**Submitter :** Dr. Patrick McGannon **Date:** 08/15/2007

**Organization :** Dr. Patrick McGannon

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1385-P-5943-Attach-1.DOC

#594

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

**Organization :** APTA

**Category :** Physical Therapist

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

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

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

Physician Self-Referral Issues.

August 15, 2007

Dear Mr Weems,

I write this letter to you as a Physical Therapist, licensed in the State of NJ for more than 22 years. I wish to offer comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception. I strongly urge CMS to remove Physical Therapy (PT) as a permitted service under the in-office ancillary exception.

My reasons for this are quite simple and direct; the ability to profit from the delivery of PT services delivered incident-to Physician services, provides an obvious incentive to deliver such services, without any benefit to Medicare beneficiaries. I would also argue that permitting such arrangements is clearly against the best interests of Medicare beneficiaries and taxpayers.

It seems to me that as concerns over funding Medicare benefits and controlling program expenditures become an ever-increasing priority; we should do everything possible to discourage overutilization and abuse of this vital program. Allowing Physicians to profit from services that they did not personally deliver, only increases such waste and abuse.

If we allow the rules of the Medicare program to permit, or even encourage such arrangements, we have no one to blame but ourselves. Sadly, the current rules of the program do allow and encourage such abuse, and we need to ensure that these rules are changed to eliminate this abusive and wasteful situation.

As you may note from my letterhead, I practice as a Consultant in Physical Therapy, and in that capacity will sometimes review services delivered in Physicians offices. I may review these serviees as an expert witness in a malpractice action, or on retainer by an insurance company in a claim dispute. I have performed such reviews for nearly ten years now.

My experience in conducting such reviews has given me a clear picture of the care delivered in these settings, and an understanding of what the true motivations in such arrangements. Rest assured that the overriding concern is not patient convenience or one-stop shopping . The incentive is clear and transparent: Referral for profit.

Moreover, I have seen a virtual explosion of these arrangements in the past 5 years or so, as Physicians apparently feel that the rules of the Medicare program permit such lucrative referral-for profit arrangements by virtue of the in-office ancillary exception. In fact, we have seen a virtual cottage industry spring up by companies setting up such Ancillary service revenue streams for Physicians, even as we struggle to finance an overburdened Medicare program.

When one considers that Physical Therapy is a profession in its own right, and that supervision of service delivery is completely unnecessary, one must question why PT should even be considered an ancillary or incident-to service. Again, the answer is simple, control of the service and control of the referral equals control of the monies for that service.

I want to tank you for considering my comments, and urge you to close this damaging loophole in the existing regulations, during your deliberation on the proposed rules for CY 2008. I ask this for the integrity of the both the Medicare program and my profession, both in the interests of Medicare beneficiaries and my fellow taxpayers.

Sincerely,

Kenneth H Mailly, PT
Mailly & Inglett Consulting, LLC
68 Seneca Trail
Wayne, NJ, 07470

CMS-1385-P-5944-Attach-1.PDF

#5444


*Bridging the Gap!*

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

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**68 Seneca Trail, Wayne, NJ, 07470**
**Tel. 973 692-0033** **Fax 973 633-9557**
**www.NJPTAid.biz**


***Bridging the Gap!***

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Sincerely,

Kenneth H Mailly, PT
Mailly & Inglett Consulting, LLC
68 Seneca Trail
Wayne, NJ, 07470



**68 Seneca Trail, Wayne, NJ, 07470**
**Tel. 973 692-0033** **Fax 973 633-9557**
**www.NJPTAid.biz**

**Submitter :** Dr. Jason Park **Date:** 08/15/2007

**Organization :** Dr. Jason Park

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** **Ms. Miriam Castro** **Date: 08/15/2007**

**Organization :** **University of Washington School of Medicine**

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

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Sincerely,
Miriam Castro
Medical Student
University of Washington School of Medicine

#5947

**Address to:**

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

**Subject:** **Physician Self Referrals**

My name is Ann Heiman. I wish to comment on the 7/12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. I am a physical therapist working at Spencer Hospital as the Director of Rehab services. We are in a relatively small area with great physicians and a great hospital. I have been practicing physical therapy since 1996 and love my field. I am hoping you can take a serious look at physician self referrals.

