Submitter : **Mr. Gabriel Ostrander** **Date: 08/15/2007**

Organization : **Mr. Gabriel Ostrander**

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.

Gabriel Ostrander

Submitter : **Date: 08/15/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS Representative:

I am writing this letter to express my concern regarding the proposed Medicare Physician Fee Schedule (MPFS) revision that will dramatically affect the reimbursement of Physical and Occupational Therapy services provided to elderly patients in my community.

This proposed method for reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care.

I understand that the AMA, the American Physical Therapy Association and the American Occupational Therapy Association, as well as other organizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these patients right to adequate and necessary medical care.

Sincerely,

Josh Hankins, MPT

Submitter : **Dr. Robin Kopeikin** **Date: 08/15/2007**

Organization : **Dr. Robin Kopeikin**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please support the proposed update in the Anesthesia Conversion Factor. Anesthesiologists have been underpaid by the Medicare program relative to other specialties since the inception of the RBRVS and this must change or face a serious decrease in available pratitioners.

Submitter : **Dr. william blackburn** **Date: 08/15/2007**

Organization : **Dr. william blackburn**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-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. Ketan Trivedi **Date:** 08/15/2007

Organization : The Cardiovascular Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CODING-ADDITIONAL CODES FROM 5-YEAR REVIEW. The federal register citation is 72 Federal Register 38122 (July 12, 2007). Letter concerning Bundling of Color Flow Doppler is attached

CMS-1385-P-5905-Attach-1.DOC

CMS-1385-P-5905-Attach-2.DOC

#5405

August 15, 2007

To Whom It May Concern:

This is regarding the bundling of color Doppler imaging into the 2D imaging billing codes for echocardiography. As a Board Certified practicing cardiologist, echocardiography is an integral part of my practice. A standard echocardiogram contains both 2D as well as color Doppler imaging. While complementary, these two modes are distinct and different. Color Doppler imaging is used to obtain information above and beyond what is given by 2D imaging, and as such, requires special skills and training to interpret. Additionally, the studies themselves take significantly more time to perform when Color Doppler imaging is included.

Its understandable that there need to be limits placed upon expenditures for healthcare. However I feel legislation should be directed at capping costs so that care is provided only by organizations that can prove their **quality** of care is first rate, rather than by bundling codes together. This will help insure that the aging American population continues to receive outstanding healthcare.

Sincerely

Ketan Trivedi MD
703-648-3266

Submitter : **Date: 08/15/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

I believe the medicare reimbursement for the Monterey area is broken. If the intent of the government was to push physicians to the point where they would makc major life decisions-they have. My choice is drop medicare and relocatc my family from Monterey county to an area where I can make a decent living and maintain a quality of life that doesn't require unsafe work hours. Thank you

Submitter :

Date: 08/15/2007

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS Representative:

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This proposed method for reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care.

I understand that the AMA, the American Physical Therapy Association and the American Occupational Therapy Association, as well as other organizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these patients right to adequate and necessary medical care.

Sincerely,
Gena Walton

Submitter : **Date: 08/15/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

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Sincerely,
Melisa Cline, MSPT

Submitter : **Date: 08/15/2007**

Organization :

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS Representative:

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This proposed method for reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care.

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Sincerely,
Gary Patterson, PTA

Submitter : **Dr. Mark Carver** **Date: 08/15/2007**

Organization : **Dr. Mark Carver**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Ronda Ash** **Date: 08/15/2007**

Organization : **Sheridan Healthcorp**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Sanford Robbins** **Date: 08/15/2007**

Organization : **Anne Arundel Medical Center**

Category : **Physician**

Issue Areas/Comments

CAP Issues

CAP Issues

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Annapolis, Maryland as part of three physician community hospital based practice.
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. Specifically, I have seen examples of urologists making quasi-employment and independent contractor arrangements with pathologists to read biopsies in their offices. As a condition for receiving this business, the pathologist must allow the urologist to bill Medicare or other private patient insurance for the professional component of the pathology service. The urologist in most cases will keep over 50% of the fee and return a small percentage to the pathologist. You can certainly see where this practice creates an economic incentive to do more biopsies. The Maryland Society of Pathologist complained to the Maryland Board of Physicians about these abusive practices and received a Declaratory Ruling from the Board in December, 2007. Unfortunately this ruling did not completely close the employment loophole for these arrangements. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.
Sincerely,
Sanford H. Robbins III, M.D.

