Submitter : Mrs. Melissa Hatch **Date:** 08/17/2007

Organization : AANA

Category : Other Practitioner

Issue Areas/Comments

Background

Background

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

This increase in Medicare payment is important for several reasons.

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Sincerely,

Melissa Hatch, CRNA
406 Hanson Rd
Durham, NC 27713

Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physicians continue to take advantage of a loophole in the Stark physician self referral law by establishing Physician Owned Physical Therapy Services (POPTS).

By allowing physicians to refer to in-house physical therapy (an exception to the Stark prohibition permitted under the in-office ancillary services), CMS allows and encourages a financial conflict of interest. The physician is incentivized to refer patients to his employee (PT) for financial gain. In cases of inappropriate care, the employee (PT) could question his employer (MD), but in many cases, the financial rewards (reimbursement fee-splitting) for both the employer (MD) and employee (PT) outweigh the ethical consideration of what is best for the patient.

When the MD directs the patient to his POPTS, the patient s freedom of choice is violated. The patient cannot go to the most qualified provider. The choice of provider has been made by the referring physician. The financial considerations take priority over the needs of the patient. This is an abuse of the patient, and often the patient is unaware that there are other options.

Utilization research has shown that patients are referred by physicians more frequently, for longer durations of care, at higher costs (to the taxpayers), to a POPTS, compared to referral to a non-POPTS.

CMS should remove physical therapy from the in-office ancillary services exception to the physician self referral law.

Submitter : Mr. Michael Gosnell **Date:** 08/17/2007

Organization : Jackson County EMS

Category : Health Care Provider/Association

Issue Areas/Comments

Ambulance Services

Ambulance Services

Our organization provides emergency ambulance services to the citizens and visitors to Jackson County Georgia. The proposed rule would have a direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. We therefore greatly appreciate this opportunity to submit comments on the proposed rule.

BENEFICIARY SIGNATURE

Our organization commends CMS for recognizing that providers and suppliers of emergency ambulance transportation face significant hardships in seeking to comply with the beneficiary signature requirements. Ambulance services are atypical among Medicare covered services to the extent that, for a large percentage of encounters, the beneficiary is not in a condition to sign a claims authorization during the entire time the supplier is treating and/or transporting the beneficiary. Many beneficiaries are in physical distress, unconscious, or of diminished mental capacity due to age or illness. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

We believe strongly, however, that the relief being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and on the hospitals. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for ambulance services.
The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. Our organization strongly objects to this new requirement as:

" Instead of alleviating the burden on ambulance providers and suppliers, an additional form would have to be signed by hospital personnel.
" Hospital personnel will often refuse to sign any forms when receiving a patient.
" If the hospital refuses to sign the form, it will be the beneficiary that will be responsible for the claim.
" The ambulance provider or supplier would in every situation now have the additional burden in trying to communicate to the beneficiary or their family, at a later date, that a signature form needs to be signed or the beneficiary will be responsible for the ambulance transportation.
" Every hospital already has the information on file that would be required by this Proposed Rule in their existing paperwork, e.g. in the Face Sheet, ER Admitting Record, etc.

It is important for CMS to realize that, for every transport of a Medicare beneficiary, the ambulance crew completes a trip report listing the condition of the patient, treatment, origin/destination, etc. AND the origin and destination facilities complete their own records documenting the patient was sent or arrived via ambulance, with the date. Thus, the issue of the beneficiary signature should not be a program integrity issue.

Submitter : **Mrs. Susan Wiseman** **Date: 08/17/2007**

Organization : **AANA**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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

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Sincerely,

Susan H. Wiseman CRNA
1504 Arroyo Drive
Windsor, CO 80550

Submitter : Mrs. Amanda Romero **Date:** 08/17/2007

Organization : AANA

Category : Nurse Practitioner

Issue Areas/Comments

Background

Background

August 17, 2007

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

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Sincerely,

Amanda L. Romero, MSN, RN, APRN,BC, SRNA
1345 Bell Road #314
Antioch, Tennessee 37013

Submitter : Maureen Lefkowitz **Date:** 08/17/2007

Organization : Interventional Pain Management of Palm Beach

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Reimbursement for Intrathecal pump management for chronic pain patients: There is much that goes into maintaining and monitoring a patient with an intrathecal pump. The liability is high, the doctor must arrange to see the patient on a moment's notice. Ordering the medication and maintaining it's availability for the pt. Pt goes in the hospital and the Doctor must eat the cost of the medication. The Doctor's are simply not getting reimbursed enough to want the liability and extra hrs it involves from nursing staff and the Doctors time, worry, and effort.The Doctor is not being even reimbursed for the refill kit whic he pays to fill the intrathecal pump.