In our town, our orthopedic physicians started there own physical therapy practice in 2003. We have seen a dramatic change of the types of patients we see at the hospital with an increase in Medicare and especially the Medicaid population. Specifically we haven't seen a high school student (unless referred from our family practice physicians), since 2003. Our practice has changed! Many patients are not aware that they have a choice, or that the physician's actually own this physical therapy clinic as they are also located in our hospital.

This letter is intended to highlight the abusive nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

Please help the physical therapists and stop referral for profit physical therapy clinics (physician owned).

Sincerely:

Ann Heiman MS, MPT
Spencer Hospital
1200 1st Ave E
Spencer, IA 51301
712-264-6192
aheiman@spencerhospital.org

**Submitter :** Ms. Donna Hicks **Date:** 08/15/2007

**Organization :** Algwydon Inc. dba Physical Therapy WoRXs

**Category :** Physical Therapist

**Issue Areas/Comments**

**Background**

Background

I am a Physical Therapist Assistant in a private practice setting in Bardstown, KY. I have been a practicing PTA for over 14 years. I am a co owner and PTA in our private practice for 6 years. I am a member of the APTA and KPTA and have been for the last 6 to 7 years and support them in their legislation regarding the abusive financial arragements that are created by POP clinics. Referral for profit is not a fair practice and undercuts the privately owned clinics and the patients who would choose to seek their services. In our town, we have our clinic and another one that is affliated with an orthopedic surgeon. We have been told that his patients are rarely given the choice as to where they can receive their physical therapy but are sent to the practice next door. This practice is paying rent for space in the orthopedic's office space.

These are my comments on the July 12 proposed 2008 physician fee schedule rule, especially the issue surrounding self-referral and the 'in-office ancillary services' exception. I feel that this is an abuse on the part of the physicians and that all patients should be given the choice of where they obtain therapy services. I support removal of this rule.

**Submitter :** **Dr. Mike Carroll** **Date: 08/15/2007**

**Organization :** **Dr. Mike Carroll**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid 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.

Mike Carroll MD

**Submitter :** **Dr. Joseph Forand** **Date: 08/15/2007**

**Organization :** **MO Ass. of Nurse Anesthetists/Soc. of Anesthesiolo**

**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:

The Missouri Association of Nurse Anesthetists, representing 800 members, and the Missouri Society of Anesthesiologists, representing another 800 members, are writing in support of the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. We are also thankful that CMS not only recognized the significant undervaluation of anesthesia services but is also addressing this complex issue by recommending significant increases in anesthesia services compensation.

The institution of RBRVS, over ten years ago, created a huge payment disparity for anesthesia care, due largely to the gross undervaluation of anesthesia work compared to other physician services. Today s Medicare payment for anesthesia services is only $16.19 per 15 minute period. To put this in perspective, $24.95 per 15 minutes or portion thereof is what plumbers are charging in Missouri during normal working hours. Clearly, the Medicare amount does not cover the cost of caring for our senior citizens, creating a system in which anesthesia providers are being forced away from concentrated Medicare population areas.

The recent RUC recommendation to offset a calculated 32 percent with a nearly $3.50 per anesthesia unit increase, while still short of plumber s charges, would go a long way towards correcting the persistent undervaluation of anesthesia services. We, therefore, are pleased to see CMS accept this recommendation and urge full implementation of the RUC s recommendation.

We believe that to ensure our patients have access to quality anesthesia services, it is imperative that CMS enact these proposals as published in the Federal Register and that the anesthesia conversion factor recommended by the RUC be implemented fully and immediately.

On behalf of our combined 1600 members, we thank you for your consideration.

Sharon Gillardi, CRNA
President,
Missouri Association of Nurse Anesthetists

Joseph M. Forand, M.D.
President,
Missouri Society of Anesthesiologists

CMS-1385-P-5950-Attach-1.DOC

#5950

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid 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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Sharon Gillardi, CRNA
President,

Joseph M. Forand, M.D.
President,

Missouri Association of Nurse Anesthetists  Missouri Society of Anesthesiologists

**Submitter :** **Dr. Robert C Foege** **Date: 08/15/2007**

**Organization :** **Beth Israel Deaconess Medical Center**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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Thank you for your consideration of this serious matter.

