circumstances are relatively rare, and hopefully will become even more rare as the industry and technology develops; however prescribers and dispensers need the ability to deliver prescription information in the most secure and efficient means possible when these temporary outages occur, and computer generated faxing may be the best alternative during temporary communications failures. Accordingly, we suggest that the computer generated fax exemption be available for prescribers/dispensers during such temporary communication failures.

Finally, we believe in the core principle that patients should have free choice to use the prescriber and the pharmacy of their preference. Accordingly, if a patient chooses to use a prescriber that has the capability to electronically prescribe using the NCPDP SCRIPT Standard but chooses a pharmacy that does not have such capability, or vice versa, that prescriber/dispenser should have the right and ability to send the prescription message by the means that is most efficient and best for the circumstances, including by a computer generated fax. Accordingly, the NCPDP SCRIPT enabled sending entity should be able

to send a computer generated fax if the receiving entity is not capable of receiving an NCPDP SCRIPT message, and the sender believes that a computer generated fax is the best and most efficient way to send the prescription message. Of course, if both the sender and the receiver are both capable of communicating with the NCPDP SCRIPT standard, then they should do so (unless another exemption applies).

We have taken the liberty to draft language that we believe captures the intent of the changes suggested above, and we encourage CMS to revise the fax exemption so as not to eliminate the exemption in its entirety, but rather to eliminate the exemption for those prescribers/dispensers who today have, or who in the future purchase or license, software that is capable of sending prescriptions messages through true electronic means in compliance with the NCPDP Script standards. Our proposed language is as follows:

Effective as of April 1, 2009, notwithstanding the requirement herein for prescribers and dispensers who electronically transmit prescription and prescription related information for covered drugs prescribed for Medicare Part D eligible beneficiaries to comply with the Foundation Standards for the communication of prescription or certain prescription related information by and between prescribers and dispensers for the transactions listed at Section 423.160(b)(1)(i) through (xii), the transmission of such prescription or prescription related information by means of computer generated facsimiles shall be permitted in the following circumstances:

1. *In the event that the prescriber/dispenser sending a transaction listed at Section 423.160(b)(1)(i) through (xii) does not own, license, or otherwise use software that has or had the capability, as of the date of the promulgation of this rule [i.e., insert date rule promulgated], to send and receive transactions compliant with the Foundation Standards, whether on the version that the prescriber/dispenser is currently using or another version of such software.*

    a. *This exemption shall not apply to prescribers/dispensers sending a transaction listed at Section 423.160(b)(1)(i) through (xii) who own, license, or otherwise use software that has or had the capability, as of the date of the promulgation of this rule [i.e., insert date rule promulgated], to send and receive transactions compliant with the Foundation Standards, but who has not upgraded to the version that is compliant with the Foundation Standards and/or has not activated that functionality.*

    b. *In addition, in the event that the prescriber/dispenser sending a transaction listed at Section 423.160(b)(1)(i) through (xii) owns, licenses, or otherwise uses software that does not have or did not*

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

Organization :

Category : **Individual**

Issue Areas/Comments

IDTF Issues

IDTF Issues

RE: Proposed Revisions of Existing IDTF Performance Standards
d. 410.33(b)(1)

Your proposal and example are only specific to a physician providing GENERAL supervision. This may have the unintended consequence of excluding physicians, that only provide Direct or Personal supervision, from the three site limitation. Please clarify if the three site limitation only applies to the performance of general supervision services, or if it applies to all physicians providing any level of supervision (general, direct, personal).

Submitter : **Dr. Beth Wright** **Date: 08/31/2007**

Organization : **Laboratory Physician Association**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

I appreciate the opportunity to submit comments on the Physicians Referral provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, for Year 2008 . I am a board certified pathologist practicing in Dallas, TX. I am part of a group of eight pathologists practicing mostly in a hospital-based setting with a small independent outpatient laboratory. I am a member of the College of American Pathologists and Texas Society of Pathologists.

I enthusiastically support the initiative of CMS to end self-referral abuses for pathology services. These irregular billing arrangements are an attempt to bypass the Stark law which prohibits physician self-referrals. Clinicians have exploited a loophole that allows them to profit from pathology services which they did not perform. I am acutely aware of several abusive arrangements in my practice area here in Dallas-Fort Worth and around the state, especially in San Antonio, TX where many of these dubious billing practices originated. They are nothing more than a fee-splitting arrangement on self-referrals of a captive patient population.

I strongly support the expansion of the anti-markup rule to purchase pathology interpretations and the exclusion of anatomic pathology from in-office ancillary services exception to the Stark law. These revisions to the medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial-interest considerations in critical decisions and are in the best interests of the patient. I believe that physicians should not be able to profit from professional pathology services unless they have personally preformed or supervised the service.

Opponents of the proposed changes argue that these dubious arrangements actually enhance patient care. I agree that the Medicare Program should ensure the highest quality of care for their patients. Restrictions on physician self-referrals are necessary to safeguard and ensure that clinical decisions are determined solely on the basis of quality and not tainted by financial incentives. The proposed changes, contrary to what opponents may argue, do not impact the availability or delivery of pathology services. They simply remove the financial conflict of interest that compromises the integrity of the medicare program. Thank you again for addressing this issue.

Sincerely,

Beth Wright, MD

Submitter : **Dr. Ron Robertson D.C.** **Date: 08/31/2007**

Organization : **Georgia Chiropractic Assn.**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

PO Box 8018

Baltimorc, Maryland 21244-8018

Rc: "TECHNICAL CORRECTIONS"

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

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

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

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

Submitter : Dr. Nita Grover **Date:** 08/31/2007

Organization : Dr. Nita Grover

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare 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 anesthesiologist are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommends that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation - a move that would result in an increase of nearly $4 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow thorough with the proposal in the Federal Register 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. Robert Charles-Liscombe** **Date: 08/31/2007**

Organization : **Greensboro College**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am writing as a concerned tax payer, health care professional, and educator of future health care professionals. I am a certified athletic trainer licensed by the State of North Carolina and professor of athletic training at Greensboro College in Greensboro, NC. I have been a practicing athletic trainer for 12 years and have a doctorate in exercise and sports science.