CMS-1385-P-5913-Attach-1.PDF

#5913

MARYLAND STATE BOARD OF PHYSICIANS

IN THE MATTER OF PETITION FOR DECLARATORY RULING

Petitioner: **Maryland Society of Pathologists, Inc.**	*	**Declaratory Ruling No. 2006-2**

* *

DECLARATORY RULING

INTRODUCTION

This Declaratory Ruing arises out of a formal petition filed on August 25, 2006, by Maryland Society of Pathologists, Inc. ("Petitioner"). Petitioner requests a ruling from the Board regarding the propriety under the Maryland Self-Referral Law of certain referrals made by urologists for pathological services when the urologist obtains a financial benefit from the performance of the referred service. Enclosed with the petition were letters setting out in more detail the factual scenarios that are being questioned.

On September 27, 2006, the Board voted to grant petitioner's request for a Declaratory Ruling under COMAR 10.32.16.03A. The Board has met and considered the petition and hereby sets out its Declaratory Ruling.

QUESTIONS PRESENTED

Petitioner asks whether referrals made under two specific factual scenarios violate the Maryland Self-Referral Law, as codified in Md. Health Occ.

Code Ann §1-301 *et. seq.* (1993).[1] Petitioner's factual scenarios are set out below and individually analyzed.

Scenario 1

> A urology group sets up a small histology laboratory within its office. The urology group either directly owns the laboratory or has a financial interest in its operation. The urology group, however, contracts with an independent pathology group to staff the laboratory and perform the pathology services. Members of the urology group refer patients (or specimens from patients) to the lab. The urology group then pays the pathology group a set fee for each slide prepared. The preparing of the slides is called the "technical component" of the pathology services. The independent, contracting pathology group performs and supervises this technical component. The urology group, however, bills the patient for this component (the technical component) of the pathology examination.
>
> In addition to supervising the laboratory, the independent pathology group provides a pathologic diagnosis on the prepared slides. Providing the pathologic diagnosis is called the "professional component" of the pathology services. The independent pathology group directly charges the patient for this professional component of the pathology examination.

Analysis

The question raised by this fact pattern is whether the referral of patients (or specimens from patients) by members of this urology group to the described histology laboratory violates the Maryland Self Referral Law. First, the transaction described above is a "referral" because it is the "establishment of a plan of care," which includes a pathologic diagnosis performed by an "outside" entity, the pathology group. Thus, it meets the definition of "referral" in § 1-301 (l) (2) (ii).

[1] Unless otherwise noted, all citations within this Declaratory Ruling refer to §1-301 *et. seq.* of the Health Occupations Article of the Annotated Code Maryland.

The next step is to determine whether or not the referral is a "prohibited referral" under §1-302(a). If the referral is included within §1-302(a), it is a prohibited referral unless an exception contained in §1-302(d) applies. Section 1-302(a) states:

> (a) *Prohibited Referrals* – Except as provided in subsection (d) of this section, a health care practitioner may not refer a patient, or direct an employee of or person under contract with the health care practitioner to refer a patient to a health care entity:
>
> > (1) In which the health care practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family owns a beneficial interest; or
> >
> > (2) With which the health care practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a compensation agreement.

§1-302(a)(2). (Emphasis added)

The urologist's referral under this scenario is a prohibited referral because the urologist holds a beneficial interest in the histology lab that will perform the referred examination. A beneficial interest is defined as an ownership interest. Section 1-301(b). This referral thus violates the Self-Referral Law unless one of the exceptions contained in §1-302(d) applies.