Robert Foege

**Submitter :** Dr. Susan Maturlo **Date:** 08/15/2007

**Organization :** Endocrinologist

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

1. To support both the House and Senate bills and enact H.R. 1293 & S1338 to define the DRA as advanced medical imaging, excluding preventive services DXA and VFA
2. To enact legislation to fix the Sustainable Growth Rate formula and implement Med Pac s recommendation of a 1.7% increase to reflect its forecast of practice cost increase in 2008.
3. To enact legislation that protects DXA and VFA from cuts imposed by CMS under the new practice expense methodology, Deficit Reduction Act and align them with federal initiatives for preventive services.
4. To re-evaluate the work component, utilization rate, and supplies for DXA and increase practice expense value.

**Submitter :** **Dr. David Theil** **Date: 08/15/2007**

**Organization :** **Rose Medical Center**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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**Submitter :** bruce quinn **Date:** 08/15/2007

**Organization :** bruce quinn

**Category :** Physician

**Issue Areas/Comments**

**IDTF Issues**

IDTF Issues

I wrote a previous comment that the clause, "if any part of the service is performed at the IDTF, the location of service is the IDTF" creates problems for carriers. For example, an IDTF in California could set up a PET facility in Alaska, do part of the image processing in California, and by the CFR definition, the location is service is California. This makes site visits extremely difficult, etc. However, it may ALSO interfere with numerous place of service rules regarding nursing homes, ASCs, etc. For example, INR testing (G0248) will be "place of service" at the IDTF in California, even if the beneficiary is in Iowa. It will be impossible to know where the beneficiary is (Iowa, Florida, Maine) because the POS is California at the IDTF office. But in addition, it will be impossible to identify if the patient is in a SNF, etc, because by definition the POS is the IDTF if any part of the testing service is performed at the IDTF. We received an inquiry whether, for a "non-part-A" resident, a SNF could bill Part A for G0248, which would be extremely costly relative to billing Part A for routine fee schedule INR lab testing. We realized that were the answer know, they could simply set up an IDTF to do the "billing" from its "office" and not the SNF. Additionally, if the IDTFs were abusive, the beneficiary in Iowa at a SNF could be billed for monthly INR by a network of IDTFs in different jurisdictions/contractors, each listing the place of service as the IDTF office. The attribution of POS to the IDTF regardless of the action POS has manifold ramifications through the payment, oversight, and regulatory system.

**Submitter :** **Dr. Paula Moffett** **Date: 08/15/2007**

**Organization :** **Medical Anesthesia Group**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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Thank you for your consideration of this serious matter.

**Submitter :** **Dr. Alan Walters** **Date: 08/15/2007**

**Organization :** **University Anesthesiology Associates**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

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**Submitter :** Mr. John Krug **Date:** 08/15/2007

**Organization :** Mr. John Krug

**Category :** Physical Therapist

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

I am a physical therapist in private practice with 30 years experience. I have always been amazed that physician-owned therapy services are allowed to exist. The abusive nature of this rediculous arrangement that allows a referral source to profit from the services he/she recommends should not be allowed to continue. It has been a destructive force in the physical therapy profession, enslaving therapists to financially greedy physicians, and even promoting the provision of so-called "therapy services" in physician offices by unlicensed ancillary personnel. This has existed in the area in which my practice is located, and has been a detrimental force on my practice since the beginning. I support the removal of physical therapy services from the in-office ancillary exception. Thank you.

**Submitter :** **Dr. Suresh Agarwal** **Date: 08/15/2007**

**Organization :** **Harvey Anesthesiologists SC.**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Suresh P. Agarwal M.D.

**Submitter :** Dr. Charles Honsinger **Date:** 08/15/2007

**Organization :** Resident in training

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

**Organization :** Dr. Michael Inman

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

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**Submitter :** **Dr. Christopher Bernards** **Date: 08/15/2007**

**Organization :** **University of Washington**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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Thank you for your consideration of this serious matter.

**Submitter :** **Dr. Alan Strobel** **Date: 08/15/2007**

**Organization :** **Dr. Alan Strobel**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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.