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

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

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

My state practiee act allows me to treat individuals that are injured during the course of physical activity, i.e. "athletes". As the population of the United States ages, increasing numbers of Medicare reeipients will suffer musculoskeletal injuries as a result of recreational and leisure time physical activity. The government and almost all health care organizations are promoting physical activity and exercise to prevent chronic disease in particular obesity and cardiovascular disease. It is inevitable that some of these individuals will require physical medicine and rehabilitation to address injuries sustained while active. I believe that it is NOT in the government's or the taxpayer's best interests to LIMIT the provision of rehabilitation to the limited number of health care providers specified and prevent other HIGHLY QUALIFIED health care professionals from providing their skills to this population of patients that is increasing in number.

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. Certified athletic trainers are highly qualified and prepared to perform rehabilitation to Medicare recipients. I hope that you will investigate the athletic training profession further and consider adding athletic trainers to the list of qualified therapy and rehabilitation providers.

Sincerely,

Robert Charles-Liscombe, EdD, ATC, LAT
Clinical Coordinator/Assoc. Profcssor
Athletic Training Education Program
Greensboro College
Greensboro, NC

Submitter : **Dr. Charles Boucek** **Date: 08/31/2007**

Organization : **Dr. Charles Boucek**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mr. Matthew Eddy **Date:** 08/31/2007

Organization : Vermont Academy

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Matthew Eddy and I work in a small private secondary school in rural Southern Vermont. I am head of sports medicine at the school, working as a certefied athletic trainer and I am also licensed in the state of Vermont to practice athletic training.

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

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

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

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

Sincerely,

Matthew Eddy, ATC

Submitter : Mr. Robert S. **Date:** 08/31/2007

Organization : Mr. Robert S.

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

482.56-
By specifing only 2 specialties of physical medicine (Physical Therapist; including Physical Therapy Assistants and Occupational Therapist;including Occupational Therapy Assistans, CMS is limiting access to quality care available to individuals. In addition to limiting choice and quality to the patients, this regulation also affects employers. In an effort to provide quality care that is effective, many employers employ Certified Athletic Trainers (ATC). It seems that this profession was omitted, maliciously or by the lack of or unwillingness to understand what is a Certified Athletic Trainer. An oversite to evaluate their (ATC) education, certification and skills has a crippling effect on the educational systems training these professionals, the health care systems and clinics who employ these individuals, the patients who benefit from the services of Certified Athletic Trainers and the Certified Athletic Traiers themselves. As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. Either the unwillingness or ingnorance of individuals to understand and learn about the Athlletic Training Profession is something that can not be over-looked. I respectfully request that you amend the proposed changes to include Certified Athletic Trainers or withdraw the proposed changes until a complete evaluation of Certified Athletic Trainers and other allied health care professionals have been evaluated by the board and included in this revision. To pass this revision without the inclusion of Certified Athletic Trainers is a blatant disservice to patients, hospitals, clinics, educators and the profession of athletic training.

Submitter : Dr. Lawrence Yee **Date:** 08/31/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Submitter : Mr. Timothy Glover **Date:** 08/31/2007

Organization : Ferris State University

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Tim Glover and I am a certified athletic trainer at Ferris State University. At FSU I work directly with the men's ice hockey team, women's soccer team, and the softball.

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

Submitter : **Mr. Brendon McDermott** **Date: 08/31/2007**

Organization : **University of Connecticut**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Brendon McDermott, and I am a certified athletic trainer. I currently work at the University of Connecticut as an instructor and athletic trainer. I have extensive training in medicine and I have attended Northeastern University for my undergraduate degree and then Indiana University for my masters degree. I currently am working towards a PhD in Exercise Physiology at the University of Connecticut.

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

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

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health 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 training received prior to being eligible for the certification examination are, in fact, more extensive than is required for physical therapists.

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.

It would be a shame to disallow athletic trainers, perhaps the most versatile, and cost-effective health care professionals, from treating patients in these settings. Please help to make sure this doesn't happen!

Sincerely,

Brendon P. McDermott, MS, ATC

Submitter : **Miss. Donna Wesley** **Date: 08/31/2007**

Organization : **North Mississippi Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Donna Wesley and I am a Certified Athletic Trainer. I have been nationally certified for 14 years and licensed in Mississippi for over ten years. Working within the high schools in northeast Mississippi, I see daily the underserved populations that are rampant throughout our great state. As president of the Mississippi Athletic Trainers' Association, I can tell you countless stories from our members on how Certified Athletic Trainers are critical allied healthcare providers that make a difference in the lives of the patients that we serve.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physieal medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experiences, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to eircumvent 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 hospital, rural clinies, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Donna Wesley, ATC, LAT, MS
Mississippi Athletic Trainers' Association
NMMC Sports Medicine Program

Submitter : **Miss. Jennifer Rieger** **Date: 08/31/2007**

Organization : **University of Oregon**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

CMS-1385-P-13677-Attach-1.DOC

1367

UNIVERSITY OF OREGON
College of Arts and Sciences

Dear Sir or Madam:

My name is Jennifer Rieger MS, ATC and I worked at the University of Oregon in the Department of Human Physiology. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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Sincerely,

Jennifer Rieger MS, ATC.
Graduate Assistant Athletic Trainer
JRieger81@aol.com

DEPARTMENT OF HUMAN PHYSIOLOGY

1240 University of Oregon. Eugene OR 97403-1240

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

Submitter : **Mrs. Julie Knutson** **Date: 08/31/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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

Sincerely,

Julie Knutson CRNA
Name & Credential
315 Lagoon Drive
Address
Palm Harbor FL 34683
City, State ZIP

Submitter : **Ms. Shannon Tomasula** **Date: 08/31/2007**

Organization : **Manalapan High School - Freehold Regional HS Distr**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certified athletic trainer at a Group IV high school in Central New Jersey, where I have been employed for 8 years. I have a Bachelor of Science degree in Exercise Science from Rutgers University and a Master of Science degree in Athletic Training from California University of Pennsylvania. Through a very lengthy 1,500 hours of internship I qualified to take the National Athletic Trainers' Association Board of Certification exam. I possess a state license in New Jersey to practice athletic training and am considered an Allied Health Care Professional in accordance with the American Medical Association standards.