The urologist's referral is not exempt from the Self-Referral Law under any of the §1-302(d) exceptions. Section 1-302(d)(2), the "group practice" exception does not apply. By the terms of this scenario, the pathology group that contracts to run the in-office histology laboratory is independent and not a member of the same group practice."[2]

---

[2] There may be additional limitations on referrals under the (d)(2) exception. *See Injured Workers' Insurance Fund, et. al,* Declaratory Ruling No. 2006-1. The Board, however, does not have to discuss these issues in order to decide this case, since the pathology group by definition is not part of the urology group's group practice.

The exception in § 1-302(d)(3) applies only if the referral is personally performed by or directly supervised by the referring physician. The urologist in this scenario is not performing the preparation of the histology slides. The independent, contracting pathology group is performing and supervising the preparation of the histology slides. "Direct supervision," by definition, requires the referring physician to be "present on the premises" and "available for consultation within the treatment area." §1-301(d). Direct supervision is a form of supervision; the "present on the premises" requirement in § 1-301(d)(3) is in addition to, and not a substitute for, the requirement of supervision. Because neither the referring urologist, nor a practitioner within his or her group practice, is in any medical sense supervising the preparation of the histology slides (the slides are being prepared under the supervision of the outside, independent, contracting pathology group), there is no "supervision" within the meaning of §1-301(d). This principle holds regardless of the location of the urologists vis-à-vis the histology laboratory. Because there is no supervision, §1-302(d)(3) does not apply to the urologist's referral.

The exception in (d)(3) does not apply for an additional reason. Exception (d)(3) applies only to referrals to *outside* entities in which the referring physician has a beneficial interest.[3] Because the histology laboratory is set up within the office of the referring urologist, it is not an outside entity; exception (d)(3), therefore, would not apply even if the urologist were "supervising" the preparation of the histology slides.

[3] The legislative documentary history and textual analysis supporting this statement is not set out here, but was discussed thoroughly in *Injured Workers' Insurance Fund, et. al,* Declaratory Ruling No. 2006-1.

The urologist's referral is not exempt from the Self-Referral Law under §1-302(d)(4) because it fails to meet all of the requirements of that exception. Section 1-302(d)(4) states:

> (d) *Exemptions from section.* – The provisions of this section do not apply to:
> (4) A health care practitioner who refers in-office ancillary services or tests that are:
>
> (i) <u>Personally furnished by</u>:
> 1. The referring health care practitioner;
> 2. A health care practitioner in the same group practice as the referring health care practitioner; or
> 3. An individual who is employed and personally supervised by the qualified referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner.
>
> (ii) Provided in the same building where the referring health care practitioner or a health care practitioner in the same group practice as the referring healthcare practitioner furnishes services; and
>
> (iii) Billed by:
> 1. The health care practitioner performing or supervising the services; or
> 2. A group practice of which the health care practitioner performing or supervising the service is a member.

Md. Health Occ. §1-302(d)(4) Code Ann. (1993). (Emphasis added)

To meet the requirements of this (d)(4) exception, three general criteria must be met: (i) the pathological examination has to be *personally furnished by* or *personally supervised by the referring practitioner or a member of the referring practitioner's group*; (ii) it must be provided within the referring practitioner's office; and (iii) it has to be billed by the referring practitioner or his or her group practice. [4]

The urologist in this scenario fails to meet the first requirement. The scenario describes a histology lab that is owned by the urology group. The

---

[4] In addition, the services referred must be "basic" and "routinely performed." § 1-301(k).

histology lab, however, is managed, supervised, staffed and operated by a subcontracting pathology group. The employees who staff the laboratory are employees of the pathology group, not the urology group. Thus, the urologist is not involved in either the performance or the supervision of the pathological examination at all, nor is any other practitioner in the urologist's group involved. Therefore, this arrangement does not meet the requirement of §1-302(d)(4)(i), and this exception is not available.