Alan F Strobel, MD CPC CHC

**Submitter :** Dr. Broughton Jolley **Date:** 08/15/2007

**Organization :** Holston Anesthesia Associates

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

I fully support the CMS idea to increase the Anesthesia conversion factor to a more reasonable rate. The current rate of sixty-five dollars an hour does not cover the cost of taking care of the seniors and disabled.If this rate is left alone it will become more and more difficult to recruit providers to the field. This would also force private payers to foot a larger bill or force hospitals to pay part of the bill to keep their operating rooms open. If one were to look at any other professional service they would find that this hourly rate affords you low quality, poor service, and low availability. Thank you for concidering this change to secure care for the seniors of the USA.

Broughton Jolley

**Submitter :** Dr. christopher kobe dc **Date:** 08/15/2007

**Organization :** Dr. christopher kobe dc

**Category :** Chiropractor

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

Dear CMS: This proposal is a discrimatory act that severely injures the medicare patient. Should CMS implement this proposal, the chiropractic patient would be discrimated against because of the steering of the patient to another practitioner who does not have a license to practice chiropractic. For example, the PA can order a diagnostic x-ray for his orthopedic bretheren and the PA is clearly not the treating provider. This CMS proposal was a reactionary political act to further contain and eventually eliminate the chiropractic profession from the medicare system. Although this proposal clearly restricts the chiropractic profession only, it states no reasonable financial reason for this action. For example if a Medicare patient comes to a physician for a cough, shortness of breath and back pain (common scenario) the physican (and chiroprator should)auscultate and consider a chest film. Let's say that there are wheezes heard and the physician orders a chest film and prescribes antibiotics for the cough and wheezes. The patient then decides to see his chiropractor for back pain. The chiropractor must differentially diagnose the patient for conditions that may contra-indicate spinal manipulation and he/she would consult the chest film, and probably demonstrate a subluxation in the thoracic region. Now, assuming that the proposal is in effect, this x-ray facility must then be notified that a chiropractor looked at those x-rays and that since the physcian treated an infection/bronchitis (seen by the diagnosis code), not the back pain, the x-ray facility must return the money recieved by Medicare for the chest film. This isn't right for CMS, Medicare or the patient. Of course CMS would say to x-ray facilities "don't worry about it, this only affects the chiropractors", thus proving professional discrimination. CMS may say if you, chiropractor, need the patient to have an x-ray, just send them to their MD, and they will refer the patient to the x-ray facility. Wrong! Again the patient cannot benefit from the appropriate diagnostic test without paying for it themselves. The MD must take over care of the patient that needs the chiropractic adjustment. The MD does not practice chiropractic and neither does his physical therapist. You, CMS, quote diagnostic testing including x-rays. This means also any lab, ultrasound, MRI, CT, Angiography and all other diagnostic procdures provided in and out of hospitals that are reviewed by a chiropractor, all these monies to should be returned to CMS. This is rediculous and the proposal is rediculously discriminatory. The proposal should not be allowed. This action focuses only at the chiropractor and does not propose any actual resloution of any cause other than someone having to much time on their hands and way too much money to crosshair the chiropractic patient.

**Submitter :** **Dr. Lyle Saltzman** **Date: 08/15/2007**

**Organization :** **Brevard Anesthesia Services**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Lyle S. Saltzman

**Submitter :** Dr. Steven Gariffo **Date:** 08/15/2007

**Organization :** Pennsylvania Foot and Ankle Associates, P.C.

**Category :** Physical Therapist

**Issue Areas/Comments**

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

Payment For Procedures And Services Provided In ASCs

The potential for fraud and abuse exists whenever physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutlization of physical therapy services under the Medicare program, and enhance the quality of patient care.

? The in-office ancillary services exception is defined so broadly in the regulations that it facilitates the creation of abusive referral arrangements.

? The in-office ancillary services exception has created a loophole that has resulted in the expansion of physician-owned arrangements that provide physical therapy services. Because of Medicare referral requirements, physicians have a captive referral base of physical therapy patients in their offices.

? Physician direct supervision is not needed to administer physical therapy services. In fact, an increasing number of physician-owned physical therapy clinics are using the reassignment of benefits laws to collect payment in order to circumvent incident-to requirements.

Thank You Acting Administrator for your consideration of my comments.