Submitter : Mr. Glen Gomez **Date:** 08/17/2007

Organization : Physiotherapy Associates Benchmark

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam,
The real issue here is the abuse caused by those physicians who provide "physical therapy services" to their patients without a licensed physical therapist supervising the actual treatment and creating a treatment plan. Many of these "physican owned- physical therapy clinics" aka "POPS" have shown to over utilize modalities, treatment sessions and bill more than the national average of other clinics. Studies have shown that these "POPS" have overbilled by the millions over the past 5 years. My other concern that training that a medical physician receives is quite different than that of a PT. PT's are specialized and trained in areas of expertise with emphasis in manual therapy techniques, exercise diagnosis and progression, and hands on- training. I feel that as a tax-payer PT's are better equipped to provide PT because of their training. Physician self-referral has to stop, millions of tax-dollars are being wasted.

Submitter : **David Barclay** **Date: 08/17/2007**

Organization : **Kalamazoo Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.
David Barclay, M.D.

Submitter : Mr. John Delaney **Date:** 08/17/2007

Organization : Mr. John Delaney

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

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Sincerely,

John T Delaney CRNA

13 Orchard Street

Blackstone, MA 01504

Submitter : Dr. Kalyani Trivedi **Date:** 08/17/2007

Organization : California Pacific Medical Center

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

I recommend that the proposed bundling (CPT 93325 with 76825, 76826, 76827, 76828, 93303, 93307, 93308, 93312, 93314, 93315 93317) be not implemented without appropriate evaluation including consideration for revision of RVUs for echo codes. Without parallel updating of the RVU value it will impact critically on the resources available for pediatric cardiology programs.

CMS-1385-P-6465-Attach-1.DOC

#6465

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Submitter : **Scott Shaffer** **Date: 08/17/2007**

Organization : **CRAFT Anesthesia, PC**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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Sincerely,

Scott K.Shaffer, CRNA
10940 County Road 240
Salida, CO 81201

Submitter : **Dr. Robert Husfield** **Date: 08/17/2007**

Organization : **Dr. Robert Husfield**

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.

Robert Husfield M.D.
Chairman Dept.of Anesthesiology
La Grange Memorial Hospital

Submitter : **Ms. Raquel Kitto** **Date: 08/17/2007**

Organization : **Ms. Raquel Kitto**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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Sincerely,

Raquel E. Kitto, MS, CRNA
14476 Bournemuth Drive
Shelby Township, MI 48315

Submitter : **Keith Scott** **Date: 08/17/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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Sincerely,

Keith Scott, CRNA
1911 S. College Street
Trenton, TN 38382

Submitter : **Date: 08/17/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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Submitter : **Date: 08/17/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have been a Physical Therapist since 1994 & over that time I have seen many changes, not the least of which has been the proliferation of physician-owned practices.
Several times a year, I am contacted by former patients wanting to resume treatment for a new condition following treatment at physician-owned facilities; they have similiar complaints (clinic too small, clinic too erowded, not enough individual attention, etc.
The bottom line is this: I have to be good to survive in practice. 'Good' means setting reasonable goal with the patient & progressing them toward functional goals. A physician-owned physical therapy practice, on the other hand is basically a monopoly. He or she generates their own flow a business via self-referral.

Submitter : Dr. Paul Hester **Date:** 08/17/2007

Organization : Anesthesia Associates of Lancaster

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.

Sincerely,

Paul S. Hester, M.D.