No other exception applies to this factual scenario. This does not mean that additional facts might not justify a finding that another exception applies. For example, if additional facts were added to Scenario 1 that showed that patients would be deprived of needed care if the prohibition on self-referrals applied, the exception in § 1-302 (d)(5) might apply.

For these reasons, a referral for pathology services as set out in Scenario 1 violates the Maryland Self-Referral Law.

Scenario 2

A urology group submits a biopsy specimen to an independent commercial laboratory. The laboratory prepares the slides and bills the patient directly for this technical component of the pathology examination. The prepared slides are then sent to the urology group's office.

The urology group contracts with a pathologist to perform a pathologic diagnosis (the "professional component") on the prepared slides. The urology group pays the pathologist a set fee that is below the market rate for this professional component. The urology group then bills the patient at the market rate for the professional component.

The pathologist discounts his or her rate below the market rate to the urology group. This discount (and the subsequent markup by the urology group) provides a financial incentive for the

urology group to refer specimens to this pathologist. Each referral to this pathologist results in additional financial gain to the urologist (through the discount-and-markup procedure).

Analysis

This analysis is not concerned with the relationship between the urology group and the independent commercial laboratory. The Board is concerned with, and sets out in its analysis below, the legality of the referrals between the urology group and the pathologist.

The referral in this scenario falls within §1-302(a) because the urology group has a "compensation arrangement" with the pathologist who performs the professional component of the examination. §1-302(a)(2). A "compensation arrangement" is defined in the Self-Referral Law as:

> [A]ny agreement or system involving any remuneration between a health care practitioner ... and a health care entity.

Md. Health Occ. §1-302(c)(1) Code Ann. (1993).

The urology group in this scenario has a compensation arrangement with the pathologist because there is an "agreement or system" by which the pathologist performs the professional component for remuneration, and the urology group receives remuneration for each referral (in the form of the discount and subsequent markup).[5]

While certain compensation arrangements with independent contractors are excluded from the Self-Referral Law, this particular compensation arrangement is not excluded:

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[5] By statute, "compensation arrangement" is defined (with many exceptions) as any "system involving any remuneration." The remuneration does not have to be paid for *health care services* in order for the system to be a "compensation arrangement." Nevertheless, that is the situation in this case, since the remuneration is being paid for the professional component.

(c)(2) "Compensation arrangement" does not include:

*　*　*

(iii) An arrangement between a health care entity and a health care practitioner or the immediate family member of a health care practitioner for the provision of any services, as an independent contractor, if:

1. The arrangement is for identifiable services.
2. The amount of the remuneration under the arrangement is <u>consistent with the fair market value</u> of the services and is not determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the referring health care practitioner; and
3. The compensation is provided in accordance with an agreement that would be commercially reasonable even if no referrals were made to the health care practitioner.

Md. Health Occ. §1-302(c)(1) Code Ann. (1993). (Emphasis added)

The Board concludes that the exception from the term "compensation arrangement" in §1-302(c)(2)(iii) does not apply. The exclusion applies only to arrangements in which the goods or services are purchased at "fair market value." *Id.* Since, according to the terms of the scenario, the payment by the urologist to the pathologist for the professional component is below fair market value, the exclusion for independent contactors does not apply. In addition, although there are many other exclusions from the term "compensation arrangement" in § 1-301(c)(2), none of these other exclusions applies to this scenario.

Because the urology group has a "compensation arrangement" with the pathology group, the urology group's referral of specimens to the pathology group is a "prohibited referral" and a violation of the Self-Referral Law unless an exception in §1-302(d) applies.