Sincerely,

Dr. Steven M. Gariffo, DPT, MBA, MPT

**Submitter :** **Dr. Robert Coolidge** **Date: 08/15/2007**

**Organization :** **consultant pharmacist**

**Category :** **Pharmacist**

**Issue Areas/Comments**

**GENERAL**

GENERAL

The individual state Boards of Pharmcy and State Boards of Medicine in partnership with DEA should determine what is a safe practice for prescription regulations, i.e. tamper resistant prescriptions and faxing of prescriptions.
Bob Coolidge RPh EMT

**Submitter :** **Mr. Ronald Wist** **Date: 08/15/2007**

**Organization :** **Peninsula Rehab**

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

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

As a physical therapist it is important to me that the patients that we serve are able to get the care they need. However, I think that in this current medical environment physicians are looking for ways to supplement their income and cover expenses. Unfortunately, too many individuals are in business and look at the "numbers" far to closely. Because of this there are abusers out there and are more self serving then patient serving. Because of this I do not support physicians either owning or referring to their PT, OT, SLP pracitces for the sole purposes of profit. This is unethical and goes against theirs and our practice acts and code of ethics. Please take these comments seriously and vote cautiously regarding this topic. Allowing physicians to make profit off of their own referrals, to their own practices is not appropriate nor ethical practice and should not be allowed. Thank you for your time and attention to this issue.
Ron Wist PT

**Submitter :** **Dr. Chrjstopher Young** **Date: 08/15/2007**

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

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

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Thank you for your consideration of this serious matter.

**Submitter :** Dr. shawn pettis **Date:** 08/15/2007

**Organization :** american society of anesthesiologists

**Category :** Physician

**Issue Areas/Comments**

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

Payment For Procedures And Services Provided In ASCs

please provide adequate reimbursement for procedures provided in ASCs,as the planned cuts may decrease patient access to these important procedures and services. thank you for your consideration.

**Submitter :** Dr. shawn pettis **Date:** 08/15/2007

**Organization :** american society of anesthesiologists

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

#5971



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

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

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

**Submitter :** **Dr. shawn pettis** **Date: 08/15/2007**

**Organization :** **interventional pain management**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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Thank you for your consideration of this serious matter.

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

**Organization :** **Physical Therapist**

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

**Issue Areas/Comments**

**GENERAL**

GENERAL

Physical Therapy services should be included in the in-office ancillary services exception

**Submitter :** **Dr. Devi Mahendran** **Date: 08/15/2007**

**Organization :** **Beth Israel Deaconess Medical Center**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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Acting Administrator
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Sincerely,

Dr Devi Mahendran

**Submitter :** **Dr. Devi Mahendran** **Date: 08/15/2007**

**Organization :** **Beth Israel Deaconess Medical Center**

**Category :** **Physician**

**Issue Areas/Comments**

**Coding-- Additional Codes From 5-Year Review**

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

Sincerely,

Devi Mahendran

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

**Organization :** Clinton Physical Therapy Center

**Category :** Physical Therapist

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Dear Administrator:

I am a private practice physical therapist who has co-owned a practice for 19 years in east Tennessee. During this time the proliferation of physician owned physical therapy clinics has become of great concern because of the inherent financial incentive to refer their patients to the practices they have invested in. We already know through the OIG study and others, that physicians overutlize physical therapy services in practices in which they own.

In my practice we have numerous examples of patients who live within a mile or 2 of our facility who are being 'strong-armed' by their physician to go to therapy at the facility in which they have a financial interest. Their facility is over 10-15 miles from their home and of greater cost and inconvenience for the patient to travel to. In discussing this with patients, the physicians are often not disclosing their financial interest. They use justifications such as, "I can watch over you at my facility" when in fact the physician is never present during any physical therapy treatment interventions. Physical therapists do not require physician direct supervision to administer physical therapy services. We have also had a patient tell us their surgeon told them, "they could no longer be their physician if they went somewhere else for therapy". This is a threat to the patient and it is obvious the physician is more interested in his financial gain than the patient's desires and conveniences.
Most of these patients have been treated at our facility previously and have had good experiences and want to return because of the quality care they received and the convenience of staying in their community. They shouldn't have to plead or argue with their physician to be able to return to their facility of choice. We have been in our community 19 years and have an excellent reputation. These physicians sometimes make statements to the patients that 'they will get better care at their facility' which is slanderous to our facility when their is absolutely no basis for this statement in light of our outcomes and patient satisfaction.