Submitter : **Dr. Mehul Sekhadia** **Date: 08/17/2007**

Organization : **Dr. Mehul Sekhadia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Mehul Sekhadia, DO
Clinical Instructor
Department of Anesthesiology and Pain Management
Northwestern Memorial Hospital

Submitter : **Mr. Andrew Olson** **Date: 08/18/2007**

Organization : **Student of Midwestern University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

Sincerely,

Andrew Olson, SRNA

12313 W Berridge ln

Litchfield Park, AZ 85340

Submitter : **Date: 08/18/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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August 20, 2007
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Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,

_Budonna Swafford, CRNA_____
Name & Credential
_227 Lake Terrace Drive_____
Address
_Hendersonville, Tn 37075_____
City, State ZIP

Submitter : Mr. Rye Garrels **Date:** 08/18/2007

Organization : Mr. Rye Garrels

Category : Other Health Care Provider

Issue Areas/Comments

Background

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August 20, 2007
Ms. Leslie Norwalk, JD
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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,
Rye Kelton Garrels, CRNA
Name & Credential
164 Raphael ct
Martinsburg, WV 25403

Submitter : **Dr. Brian Calhoun** **Date: 08/18/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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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. Quality of care cannot be taken for granted. At some reimbursement level, quality suffers.

Sincerely,
Brian Calhoun, M.D.

Submitter : Mr. Chau Tran **Date:** 08/18/2007

Organization : Mr. Chau Tran

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Chau Tran, CRNA

Submitter : **Sharon Pearce** **Date: 08/18/2007**

Organization : **Sharon Pearce**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

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

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Sincerely,

Sharon Pearce, CRNA, MSN
1366 Beeks Nursery Road
Lexington, NC 27292

Submitter : **Date: 08/18/2007**

Organization :

Category : **Local Government**

Issue Areas/Comments

Ambulance Services

Ambulance Services

Beneficiary Signature

Thank you for the opportunity to submit comment.

'...and (3) a signed contemporaneous statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the time and date that the beneficiary was received by that facility.' This portion of the requirement is unnecessary.

To include all three requirements is not taking away burden on the ambulance provider - it is placing further requirements to now document 3 different but similar items on each emergency response for medicare beneficiaries. To make these changes, you must consider the implications for EMS providers in the area of altering existing electronic medical records software to accommodate the additional statements. As we have moved to electronic records and electronic signatures for our patients and staff along with the statement from the hospital that they received the patient, creating a new paper form would be inpractical and unnecessary and not conducive to maintain electronic records. We would be required to work with our software vendor to alter the programming code to include additional statements/signature area which will likely require a fee associated with a custom change to the program. This could possibly be prevented if an EMS system was allowed to establish a policy statement that the current acquisition of signatures also indicates the making of the contemporaneous statement required by the proposed rule. If signatures cannot be combined for multiple purposes, and if use of the existing documentation of the date/time/location of transport is not permitted, the additional burden on EMS systems to obtain additional documentation is underestimated.

As to the requirement of obtaining a signature from the receiving facility, again, this is not always practical due to the burdened emergency department staff and system. Many times, signatures may not be obtained due to staff unavailability in the emergency department. The requirement of obtaining all three pieces is unnecessary and overkill. The EMS system already gathers the date/time/location of the patient; the addition of a separate statement verifying is unnecesssary as the paramedic already signs the patient care record verifying the information included and should suffice for verification of patient information/lack of signature. Currently, our staff indicates in the signature location for the patient the reason for not signing; this should suffice without the need for reprogramming our software to now include an additional statement. If signatures cannot be combined for multiple purposes, the cost associated with adding an additional signature line and statement will be incurred for software modifications; the options of using paper is contradictory to the universal effort to maintain electronic medical records and would create a burden of space and time to file and associate the form with the electronic record.

Thanks for allowing comment and we trust you will consider the additional issues of requiring multiple signatures on a apparently separate form and process.