None of the exceptions to §1-302(d) apply. First, exception (d)(2) deals only with referrals to another practitioner in the "same group practice." In this

scenario, however, the pathologist is not a member of the urology group's group practice. Thus, exception (d)(2) plainly does not apply.[6]

Second, exception (d)(4) does not apply. This exception deals with "in-office" ancillary services. In this scenario, however, the professional component of the pathology examination is rendered by a contractor outside of the referring urologist's office, and therefore beyond the scope of (d)(4). And in any case, exception (d)(4) requires that the referring physician (or a physician in that group) personally perform or supervise the service – and in this scenario neither the referring urologist nor a member of the referring urologist's group either performs or supervises the professional component in this scenario. For both of these reasons, exception (d)(4) does not apply.

A third exception that needs to be considered in this scenario is the "direct supervision exception" contained in §1-302(d)(3), which permits referrals to entities in which the referring physician has a beneficial interest, provided that the referring physician personally performs or directly supervises the service. Section 1-302(d)(3) states:

> (d) *Exemptions from section.* – The provisions of this section do not apply to:
>
> * * *
>
> (3) A health care practitioner with a <u>beneficial interest</u> in a health care entity who refers a patient to that health care entity for health care services or tests, if the services or tests are <u>personally performed by or under the direct supervision of the referring health care practitioner</u>.

Md. Health Occ. §1-302(d)(3) Code Ann. (1993) (Emphasis added.)

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[6] There are additional limitations on referrals under the (d)(2) exception, *see Injured Worker's Insurance Fund, et. al.*, Declaratory Ruling No. 2006-1, but the Board does not have to consider these additional limitations in this case.

The referral in this scenario, however, fails to meet either of the two requirements emphasized above. First, the urology group member does not have a beneficial interest in the practice of the pathologist to which the referral was made. In this scenario, the urologist merely has a contractual relationship with the pathologist; this is not a beneficial interest. Thus, the referral fails to meet the requirements of the exception in §1-302(d)(3) for this reason alone.

Second, the referring urologist does not perform or supervise any part of the examination. Under the "direct supervision requirement" of this exception, the referring physician must either directly supervise or personally perform the referred service or test. The urologist in this scenario does not in any sense either perform or supervise any part of the pathologic examination. Both components of the pathology exam are performed outside of the urologist's office by outside contractors who are not members of the urology group. The urologist acts simply as a purchaser and reseller to the patient. Therefore, because the urologist does not perform or supervise any part of the pathology examination, §1-302(d)(3) does not exempt the urologist's referral.

Since none of the exceptions apply, a referral made under this scenario violates the Maryland Self-Referral Law.[7]

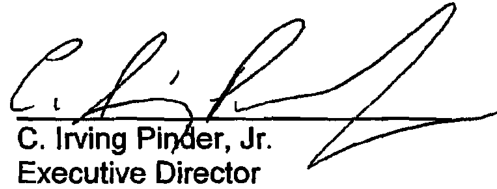
Conclusion

The referrals described above in both Scenario One and Scenario Two violate the Maryland Self-Referral Law, as codified in §1-301 *et seq.* This ruling

[7] This Declaratory Ruling is limited to the general rule and the exceptions found in (d)(2), (d)(3) and (d)(4). The scenarios dealt with here did not bring into play the other exceptions found at (d)(1) and at (d)(5) through (11). Additional facts altering the scenarios could result in a finding that an exception found in (d)(1) or (d)(5) through (d)(11) applies.

is binding on the Board and the Petitioner with regard to these specific factual scenarios.

12/29/06
Date



C. Irving Pinder, Jr.
Executive Director

NOTICE OF RIGHT TO APPEAL TO COURT

Petitioner Maryland Society of Pathologists, Inc., if dissatisfied with this Declaratory Ruling, is entitled to appeal the ruling to the circuit court under Md. State Gov't Code Ann. § 10-305 (c).

Submitter : Mrs. Carol Grossman

Date: 08/15/2007

Organization : Sheridan HealthCorp

Category : Health Care Provider/Association

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Please consider increasing the payments for anesthesia services

Submitter : William Schultz **Date:** 08/15/2007

Organization : William Schultz

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Please carefully consider all factors concerning payment levels to medical professional that provide MEDICARE services. Please adjust payments to equitably compensate PROVIDERS in consideration of the
ever infating U.S, economy. Alternatively terminate the MEDICARE
program.