The continuation of the loophole in the Stark physician self-referal law needs to be looked at seriously and stopped. This is in the best interest of the patient.

Thank your for your consideration of these comments.

Sincerely,
Kelly J. Lenz, PT

**Submitter :** **Mr. John Pozar** **Date: 08/15/2007**

**Organization :** **Rush University Medical Center, Chicago, IL**

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

**Issue Areas/Comments**

**Background**

Background

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

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA) and a student studying to become a future nurse anesthetist at Rush University in Chicago, I am writing 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 health care 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 under served America. Medicare patients and health care 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 acknowledgment that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

John Pozar
Student Registered Nurse Anesthetist
Rush University

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

**Organization :**

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

**Issue Areas/Comments**

**Background**

Background

Rep Stark had it right the first time.

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Physicians who refer to a clinic where ownership is asking for the fox to guard the hen house. Fraud and abuse is the rule rather than the exception. I have contracted with Physicians and seen the over utilization of physical therapy first hand.

Ancillary services must be removed from thc exceptions to physician self referral. Stop this madness and protect the consumer.

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

**Organization :**

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

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

I would like to comment that in my experience - there are Physician owned Physical Therapy services in my area where the care given is both excessive and also provided in an environment not conducive to quality care. As an owner of a Physical Therapist owned private practice - I have lost Therapists to Physician owned practices because the Therapists were recruited by them with the promise of higher pay and greater contact with physicians. In fact, those Therapists were put in situations where they were treating an exorbitant amount of patients per day - with no time to provide quality or individual care and had very little or no contact or direction from the physicians. The Physician practices are actually reimbursed a greater amount for services than those that are provided in a Physical Therapy owned practice. There are four Physical Therapists in my practice who left my practice to work in Physician owned practices in the past year who have now chosen to resign from those positions due to the poor quality of care they were being asked to provide. Other Therapists are still being recruited with the same kind of promises. I submit that the potential for abuse in this pattern of self-referral is dangerous for the consumer. The care is not even adequate but the doctors in this group have even stated that quality must be sacrificed for quantity. I, myself, have just recently been in contact with a Physician practice who had experienced the resignation of their Physical Therapists due to these kind of poor working and poor professional services. I thought the Physician practice was ready to hopefully allow my practice to provide the Physical Therapy services and bill under my organization and management. I suggested that I rent the space from them and then provide service as I do in our offices that are Physical Therapist owned. This way I could control the quality of the services provided. The Physicians' practice manager said no, that's not what they had in mind - they wanted to hire the Therapists and bill for them because it was very profitable for them - and they were interested in my supplying them with these Therapists and then manage them receiving a management fee - and then it was stated that their practice would also then steer more patients toward my practice offices in other locations. I thought this sounded suspiciously close to fee splitting or at least unethical practice and declined the offer. I should mention that this was not the Physicians offering, but it was their practice manager, so these Therapists are being managed by non-Physician personnel. This is one instance but the same conditions are present in two local Physician owned groups with which I am in contact. I believe this is indicative of conditions all over in relation to these kind of practices. The Stark law was intended to protect from this kind of abuse. Besides fostering poor care for the patient consumer, this also makes it difficult for practices such as mine to survive when we are trying to provide quality of care, with Therapists who are concerned about the individual patient and their needs and not just about treating huge numbers of patients for profit. I believe that Physical Therapy services should not be allowed under the in-office ancillary services exception. Please act to remove Physical Therapy from the in-office ancillary services exception to the federal physician self-referral laws. Thank you.

**Submitter :** Mrs. Lynda Venters **Date:** 08/15/2007

**Organization :** Santa Fe Anesthesia Specialists, PC

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** Dr. Gordon Langston **Date:** 08/15/2007

**Organization :** ACC

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

CMS-1385-P - Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies

Please support these revisions. We have struggled with increases in cost that we have no control over and have had little relief on the funding side. Thank you in advance.