Submitter : **Dr. John McDowell** **Date: 08/18/2007**

Organization : **Dr. John McDowell**

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
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Sincerely,
John McDowell, MD

Submitter : **Mr. Matthew Bryant** **Date: 08/18/2007**

Organization : **Mr. Matthew Bryant**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,

Matthew Bryant RN, CCRN, SRNA
301 Wilcrest Drive #6803
Houston, TX 77042

Submitter : **Mrs. Sandra Doiron** **Date: 08/18/2007**

Organization : **Martin County Anesthesiology**

Category : **Other Health Care Professional**

Issue Areas/Comments

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Sincerely,
Sandra Doiron, CRNA

Submitter : **Mr. stanley kristiansen** **Date: 08/18/2007**

Organization : **aana**

Category : **Other Health Care Professional**

Issue Areas/Comments

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Stanley Kristiansen CRNA
880 romans way
bloomington Indiana
47401

Submitter : **David Dornhoffer** **Date: 08/18/2007**

Organization : **David Dornhoffer**

Category : **Other Health Care Professional**

Issue Areas/Comments

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Please respect the aged and rural population enough to ensure them access to the highest quality of anesthesia care possible.

Submitter : **Ms. Nanciann Klein** **Date: 08/18/2007**

Organization : **American Association of Nurse Anesthetists (AANA)**

Category : **Other Health Care Professional**

Issue Areas/Comments

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Thank You.
Nanciann Klein, SRNA
Baltimore, MD

Submitter : Dr. Todd Watson **Date:** 08/18/2007

Organization : Western Carolina University

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Excluding physical therapy services as an 'in-office ancillary service' is an important provision for consumers. First, self-referral limits consumer choice. The consumer may not recognize this loss of choice, as typically no other option is offered to the patient. Observation of the above board responsibility between physician and patient is vital to preserving both consumer choice and the autonomous practice of the physical therapist.

Secondly, there exists conflict of interest when the physical therapist is employed by the physician which may comprimise the best interests of the patient for financial gain by the physician owner. Having a financial interest in physical therapy services to which a physician refers a patient may cloud the physician s judgment as to the need for the referral, as well as the length of treatment required. Similarly, the physical therapist employed by a physician may face pressure to evaluate and treat all patients referred by the physician, without regard to the patient s needs. The consumer is most often unaware of any conflict of interest, and assumes no conflict of interest exists when physical therapy is provided within the physician s office. Physician associations have argued that self-referral to a physician-employed physical therapist is not a conflict of interest by labeling physical therapy as an ancillary service, , one provided incident to physician practice. However, the suggestion that physical therapy is not a separate profession is clearly wrong.

Finally, physician self-referral creates economic and financial harm. Physician owned physical therapy services (POPTS) are nothing more than referral for profit. POPTS would not exist if these 'in-office ancillary services' were budget negative or even budget neutral. The fact is they are extremely buget positive. The harm done by POPTS is not merely a matter of principle or abstract ethics. Health policy researchers have provided data demonstrating specific harms from conflict of interest in physical therapy referrals. Studies have demonstrated that POPTS arrangements have a significant adverse economic impact on consumers, third-party payers, and physical therapists. In a study examining costs and rates of use in the California Workers Compensation system, Swedlow et al reported that physical therapy was initiated 2.3 times more often by the physicians in self-referral relationships than by those referring to independent practices (NEJM 1992). In a subsequent symposium address by two of the study s authors, Johnson and Swedlow noted that physical therapy accounted for an estimated $575 million per year in California workers compensation costs. Furthermore, they concluded that the phenomenon of self-referral or POPTS generates approximately $233 million per year in services delivered for economic rather than clinical reasons. (1992)

In a study appearing in the Journal of the American Medical Association, Mitchell and Scott documented higher utilization rates and higher costs associated with services provided in POPTS (referred to as joint venture clinics) in the state of Florida.(JAMA 1992) The study revealed greater utilization of physical therapy services by the joint venture clinics, rendering on average about 50 percent more visits per year than their counterparts. It also concluded that visits per physical therapy patient were 39 percent higher in joint venture clinics.(p2057) Joint venture clinics also generated almost 32 percent more net revenue per patient than their counterparts.

In conclusion I would like to state that I support legislative and regulatory measures at both the state and federal levels to ban physician ownership of physical therapy services. I have attached a copy of the American Physical Therapy Association's Position on POPTS to provide greater detail of the ramifications of referral for profit.