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

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

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

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Sincerely,

Shannon Tomasula,MS, ATC
Certified Athletic Trainer
Manalapan High School
Manalapan, New Jersey

Submitter : Dr. William McRoberts **Date:** 08/31/2007

Organization : Holy Cross Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 (the Proposed Rule) published in the Federal Register on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.
I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services.

I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.

This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. This disconnect between the Medicare specialty and their practice expenses is made worse by the fact that anesthesiologists have the lowest practice expense of any specialty. The high utilization rates of anesthesiologists (and their extremely low practice expenses) drive the payment rate for the interventional pain procedures, which does not accurately reflect the resource utilization associated with these services. This results in payment rates that are contrary to the intent of the Medicare system physician payment reflects resources used in furnishing items and services to Medicare beneficiaries.

I urge CMS to make a modification to its practice expense methodology as it pertains to interventional pain services such that its methodology treats physicians who list anesthesiology as their primary specialty and list interventional pain as their secondary specialty designation as interventional pain physicians for rate-setting.

II. CMS Should Develop a National Policy on Compounded Medications Used in Spinal Drug Delivery Systems

We urge CMS to take immediate steps to develop a national policy as we fear that many physicians who are facing financial hardship will stop accepting new Medicare beneficiaries who need complex, compounded medications to alleviate their acute and chronic pain. Interventional pain physicians frequently use compounded medications to manage acute and chronic pain when a prescription for a customized compounded medication is required for a particular patient or when the prescription requires a medication in a form that is not commercially available.
A significant cost to the physician is the compounding fees, not the cost of drug ingredient.

We urge CMS to adopt a national compounded drug policy for drugs used in spinal delivery systems by interventional pain physicians.

III. CMS Should Incorporate the Updated Practice Expenses Data from Physician Practice Survey in Future Rule-Making

I commend CMS for working with the AMA, specialty societies, and other health eare professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.
IV CMS Should Work Collaboratively with Congress to Fix the SGR Formula so that Patient Access will be preserved.
The sustainable growth rate (SGR) formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions.
William Porter McRoberts, M.D.
Chief,Pain Sve, Holy Cross Hospital

CMS-1385-P-13680-Attach-1.DOC

CMS-1385-P-13680-Attach-2.DOC

Submitter : Mr. Matthew Eddy **Date:** 08/31/2007

Organization : Vermont Academy

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Matthew Eddy and I work in a small private secondary school in rural Southern Vermont. I am head of sports medicine at the school, working as a certefied athletic trainer and I am also licensed in the state of Vermont to practice athletic training.

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Submitter : Dr. Josh Griffin **Date:** 08/31/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. Laura Sirrine **Date:** 08/31/2007

Organization : CJW Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-13683-Attach-1.DOC

13683

CJW Sports Medicine

CJW Medical Center

HCA Virginia

Dear Sir or Madam:

My name is Laura Sirrine and I am a certified athletic trainer practicing in the Commonwealth of Virginia. I earned my Bachelor's degree in Psychology and my Master of Education in Athletic Training. I am nationally certified to practice athletic training by the Board of Certification for the Athletic Trainer. In addition, I am licensed to practice as an athletic trainer in the Commonwealth of Virginia. I currently work in a clinic/outreach setting for CJW Sports Medicine. Unfortunately, due to law changes, while in the clinic I am unable to perform any duties that I am certified to do. I have been reassigned to administrative duties that include the education of area coaches and parents. While doing outreach, I work with the athletes at a local high school. I am responsible for the healthcare and wellbeing of those athletes.

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

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

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

Sincerely,

Laura A. Sirrine, MEd, ATC

Submitter : Mr. Brett Tice **Date:** 08/31/2007

Organization : Mr. Brett Tice

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Not only were they asking they asking us to do unneeded or extravagant treatments but they were also asking us to do more treatments. We were completely full. 3,000 square feet with four treatment rooms and we had every bed and piece of equipment in use all the time. But they continued sending patients. When we complained that we were too busy and wanted to refer some patients out to other clinics they were very upset but they finally let us refer a few out. .

I found out one thing that completely amazed me. From the beginning I sat in on the Directors Meetings. I heard them ask for the codes listed from highest reimbursement to the lowest, I heard the sales people come in and tell them how much a custom knee brace could be billed for. I saw the projections about how much money they could make in therapy. It was incredible. They were profiting 30,000 per month from two therapists. I had been struggling in my own clinic and made $86,000 per year as the owner/therapist and these same Doctors had been sending me all their patients!!!

The original Stark Law, smartly, did not allow self referral to happen. Somewhere along the line the loop hole was inserted into the law. I have seen that when a doctor has an opportunity to generate revenue they go for it and the results are over utilization, over billing, and a lower standard of care.

Brett Tice PT
Licensed Physical Therapist

2426 Hunter Drive
Harlingen Texas 78550

Phone:428-8951
Fax: 956-428-0232
Cell: 956-202-3824

CMS-1385-P-13684-Attach-1.DOC

1368-1

RE: Physician Self-Referral Issues.