Submitter : Ms. Nancy Hopwood **Date:** 08/15/2007

Organization : Sheridan Healthcorp, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Nancy Hopwood, CP
Litigation Coordinator

Submitter : **Mrs. Patricia Correchet** **Date: 08/15/2007**

Organization : **Sheridan Healthcare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

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 seniors, and is creating a situation in which anesthesiologists are being forced away from areas with high Medicare populations.

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Don Pearson Jr.** **Date: 08/15/2007**

Organization : **University of Tennessee Medical Center**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Dear Ms. Norwalk:

As a Teaching Anesthesiologist at the University of Tennessee Medical Center at Knoxville, I am writing to express my fervent support of the RUC sponsored increase in anesthesia payments in the 2008 Physician Fee Schedule. I am grateful that the RUC and CMS have recognized the previous gross under valuation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, a huge payment disparity for anesthesia care was created 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 conversion factor is actually lower than it was in 1990 and is less than 36% of the average commercial insurance conversion factor. In contrast, MedPAC reports that Medicare payments to other physician groups average 80% of commercial insurance payments. Furthermore, 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. As a teaching institution, our residency and nurse anesthetist training programs are in jeopardy because of the concomitant impacts of the under valuation of the conversion factor for anesthesia and the teaching penalty of 50% reduction in payments when anesthesia trainees are involved in the care of the Medicare patient.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work under valuation. This move would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services and help ameliorate the impact of the teaching penalty .

Full and immediate implementation of the increase in the anesthesia conversion factor as recommended by the RUC is an imperative which cannot be ignored to ensure that our patients have access to needed anesthesiology medical care.

Thank you for your consideration of this serious matter.

Don R Pearson Jr, MD

CMS-1385-P-5918-Attach-1.DOC

#5918

Leslie V. Norwalk, Esq.
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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Full and immediate implementation of the increase in the anesthesia conversion factor as recommended by the RUC is an imperative which cannot be ignored to ensure that our patients have access to needed anesthesiology medical care.

Thank you for your consideration of this serious matter.

Don R Pearson Jr, MD

Submitter : **Mark Mandabach** **Date: 08/15/2007**

Organization : **University of Alabama Department of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

Background

Background

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Sincerely yours,

Mark G. Mandabach, M.D.

Submitter : **Date: 08/15/2007**

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

PLEASE APPROVE0THIS INCREASE. PEOPLE NEED ANESTHESIA IN ORDER TO GET SURGERY AND A LOT OF PEOPLE CAN'T AFFORD IT.

Submitter : **Ms. Brenda Key** **Date: 08/15/2007**

Organization : **Ms. Brenda Key**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : Dr. Dawn Zablocki **Date:** 08/15/2007

Organization : St. John's Health Clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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Thank you for your consideration of this serious matter.

Dawn Zablocki, MD

Submitter : **Ms. Vicki Horton** **Date: 08/15/2007**

Organization : **Spectrum Orthopaedics, Inc.**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I feel in-office therapy (PT and OT) services are beneficial to patients. The therapists are instructed in the therapy ordered by each physician. They also have direct access to the physicians if there are questions or suggestions. The physician also has immediate feedback on the status of the patient in therapy. Such therapy is convenient for the patient - located within the physician office, the patient is familiar with the staff and location and can sometimes see the physician and have therapy the same day. Also, for patients requiring immediate therapy services, they can go to therpay directly from the seeing the physician and are able to obtain immediate services.

Submitter : d abbott

Date: 08/15/2007

Organization : sheridan health

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

give anesthesia medicare/medicaid more funds for patients.