CMS-1385-P-6487-Attach-1.PDF

#648

Position on Physician-Owned Physical Therapy Services (POPTS)

January 2005

An American Physical Therapy Association White Paper

An American Physical Therapy Association White Paper

Position on Physician-Owned Physical Therapy Services (POPTS)

January 2005

Introduction

Physical therapy referral for profit describes a financial relationship in which a physician, podiatrist, or dentist refers a patient for physical therapy treatment and gains financially from the referral. A physician can achieve financial gains from referral by (a) having total or partial ownership of a physical therapy practice, (b) directly employing physical therapists, or (c) contracting with physical therapists. The most common form of referral for profit relationship in physical therapy is the physician-owned physical therapy service, known by the acronym "POPTS." The problem of physician ownership of physical therapy services was first identified by the physical therapy profession in the journal *Physical Therapy* in 1976.[1] While POPTS relationships were still limited in number in 1982, Charles Magistro, former APTA President, characterized POPTS as, "a cancer eating away at the ethical, moral and financial fiber of our profession."[2]

For many years, the American Physical Therapy Association (APTA) has opposed referral for profit and physician ownership of physical therapy services, taking the position that such arrangements pose an inherent conflict of interest impeding both the autonomous practice of the physical therapist and the fiduciary relationship between the therapist and patient. What became known as "the POPTS issue" was addressed by APTA's House of Delegates in 1983, 1985, and 1999, with APTA specifically opposing referral for profit arrangements between physicians and physical therapists.[3,4,5] The 2003 APTA House of Delegates once more resolved to develop state and federal legislative initiatives to achieve legal prohibition of POPTS.[6] However, in recent years, facing pressures of decreasing revenues and increased costs of malpractice insurance premiums, and aided by weakening of federal antitrust legislation, physicians have accelerated the addition of POPTS to their practice. APTA's push to achieve autonomous practice and direct access are in conflict with the medical profession's renewed push to subsume physical therapy as an ancillary service for financial gain.

At the center of the clash between these two opposing forces are two questions: First, should one profession be able to claim financial control over another? Second, what are the real and potential consequences of referral-for-profit relationships and, more specifically, POPTS? Physical therapists must be unified in their vision of physical therapy as a profession, accepting the rights and responsibilities that come with such a designation. Only when members of the profession view themselves as autonomous professionals will they present themselves to consumers and the medical community as such and curtail their own participation in referral-for-profit relationships, including POPTS. Within physical therapy practice and the broader medical community, there must be renewed examination of the ethical and legal consequences of referral-for-profit relationships, and a push to strengthen legislative and regulatory prohibitions of such relationships.

Evolution of Physical Therapy as an Autonomous Profession

A profession commonly is defined as an occupation, the practice of which influences human well being and requires mastery of a complex body of knowledge and specialized skills, requiring both formal education and practical experience.[7] Other elements of a profession include responsibility for keeping and advancing a body of knowledge; setting credible, useful standards; and self-governance.

In less than 80 years, the physical therapy profession evolved from a small group of women providing physical therapy to World War I soldiers and veterans to more than 110,000 men and women licensed as physical therapists and assistants, more than 66,000 of whom are represented by its professional organization, APTA. Physical therapists formed their first professional association in 1921. By the end of the 1940s, the APTA established its policy-making body, the House of Delegates.

As the Association further formalized its professional identity, the House of Delegates approved the Association's Code of Ethics in 1935, articulating principles for the ethical practice of physical therapy. The APTA Judicial Committee (now the Ethics and Judicial Committee) in 1981 adopted the Guide for Professional Conduct, which interprets the Code of Ethics. APTA further described the profession with the publication of *Guide to Physical Therapist Practice*,[8] representing a "framework for describing and implementing practice."[9]

In 1977, the Association assumed independent control for establishing educational standards through the Committee on Accreditation in Education (CAE), the forerunner of the Commission on Accreditation in Physical Therapy Education (CAPTE). As the profession expanded the scope of its services and the clients it served, physical therapy education programs also evolved, growing in depth and length from certificate programs to bachelor's and master's degrees. By 2007, 80 percent of all entry-level physical therapist education programs will be at the doctoral level, reflecting APTA's Vision 2020 Statement, "By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy."[10]

Simultaneous with the profession's development of rigorous educational standards, a successful movement for licensure as autonomous practitioners was mounted. State licensure eventually replaced a "registry" that had been controlled by a physician board, culminating in physical therapist licensure in all 50 states.