CMS,

I am a physical therapist in South Texas. I have worked in and around POPT's for much of my career and I have first hand knowledge of the problems created for patients and CMS when a Doctor is in charge of an ancillary service. I opened a physical therapy clinic in 2001 and struggled for two years until I found out that four of my major referral sources were going to merge in the same shopping center where my clinic was located. I knew they planned on opening an "in office" therapy clinic and I knew I was going to have to close down if they did. Luckily (I guess) for me they approached me about buying my clinic. I sold my clinic to them and went to work for them. I worked for them for two years and was eventually promoted to practice manager over the whole medical practice including their multiple ancillary services. I also sat on the Board of Directors and heard the conversations and debate about the ancillary services. There is no question or doubt in my mind that the loop-hole created in the stark law has caused over utilization, over billing, and a lower standard of care.

The first day that I started working for these physicians I was introduced to a machine that I had never heard of. It was a Matrix machine. If you are not familiar with it, it is an electrical stimulation machine that has suction cups. The salesman told the Doctors that if they gave every patient that treatment for 30 minutes they could bill; 2 estim units, 2 myofascial release units, 2 neuromuscular reeducation units. I did not know this at first. I was told to give this to every patient prior to treatment. The other therapist and I were dumbfounded and did some quick research and found out that several Doctors had been prosecuted for the use of this machine and we promptly refused to carry out the instructions from the Doctors. The doctors were upset but decided to use their own staff to do this for two weeks prior to referring them to therapy.

This machine's only purpose was to increase billing. Although patients were impressed by and enjoyed it, it was not doing what it was billing for.

I also thought it was strange that Doctors that I had worked with for years were suddenly sending "types" of patients to therapy that they had never sent before. For instance, they started sending all the ankle sprains to therapy for gait training. People who they would have taught crutch use to in their office for 5 minutes were now referred to therapy for 3-6 visits for the same thing. They also sent for longer periods of time. For unknown reasons the local standard that Doctors in my home town use for therapy is three times a week for three weeks. These Doctors had been sending me these scripts for years so I was concerned when I noticed that their standard had doubled from 3x3 to 3x6.

I remember one specific incident when a lady had injured her knee and was referred to therapy. After six weeks she had made very little progress. I documented this and told her that therapy was ineffective in her case and that she would not be returning to therapy unless she had surgery or other intervention. She went to my Doctor and returned the next day with a script for six more weeks. I went to the Doctor and asked if he had read my Discharge note. His response was that he had read it but the lady refused surgery and still has pain so he had no other options than to keep her in therapy.

This problem doubled when they brought in Durable Medical Equipment. The four Doctors came to the therapy department and told us that they wanted every knee patient to receive a custom knee brace. When we refused to do it for them they hired an untrained person in their clinic whose only job was to fit knee braces all day long.

Not only were they asking they asking us to do unneeded or extravagant treatments but they were also asking us to do more treatments. We were completely full. 3,000 square feet with four treatment rooms and we had every

bed and piece of equipment in use all the time. But they continued sending patients. When we complained that we were too busy and wanted to refer some patients out to other clinics they were very upset but they finally let us refer a few out. .

I found out one thing that completely amazed me. From the beginning I sat in on the Directors Meetings. I heard them ask for the codes listed from highest reimbursement to the lowest, I heard the sales people come in and tell them how much a custom knee brace could be billed for. I saw the projections about how much money they could make in therapy. It was incredible. They were profiting 30,000 per month from two therapists. I had been struggling in my own clinic and made $86,000 per year as the owner/therapist and these same Doctors had been sending me all their patients!!!

The original Stark Law, smartly, did not allow self referral to happen. Somewhere along the line the loop hole was inserted into the law. I have seen that when a doctor has an opportunity to generate revenue they go for it and the results are over utilization, over billing, and a lower standard of care.

Brett Tice PT
Licensed Physical Therapist

2426 Hunter Drive
Harlingen Texas 78550

Phone:428-8951
Fax: 956-428-0232
Cell: 956-202-3824

Submitter : **Mr. Brian Brister** **Date: 08/31/2007**

Organization : **Samford University Nurse Anesthesia Program**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007

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

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

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

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

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

As a current nurse anesthesia student, I find this EXTREMELY important to my profession and to health care quality by recuiting and keep good CRNAs in the health care industry. I hope you take this comment very seriously and I hope you make the right decision.

Sincerely,

Brian T. Brister, RN, SRNA Samford Univeristy Nurse Anesthesia Program
3550 Grandview Parkway Apt # 111
Birmingham, AL 35423

CMS-1385-P-13685-Attach-1.DOC

1385

August 29, 2007

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

RE: CMS–1385–P (BACKGROUND, IMPACT)

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Brian T. Brister, RN, SRNA Samford Univeristy Nurse Anesthesia Program
3550 Grandview Parkway Apt # 111
Birmingham, AL 35423

Submitter : Mr. Jason Cruickshank **Date:** 08/31/2007

Organization : Cleveland Clinic

Category : Other

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Jason Cruickshank, ATC, CSCS. I am a Certified Athletic Trainer and Certified Strength and Conditioning Specialist with Cleveland Clinic in Ohio and currently operate in the outpatient physical therapy department providing therapeutic services to our non-Medicare patients. I graduated from Baldwin-Wallace College in Berea, Ohio with a degree in Athletic Training in 1998. I attained my national licensure through the National Athletic Trainers' Association's Board of Certification in 2000. I attained my state licensure to practice in Ohio in 2000 and recently attained my National Strength and Conditioning Association certification this past July. After seven successful years of employment I have done all this as a means to hold myself to a higher standard for patient care within my employment setting but I fear it may all be for not.

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

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

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

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

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

Sincerely,

Jason A. Cruickshank, ATC, CSCS

Submitter : Dr. GREGORY MEHAFFEY **Date:** 08/31/2007

Organization : UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : **Wishard Anesthesia Group, LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely, John Hasewinkel M.D.

Submitter : Ms. Kristine Zeller **Date:** 08/31/2007

Organization : Cardiovascular Medicine, PC

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

We agree with the American College of Cardiology's position based upon data that the color flow doppler (93325) should not be bundled adn should remain separate from all other echocardiography codes due to the fact that it is NOT intrinsic to all other echo procedures, the other eodes DO NOT include reimbursement for the color flow doppler and a code bundling of 93307, 93325 dand 93320 has already been approved by CPT and wil be valued by the RUC in Sept 2007.