CMS-1385-P-5925

Submitter : **Jackie Dewyea** **Date: 08/15/2007**

Organization : **Burlington Fire Dept Ambulance**

Category : **Local Government**

Issue Areas/Comments

Beneficiary Signature

Beneficiary Signature

Specifie examples to our Ambulance Service:

The Burlington Fire Department Ambulance service performs well over 5000 emergency transports a year and it is a city government department. Budgets for this service are limited and we perform the ambulance billing always looking for a way to be efficient. Postage has risen and to obtain the beneficiary signature form it requires postage on our part plus postage on the patients part. Our expenses could be lower by eliminating the requirement for that signature for emergency ambulance transports. It would also allow more efficient submission of claims. We are HIPAA compliant and the HIPAA Privacy Rule already allows disclosure for billing purposes. It therefore is contradictory to that requirement to mandate that we obtain the signature at time of transport or before submitting the claim. It is sometimes a burden to obtain the signed form due to the acute condition of the patient; some patients do not have family in the area; some are simply unable to respond medically or mentally. This usually results in multiple attempts to contact patients by mail or telephone adding to the administrative and postage costs. An emergency transport is not an elective service and thus should be exempt from the beneficiary signature rule.

Submitter : **Mrs. Meagan Justus** **Date: 08/15/2007**

Organization : **iMed Group**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Maria Kei** **Date: 08/15/2007**

Organization : **Mrs. Maria Kei**

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 : **Kathy Setticase** **Date: 08/15/2007**

Organization : **TIVA Healthcare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Kathy Setticase
Recruiting Manager

Submitter : **Dr. Michael Kerner** **Date: 08/15/2007**

Organization : **Dr. Michael Kerner**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P
Ancsthesia Coding (Part of 5-Year Rcvicw)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Ian Darling** **Date: 08/15/2007**

Organization : **Anesthesia and Pain Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Sincerely
Ian Darling, MD

Submitter : **Mr. Charles Ladt** **Date: 08/15/2007**

Organization : **individual**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

The Centers for Medicare and Medicaid Services (CMS), must make sure that Medicare beneficiaries have adequate access to anesthesiology care. Current Medicare payment levels in anesthesiology do not meet this standard. It is critical that CMS administrators improve payment so that everyone has access to care.

I am aware that on July 2, the Medicare program announced that it is considering an increase in payments for anesthesia. The considered proposal for the anesthesia conversion factor of about $3.30 per unit more than was projected for 2008 is essential and needs to be a minimal starting place.

Thank You for your time and consideration.

Submitter : **Date: 08/15/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Ancillary services provided in office by physicians should not include physical or occupational therapy. As a PT who has worked in this environment I can speak of the abuse. The owner physicians often referred inappropriate patients to therapies--and then directed the therapist on how to treat. The emphasis was on quantity of care, not quality. Often the physicians pushed for services that aides or PTAs could perform--to increase dollars generated while administering lesser quality (and often superfluous) treatments. I am now in private practice and my practices are so much better--my Medicare utilization is 35% lower than at my old employer and my outcomes are as good--probably better. Please consider that the Medicare Cap needs to be repealed to allow the subscribers the treatments they need, therefore the most sensible way to decrease medicare dollar spending is to revoke the ancillary services provision allowing referral for profit to PT and OT services.

Thank you for your time,

Submitter : **Dr. Robert Erickson, II** **Date: 08/15/2007**

Organization : **Dr. Robert Erickson, II**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

We have used therapy inthe office for 27 years. We have had no issues arrise. the care is convenient, inexpensive and patien friendly. I have never had a patient injured or set back in the office therapy. I have had multiple patient problems when treated at off cite therapy facilities. Furthermore the therapists in the office have direct physician oversite which does not happen in free standing settings. I would be happy to come to Washington and testify concerning this issue.

Submitter : **Dr. Brian Boyle** **Date: 08/15/2007**

Organization : **Dr. Brian Boyle**

Category : **Physical Therapist**

Issue Areas/Comments

Physlclan Self-Referral Provisions

Physician Self-Referral Provisions

Please remove physical therapy services from the "in-office ancillary services" exception to the Stark II laws. The practice of physical therapy is licensed in all 50 states with many of those states having direct access to patient care for physical therapy. Unfortunately as the ruling is worded now, there is a great potential for fraud and abuse. When physicians use un-skilled providers to provide care there is no telling what type of care is being provided.