Gordon M Langston MD

**Submitter :** Ms. Christine Wells **Date:** 08/15/2007

**Organization :** Sheridan Healthcorp

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

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Thank you for your consideraton of this serious matter.
Christine Wells

**Submitter :** Dr. Leopoldo Rodriguez **Date:** 08/15/2007

**Organization :** Aventura Hospital and Medical Center

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Leopoldo G Rodriguez MD
Diplomate American Board of Anesthesiology
Fellow of the American Academy of Pediatrics (Anesthesiology)
Diplomate of the National Board of Echocardiography (PTE)
Chief of Anesthesiology
Aventura Hospital and Medical Center
20900 Biscayne Blvd
Aventura FL 33180
305-682-7210

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

**Organization :** SOS Rehabilitation

**Category :** Physical Therapist

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

As a praticing physical therapist, employed by a group of physician's,I am opposed to changes in the "ancillary services" regulations being proposed. Although employed by physicians, I am able to treat in an autonomous manner, and my opinion matters. Having worked the previous 19 years in private practice I can truly speak to both sides of the issue and it is clear to me that although there are positives and negatives to both sides, physicians should not be barred from offering patients in-house services should they (the patient) elect to utilize them. Please leave the current Stark regulations in place and do not fall prey to lobbyists that have you believe that the current system does not work.

**Submitter :** Dr. Fernando Ortiz **Date:** 08/15/2007

**Organization :** Dr. Fernando Ortiz

**Category :** Physician

**Issue Areas/Comments**

**Coding-- Additional Codes From 5-Year Review**

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**Submitter :** **Dr. Joseph Rogers** **Date: 08/15/2007**

**Organization :** **Clarksville Chiropractic**

**Category :** **Chiropractor**

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

Sincerely,
Dr. Rogers

**Submitter :** **Dr. Brooke Gajeski** **Date: 08/15/2007**

**Organization :** **Dr. Brooke Gajeski**

**Category :** **Chiropractor**

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

I am a chiropractic radiologist and this proposed item very much upsets me. Not only, as a chiropractor, can I not bill CMS for any films I take, but further I can not even under the proposed item, send those patients to a facility to get the films taken to properly treat the patient. Being a radiologist and chiropractor this is an even more important issue to me. As a chiropractor, radiographic information is a must for us to effectively and safely treat a patient. The proposed rule dated July 12th contained an item under the technical corrections section calling for the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a MD or DO and used by a Doctor of Chiropractic to determine a subluxation, be eliminated. I am writing in strong opposition to this proposal.

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

Sincerely,
Dr. Gajeski

**Submitter :** **Dr. Steven Wheeler** **Date: 08/16/2007**

**Organization :** **Dr. Steven Wheeler**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Leslie V. Norwalk, Esq.
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Attention: CMS-1385-P
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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

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

Thank you for your consideration of this serious matter.

Steven Wheeler, M.D

**Submitter :** Dr. Ron Joyner **Date:** 08/16/2007

**Organization :** Joyner Rehabilitation Center

**Category :** Physical Therapist

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Dear administrators,
I would like to address that the issue of Referral for Profit is alive and well in this state and country. The legalized formats that are circumventing the Stark law are currently hiding in the form of LLCs with mega buck centers that now house everything from the doctors office, clinical labs, radiology x-ray and MRI, surgcy centers, PT/OT, and multiple other entitics These havc bccn previously addressed in regulation. It has been brought to my attention that CMS is considering opening or loosening the regulations governing these type referral for self profit organizatins. You have been givcn rcliable and valid data that shows misusc and fraud within these organizational structures. How do you not protect the public then from those that continue their fclonious behavior. I strongly condemn the thought you may have of opening pandora's box with removal of the Stark Law. The healthcare of the American society is being forced to makc extemely difficult decisions on their healthcare and to add insult by renewing the free for all battle with such illegal behavior and sham is hypocrisy. A capitalist society with free enterprise is not currently being held to high standards. The people of this country need protection not a renewal of corruption that ha been previously documented and is curnetly held accountable at this very time. Just this month in Miami your fraud division uncovered over $100 million of fraudulent billing. wouldn't that make you examine the continued loss of tax dollars. Many studies reveal these type practices abusc the recipient in waste as well as the poor taxpayer who pays twice for such corruption. I ask for a No vote on lifting or weakenig the Stark LAw. It needs to be re-visited with more teeth than what is currently being rendered. I would hope common sense prevails and not the inept excuses so often heard. Buying and selling public trust has it's price which the Stark law helped maintain. i would hope you will continue to do the same and no less.
Ron Joyner