Physician Self-Referral Provisions

Physician Self-Referral Provisions

We oppose the changes to per-click payments in space and equipment leases and under arrangement services. Elimination of such arrangements will increase Medicare expenditures by increasing faciliy, equipment and staffing expenses. We believe that accreditation of facilities providing services would be much more beneficial in reduction of healthcare costs. We support allowing physicians and hospitals the ability to make sound business decisions in the rational distribution of health care assets with collaborative efforts.

Recalls and Replacement Devices

Recalls and Replacement Devices

Having experienced SEVERAL incidents of device recalls and dealing with the subsequent patient concerns and evaluations, we suggest that Medicare create a recall-specific code to be used when such device recalls occur that physicians can bill under adn track the additional time and work associated with these recalls.

Resource-Based PE RVUs

Resource-Based PE RVUs

As a busy cardiology practice with over 32 providers, our data supports CMS' decision to keep the equipment utlilzation rate at the current rate of 50%. Increasing the rate to 70% is not an accurate reflection and therefore not substantiated.

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

Organization : CRNA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

Michael J. Sarwinski, CRNA, MS

Submitter : Dr. Robert Gutekunst **Date:** 08/31/2007

Organization : Pathology and Forensic Consultants

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P. I am a Board Certified Pathologist and Fellow of the College of American Pathologists. I live and practice in Ft. Wayne, IN, in a 4-member group providing pathology services at 3 regional hospitals and a regional forensic center.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group's patients. I specifically refer to so-called "pod labs". A urology group "owns" one of these time share arrangements in another state, and sends all of their biopsies to that lab. The lab and pathologist become a "member" of the group when performing their services. There is some question as to whether these pathologists are licensed in Indiana, and what the quality control mechanisms are to ensure proper patient care (e.g.,peer review). These are not send out cases for second opinion, these are primary diagnoses by a pathologist who is contractually part of the

urology group in Indiana. That urology group is billing all CPT codes for pathology services at a higher rate than what is being paid to the pathologist. I believe that this type of arrangement is an abuse of the Stark law prohibition against physician self-referral. If 5 biopsy specimens are good, could 10 be better? I support revisions to close the loopholes that allow physicians to profit from pathology services.

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

All medical services should be provided in the best interests of the patient, and restrictions on physician self-referrals are an imperitive program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services but are only designed to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Respectfully,
Robert W. Gutekunst, MD
Pathologist

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

Organization : **Mr. Michael Angeloro**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 31, 2007

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

Dear Administrator:

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

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Sincerely,

Michael B. Angeloro, CRNA
1405 Windward Lane
Niceville, FL 32578

Submitter : **Ms. Tami Eiswerth** **Date: 08/31/2007**

Organization : **Geisinger HealthSouth**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Tami Eiswerth and I am a certified athletic trainer. I currently work in the high school setting as a contracted employee of a hospital-based clinic.

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

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

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

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

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

Sincerely,

Tami L. Eiswerth, MS, ATC (and/or other credentials)

Submitter : Dr. deborah cahill **Date:** 08/31/2007

Organization : Dr. deborah cahill

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter. This is particularly important in the state of RI, given our large Medicare population and our difficulty in attracting and retaining anesthesiologists in RI.

Deborah Cahill, MD

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

Organization : Thomas C. Lee, MD, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

It is ESSENTIAL that physician anesthesiologists get a SIGNIFICANT increase in reimbursement from Medicare. The payment that medicare provides to anesthesiologists now is WAY BELOW what's needed to keep up with increasing cost of living, practice expenses, and liability, and the present reimbursement rate has not increased significantly for too many years, while the overall practice cost in recently years has skyrocketed enormously. This low rate of reimbursement discourages and provides absolutely NO incentive or motivation for anesthesiologists to take are of medicare patients, who are usually plaqued with multiple medical conditions that present a real challenge for anesthesiologists when taking care of these sick patients under anesthesia, usually for surgeries that have significant amount of mortality and morbidity risks!

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

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Administrator:

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

Healthfully yours,

Louise Scudieri, CRNA, MS
1613 Thousand Oaks Dr
Decatur, Texas 76234

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

Organization :

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

Submitter : **Dr. Bernard Gallacher** **Date: 08/31/2007**

Organization : **North Houston Anesthesiology**

Category : **Federal Government**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Bernard P Gallacher, MD

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

Organization : Mr. David Bandy

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

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

Organization :

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

Sana Ata M.D.
Chairman, Dept. of Anesthesia
Lahey Clinic

Submitter : Ms. Cindy Rogers **Date:** 08/31/2007

Organization : Ms. Cindy Rogers

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-1385-P-13701-Attach-1.DOC

CMS-1385-P-13701-Attach-2.DOC

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, "Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008" (the "Proposed Rule") published in the *Federal Register* on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.

There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the "all physicians" crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians' ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries' access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the physicians that list interventional pain or pain management as their primary Medicare specialty designation, as "interventional pain physicians" for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

RESOURCE-BASED PE RVUs

I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to "all physicians" for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. Interventional pain is an inter-disciplinary practice that draws on various medical specialties of anesthesiology, neurology, medicine & rehabilitation, and psychiatry to diagnose and manage acute and chronic pain. Many interventional pain physicians received their medical training as anesthesiologists and, accordingly, clinically view themselves as anesthesiologists. While this may be appropriate from a clinically training perspective, their Medicare designation does not accurately reflect their actual physician practice and associated costs and expenses of providing interventional pain services.

This disconnect between the Medicare specialty and their practice expenses is made worse by the fact that anesthesiologists have the lowest practice expense of any specialty. Most anesthesiologists are hospital based and do not generally maintain an office for the purposes of rendering patient care. Interventional pain physicians are office based physicians who not only furnish evaluation and management (E/M) services but also perform a wide variety of interventional procedures such as nerve blocks, epidurals, intradiscal therapies, implant stimulators and infusion pumps, and therefore have practice expenses that are similar to other physicians who perform both E/M services and surgical procedures in their offices.