Physical therapists are bound by legal and ethical guidelines. When someone is practicing physical therapy and they are licensed to do such they can be reprimanded and governed by their state board of licensing. If a non-licensed person is providing some sort of treatment under the guise of "physical therapy" services there is no governing body to regulate their practice. This is unsafe for the public and should never be allowed.

Also any referral for profit situation should be avoided at all costs. We have three physician groups in our area that all have physical therapy services as part of their own office. Unfortunately these physician offices often cherry pick the patients that have the best insurance and send those to their own office and refer the others out to other clinics in town such as ours. This has nothing to do with the care they recieve, only financial gains. I understand that business is what it is, but when someone stands to benefit financially why would they not refer to themselves. Worse yet is that physicians can hire anyone to perform care under their "supervision." This person may have a physical therapy degree, but if a physical therapist is demanding $70,000 a year in salary or more and someone else less qualified only wants $35,000 a year, I ask who is going to get the job? Especially when finances are the reason why physical therapy is being offered in the first placc.

I thank you for your time and for allowing mc to comment.

Submitter : **Ms. Ingrid Kelly** **Date: 08/15/2007**

Organization : **TIVA HealthCare**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Thank you for your consideration of this serious matter.

Ingrid Kelly

Submitter : **Ms. Kay Scanlon** **Date: 08/15/2007**

Organization : **Ms. Kay Scanlon**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

It is CRUCIAL that you uphold the requirements for ancillary services. I have heard horror stories from patients who received treatments from unlicensed individuals causing them harm and delayed resolution of their symptoms. Only Physical THerapists have the unique training to provide true physical therapy servies, anything else is merely a sham. PLEASE UPHOLD the current regulation requiring physical therapists are the only ones that can provide physical therapy care as an anxillary service. Thank you for your attention in this matter.

CMS-1385-P-5938

Submitter : Ms. Jill Kopeikin

Date: 08/15/2007

Organization : Dechert LLP

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As an interested consumer, I'd like to see competent professionals stay in the field. Please support the increase for the Anesthesia Conversion Factor.

Submitter : **Dr. Marjean Eastmond** **Date: 08/15/2007**

Organization : **Dr. Marjean Eastmond**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-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 serviees stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Mitchell Stern** **Date: 08/15/2007**

Organization : **Sheridan Children's Healthcare**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Sincerely yours,
Mitchell E. Stern, MD

Submitter : **Dr. John Valadka** **Date: 08/15/2007**

Organization : **Dr. John Valadka**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

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

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

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

Submitter : **Date: 08/15/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please consider closing the Stark II loophole that allows physician owned physical therapy services. As a physical therapist practicing in a hospital based outpatient deparmtment for most of my career, I have witnessed over the past several years an increase in physician owned therapy services. I currently work for a hospital system in a multi-state location and this has occurred over the entire country, not just regionally. The situation causes not only a loss of autonomy of practice for therapists but reduces the ability for therapists to choose employment in an ethical manner. It sets up a situation by which the employeed therapist may be 'pressured' to treat that patient for more visits/units than they may have found medically necessary if they were a clnician not under the employee of the physician. Medicare requires a physician referral before a therapist can evaluate the needs of the patient. By allowing physician to own their therapy practices, because the physician determines frequency and duration of the therapy, they can potentially be motivated by monetary gain rather than clinical judgement. This creates abuse of the system. If a physician referred a patient to a therapist not in their employee or responsible to answer to the physician from a financial standpoint, this is a situation much more likely to create an objective clnical judgment from the physician on the individual needs of that patient.

Please consider closing the loophole that allows physicians to use physical therapists as designated health services. Thank you for your consideration of this comment.