Furthermore, the utilization rates for interventional pain and pain management specialties are so low that they are excluded from Medicare rate-setting or have very minimal affect compared to the high utilization rates of anesthesiologists. CMS utilization files for calendar year 2007 overwhelming report anesthesiologists compared to interventional pain physicians and pain management physicians as being the primary specialty performing interventional pain procedures. The following table illustrates that anesthesiologists are reported as the primary specialty providing interventional pain services compared to interventional pain physicians

CPT Code	Anesthesiologists - 05	Interventional Pain Management Physicians

	(Non-Facility)	- 09 (Non-Facility)
64483 (Inj foramen epidural l/s)	59%	18%
64520 (N block, lumbar/thoracic)	68%	15%
64479 (Inj foramen epidural c/t)	58%	21%
62311 (Inject spine l/s (cd))	78%	8%

The high utilization rates of anesthesiologists (and their extremely low practice expenses) drive the payment rate for the interventional pain procedures, which does not accurately reflect the resource utilization associated with these services. This results in payment rates that are contrary to the intent of the Medicare system—physician payment reflects resources used in furnishing items and services to Medicare beneficiaries.

I urge CMS to make a modification to its practice expense methodology as it pertains to interventional pain services such that its methodology treats physicians who list anesthesiology as their primary specialty and list interventional pain as their secondary specialty designation as interventional pain physicians for rate-setting. This pool of physicians should be cross-walked to "all physicians" for practice expenses. This will result in a payment for interventional pain services that is more aligned with the resources and costs expended to provide these services to a complex patient population.

I urge CMS not to delay implementing our proposed recommendation to see if the updated practice expenses information from the Physician Practice Information Survey ("Physician Practice Survey") will alleviate the payment disparity. While I believe the Physician Practice Survey is critical to ensuring that physician services are appropriately paid, I do not believe that updated practice expense data will completely resolve the current underpayment for interventional pain services. The accurate practice expense information for interventional pain physicians will continue to be diluted by the high utilization rates and associated low practice expenses of anesthesiologists.

II. CMS Should Develop a National Policy on Compounded Medications Used in Spinal Drug Delivery Systems

We urge CMS to take immediate steps to develop a national policy as we fear that many physicians who are facing financial hardship will stop accepting new Medicare beneficiaries who need complex, compounded medications to alleviate their acute and chronic pain. Compounded drugs used by interventional pain physicians are substantially different from compounded inhalation drugs. Interventional pain physicians frequently use compounded medications to manage acute and chronic pain when a prescription for a customized compounded medication is required for a particular patient or when the prescription requires a medication in a form that is not commercially available. Physicians who use compounded medications order the medication from a compounding pharmacy. These medications typically require one or more drugs to be mixed or reconstituted by a compounding pharmacist outside of the physician office in concentrations that are not commercially available (*e.g.*, concentrations that are higher than what is commercially available or multi-drug therapy that is not commercially available).

The compounding pharmacy bills the physician a charge for the compounded fee and the physician is responsible for paying the pharmacy. The pharmacy charge includes the acquisition cost for the drug ingredients, compounding fees, and shipping and handling costs for delivery to the physician office. A significant cost to the physician is the compounding fees, not the cost of drug ingredient. The pharmacy compounding fees cover re-packaging costs, overhead costs associated with compliance with stringent statutes and regulations, and wages and salaries for specially trained and licensed compounding pharmacists bourn by the compounding pharmacies. The physician administers the compounded medication to the patient during an office visit and seeks payment for the compounded medication from his/her carrier. In many instances, the payment does not even cover the total out of pocket expenses incurred by the physician (*e.g.*, the pharmacy fee charged to the physician).

There is no uniform national payment policy for compounded drugs. Rather, carriers have discretion on how to pay for compounded drugs. This has lead to a variety of payment methodologies and inconsistent payment for the same combination of medications administered in different states. A physician located in Texas who provides a compounded medication consisting of 20 mg of Morphine, 6 of mg Bupivicaine and 4 of mg Baclofen may receive a payment of $200 while a physician located in Washington may be paid a fraction of that amount for the exact same compounded medication. In many instances, the payment to the physician fails to adequately cover the cost of the drug, such as the pharmacy compounded fees and shipping and handling. Furthermore, the claim submission and coding requirements vary significantly across the country and many physician experience long delays in payment.

We urge CMS to adopt a national compounded drug policy for drugs used in spinal delivery systems by interventional pain physicians. Medicare has the authority to develop a separate payment methodology for compounded drugs. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA") mandated CMS to pay providers 106% of the manufacturer's Average Sales Price ("ASP") for those drugs that are separately payable under Part B. The language makes clear that this pricing methodology applies only to the sale prices of manufacturers. Pharmacies that compound drugs are not manufacturers, and Congress never contemplated the application of ASP to specific drug compounds created by pharmacies. Accordingly, CMS has the discretion to develop a national payment policy.

We believe that an appropriate national payment policy must take into account all the pharmacy costs for which the physicians are charged: the cost of the drug ingredient, the compounding fee costs, and the shipping and handling costs. We stand ready to meet with CMS and its staff to discuss implementing a national payment policy.

III. CMS Should Incorporate the Updated Practice Expenses Data from Physician Practice Survey in Future Rule-Making

I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge

CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

IV CMS Should Work Collaboratively with Congress to Fix the SGR Formula so that Patient Access will be preserved.

The sustainable growth rate ("SGR") formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

Because of the flawed formula, physicians and other practitioners disproportionately bear the cost of providing health care to Medicare beneficiaries. Accordingly, many physicians face clear financial hardship and will have to make painful choices as to whether they should continue to practice medicine and/or care for Medicare beneficiaries.

CMS should work collaboratively with Congress to create a formula that bases updates on the true cost of providing healthcare services to Medicare beneficiaries.

***

Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

Cindy Rogers
81 Lakeview Drive
Paducah, KY 42001

Submitter : Dr. Stanton Honig **Date:** 08/31/2007

Organization : The Urology Center, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attached Letter

CMS-1385-P-13702-Attach-1.DOC

CMS-1385-P-13702-Attach-2.DOC

1362

August 30, 2008

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

Comments of CMS 2008 Proposals

Dear Mr. Kuhn:

CMS should work with Congress to fix the Sustainable Growth Rate to prevent the upcoming 10% cut to physicians who provide services to Medicare beneficiaries. Drastic cuts will total 40% over the next 8 years. Over the same period, the Medicare Economic Index (MEI) will increase 20%. How long will physicians be forced to ask for a legislative fix from Congress?

Although no specific proposals exist from CMS, any change to the Stark "in-office" ancillary exception would unduly harm the ability of urologists to provide efficiencies and needed services to patients. Services provided under the exception are important to healthcare delivery. CMS should not further limit this already complex and burdensome regulation.

Under the proposed rule regarding reassignment and diagnostic testing, the only technical or professional services a medical group could mark up would be those by the group's full time employees. This would significantly hurt the ability of group practices with in-office imaging equipment to utilize independent contractors and part-time employees to perform professional services. We understand CMS desire to prevent "mark-ups" and gaming the system but offices with in-office imaging equipment to utilize independent and part-time employees to perform high-quality professional interpretation services.

Prohibition of "under arrangements" rule will prohibit the provision of that are provided to a hospital through a joint venture in which you have an ownership interest, (such as radiation therapy or lasers). This will be detrimental to patient care because of access to these are expensive in our community and across the country. In addition, CMS has taken efforts through a variety of different regulations through the years to eliminate duplication of services. If CMS or Congress were to prevent or further limit the ability to Joint venture with hospitals and other practices it may create an environment that would induce physicians to provide more services in-house under the practice exclusion. Each practice group will buy their own equipment or subject patients to return to the more costly and efficient hospital providers.

We understand the important of striking a balance between fraud and abuse and promoting efficiency and protecting patient access to care. As a urologist, these regulations, if implemented would have a negative effect on innovation, efficiency and patient access to care. Please consider suggested changes and withdraw these proposals.

CMS should not be considering making significant changes to Stark rules on an annual basis or for inclusion in the Physician Fee Schedule. Too many financial and business arrangements, legal contracts and services are involved to be altered on a yearly basis or through a piecemeal approach.

In sum, the proposed rules create two levels of uncertainty: (1) significant lack of clarity within the specific proposals themselves; and (2) general instability due to the prospect of annual changes to Stark.

Thank you for your time and attention to this very important matter.

Sincerely,

Richard Dean, M.D.

Richard Dean, M.D.

Ralph DeVito, M.D.

Ralph DeVito, M.D.

David Hesse, M.D

David Hesse, M.D.

Stanton Honig, M.D.

Stanton Honig, M.D.

Thomas Martin, M.D.

Thomas Martin, M.D.

M, Grey Maher, M.D.

M, Grey Maher, M.D.

Submitter : **Dr. Marina Shindell** **Date: 08/31/2007**

Organization : **Dr. Marina Shindell**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. Bridget Bandy **Date:** 08/31/2007

Organization : Mrs. Bridget Bandy

Category : Individual

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

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

Organization : WPAHS

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I strongly support proposal to increase anesthesia payments under 2008 Physician Fee Schedule.
re:cms-1385-p

Submitter : Ms. Sherrie Weeks **Date:** 08/31/2007

Organization : University of Maine

Category : Academic

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Sherrie Weeks and I am an Athletic Training educator at the University of Maine. As Program Director, I work directly with students to ensure they receive the proper education enabling them to be competent athletic trainers. The course work is rigorous and time consuming, but the students leave college with a very strong work ethic and knowledge base. I am writing today to help graduating athletic training students as they enter the professional world of medicine. I also practice as an athletic trainer and am very concerned about our future as practicing allied health care workers.

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

Submitter : Dr. Carey Girgis **Date:** 08/31/2007

Organization : Girgis Chiropractic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

In reference to FILE Code CMS-1385-P -- How can it be in the best interest of our senior citizens to not cover their x-rays that are needed for a chiropractor to make a proper and correct diagnosis. It is not good for a chiropractor to begin treatment without x-rays any more than it would be for an orthopedic doctor to begin treatment without x-rays. Chiropractic has been proven to be a very beneficial treatment for people with pain, and to deny x-rays for those medicare patients who come to us is nothing more than prejudice against our profession. I strongly encourage you to continue to allow our patients to get x-rays at medical facilities, and even more, these x-rays should be covered in our office, due to our training and expertise in taking these x-rays. Having the x-rays in our office would be cheaper for Medicare in the long run.

Sincerely,

Dr. Carey A. Girgis

Submitter : Mr. Nicholas Bandy **Date:** 08/31/2007

Organization : Mr. Nicholas Bandy

Category : Individual

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

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

Organization : **Judy Hathcock**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Judy Hathcock

Submitter : **Mr. Donald Brown** **Date: 08/31/2007**

Organization : **HCA Hospitals-Cartersville Georgia**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My Name is Donald F. Brown, Jr. I am an American citizen and voter. I support my country and everything it stands for, but eliminating jobs for individuals qualified to do such services goes against all that this country was founded on. This is not a government issue. This is a free market and should remain such with the consumer and physician having the liberty to use which ever licensed and certified professional they choose. Hospitals, secondary schools and outreach clinics also should have the chose to hire whom they choose without being told by the government who they have to hire. I am a single parent of two boys. The bread winner for my family. I have a Master's degree in Athletic Training and 18 years of work experience in the hospital, clinical setting. I do rehabilition on orthopaedic injuries and surgeries for HCA hospital-Cartersville Georgia. I am nationally certified by the National Athletic Trainer's Association and state of Georgia licensed to do such services.

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

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

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

The lack of aceess and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to 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,

Donald F. Brown, M.S.,ATC, LAT.
F&A.M. Mackey Lodge #120 of Cave Spring Georgia

Submitter : **Ms. Alexandria Bandy** **Date: 08/31/2007**

Organization : **Ms. Alexandria Bandy**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Mr. Frank Freund **Date:** 08/31/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Elizabeth Bandy** **Date: 08/31/2007**

Organization : **Ms. Elizabeth Bandy**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : Mr. Chance Green **Date:** 08/31/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Dear Administrator:

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This increase in Medicare payment is important for several reasons.

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

Organization : The Urology Center, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attached Letter (Word Document)

CMS-1385-P-13716-Attach-1.DOC

August 30, 2008

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

Comments of CMS 2008 Proposals

Dear Mr. Kuhn:

CMS should work with Congress to fix the Sustainable Growth Rate to prevent the upcoming 10% cut to physicians who provide services to Medicare beneficiaries. Drastic cuts will total 40% over the next 8 years. Over the same period, the Medicare Economic Index (MEI) will increase 20%. How long will physicians be forced to ask for a legislative fix from Congress?

Although no specific proposals exist from CMS, any change to the Stark "in-office" ancillary exception would unduly harm the ability of urologists to provide efficiencies and needed services to patients. Services provided under the exception are important to healthcare delivery. CMS should not further limit this already complex and burdensome regulation.

Under the proposed rule regarding reassignment and diagnostic testing, the only technical or professional services a medical group could mark up would be those by the group's full time employees. This would significantly hurt the ability of group practices with in-office imaging equipment to utilize independent contractors and part-time employees to perform professional services. We understand CMS desire to prevent "mark-ups" and gaming the system but offices with in-office imaging equipment to utilize independent and part-time employees to perform high-quality professional interpretation services.

Prohibition of "under arrangements" rule will prohibit the provision of that are provided to a hospital through a joint venture in which you have an ownership interest, (such as radiation therapy or lasers). This will be detrimental to patient care because of access to these are expensive in our community and across the country. In addition, CMS has taken efforts through a variety of different regulations through the years to eliminate duplication of services. If CMS or Congress were to prevent or further limit the ability to Joint venture with hospitals and other practices it may create an environment that would induce physicians to provide more services in-house under the practice exclusion. Each practice group will buy their own equipment or subject patients to return to the more costly and efficient hospital providers.

We understand the important of striking a balance between fraud and abuse and promoting efficiency and protecting patient access to care. As a urologist, these regulations, if implemented would have a negative effect on innovation, efficiency and patient access to care. Please consider suggested changes and withdraw these proposals.

CMS should not be considering making significant changes to Stark rules on an annual basis or for inclusion in the Physician Fee Schedule. Too many financial and business arrangements, legal contracts and services are involved to be altered on a yearly basis or through a piecemeal approach.

In sum, the proposed rules create two levels of uncertainty: (1) significant lack of clarity within the specific proposals themselves; and (2) general instability due to the prospect of annual changes to Stark.

Thank you for your time and attention to this very important matter.

Sincerely,

Richard Dean, M.D.

Richard Dean, M.D.

Ralph DeVito, M.D.

Ralph DeVito, M.D.

David Hesse, M.D

David Hesse, M.D.

Stanton Honig, M.D.

Stanton Honig, M.D.

Thomas Martin, M.D.

Thomas Martin, M.D.

M, Grey Maher, M.D.

M, Grey Maher, M.D.

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

Organization : **Beatrice Christopher**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Harvey Auerbach **Date:** 08/31/2007

Organization : Cape Cod Anesthesia Associates, Inc

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Harvey Auerbach, M.D.

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : Ms. Melissa Kemper **Date:** 08/31/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Dear Administrator:

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This increase in Medicare payment is important for several reasons.

Submitter : Ms. Beth Degenahrt **Date:** 08/31/2007

Organization : St. Vincent's Healthcare

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I feel it is time that our anesthesiologists are adequately paid for the care they give patients.

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

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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Submitter : Dr. Ralph DeVito **Date:** 08/31/2007

Organization : The Urology Center, P.C.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attached Letter (Word Document)

CMS-1385-P-13723-Attach-1.DOC

13723

August 30, 2008

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

Comments of CMS 2008 Proposals

Dear Mr. Kuhn:

CMS should work with Congress to fix the Sustainable Growth Rate to prevent the upcoming 10% cut to physicians who provide services to Medicare beneficiaries. Drastic cuts will total 40% over the next 8 years. Over the same period, the Medicare Economic Index (MEI) will increase 20%. How long will physicians be forced to ask for a legislative fix from Congress?

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Thank you for your time and attention to this very important matter.

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Richard Dean, M.D.

Richard Dean, M.D.

Ralph DeVito, M.D.

Ralph DeVito, M.D.

David Hesse, M.D

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Thomas Martin, M.D.

M, Grey Maher, M.D.

M, Grey Maher, M.D.

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

Organization : **Caroline Christopher**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Submitter : Ms. Jackie Kingma **Date:** 08/31/2007

Organization : A.T. Still University

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Thank you very much for the opportunity to address this matter. I am a certified athletic trainer, a licensed physical therapist and a certified physician assistant. Presently, I am an associate professor at A.T. Still University in Mesa, AZ. I teach in the post-professional graduate athletic training education program. I also have had teaching responsibilities in the physician assistant studies program teaching in their advanced Master of Science distance education program. I have been at A.T. Still University since 1995. Prior to my present position, I was employed at various institutions as an educator in athletic training curriculums and also worked as a teaching assistant in physical therapy and as a clinical 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 an additional lack of access to quality health care for my patients. As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services. 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,
Jackie J. Kingma, M.S., ATC, PA-C, PT

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

Organization : **Jonathan Sachs**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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