For 25 years, the profession has demonstrated its commitment to establishing a unique and complex body of knowledge through the work of the Foundation for Physical Therapy. The Foundation has funded research that supports the development of evidence-based physical therapist practice, awarding more than $10 million in grants and scholarships to hundreds of researchers.

Physical Therapist: Professional Practice Owner or Employee?

Clearly, physical therapy meets the definitions of profession. As such, physical therapists should enjoy the legal protections accorded other professionals. In many states, professionals may not practice as agents of corporations except those formed as professional corporations,

in which all owners must be licensed to practice one profession. By adopting such laws states have prevented the inherent conflict that exists when one profession refers to another within the corporation for financial gain.

Historically, physical therapists were employed most frequently by hospitals, or other health care institutions. Ideally, as health care delivery evolves into other business models, physical therapists will seek business arrangements allowing control of the practice to be held by physical therapists, operating as independent or autonomous professionals. However, because physicians still largely control referrals for physical therapy, many physical therapists elect to become employees of physician professional corporations. A 2004 APTA survey on POPTS reported that more than 80 percent of the responding therapists encountered situations in which physicians retained patients within their own practices, rather than referring patients to other physical therapy providers.[11]

Real and Potential Effects of POPTS on Consumers

Conflict of Interest. Once a physical therapist is employed by a physician or physician group, a conflict of interest exists, in which the best interests of the patient or client may be compromised for financial gain by the physician owner. Having a financial interest in other services to which a physician refers a client may cloud the physician's judgment as to the need for the referral, as well as the length of treatment required. Similarly, the physical therapist employed by a physician may face pressure to evaluate and treat all patients referred by the physician, without regard to the patient's needs. The consumer is likely unaware of any conflict of interest, assuming no conflict of interest exists when the service is provided within the physician's office. Physician associations have argued that self-referral to a physician-employed physical therapist is not a conflict of interest by labeling physical therapy as an "ancillary service,", one provided "incident to" physician practice. However, the suggestion that physical therapy is not a separate profession is clearly wrong.

Loss of Consumer Choice. In addition to inherent conflicts of interest that exist within POPTS, physician referral to services within his/her office, or to those with whom he/she may have a financial interest, limits the consumer's right to choose his/her physical therapist. The consumer may not recognize this loss of choice, as no other option is offered. Observation of the fiduciary responsibility between physician and patient is vital to preserving both consumer choice and the autonomous practice of the physical therapist.

Economic and Financial Harm. The harm done by POPTS is not merely a matter of principle or abstract ethics. Health policy researchers have provided data demonstrating specific harms from conflict of interest in physical therapy referrals. Studies have demonstrated that POPTS arrangements have a significant adverse economic impact on consumers, third-party payers, and physical therapists. In a study examining costs and rates of use in the California Workers' Compensation system, Swedlow et al reported that physical therapy was initiated 2.3 times more often by the physicians in self-referral relationships than by those referring to independent practices.[12] In a subsequent symposium address by two of the study's authors, Johnson and Swedlow noted that physical therapy accounted for an estimated $575 million per year in California workers' compensation costs. Furthermore, they concluded that the

"phenomenon" of self-referral or POPTS "generates approximately $233 million per year in services delivered for economic rather than clinical reasons."[13]

In a study appearing in the *Journal of the American Medical Association*, Mitchell and Scott documented higher utilization rates and higher costs associated with services provided in POPTS (referred to as joint venture clinics) in the state of Florida.[14] The study revealed greater utilization of physical therapy services by the joint venture clinics, rendering on average about 50 percent more visits per year than their counterparts. It also concluded that visits per physical therapy patient were 39 percent higher in joint venture clinics.[14(p2057)] Joint venture clinics also generated almost 32 percent more net revenue per patient than their counterparts.

Rationale for Opposition to POPTS

Ethical Prohibitions. APTA and the American Medical Association actually agree on the fundamental principle of conflict of interest. The APTA Code of Ethics[15] and Guide for Professional Conduct [16] require that a physical therapist shall seek only such remuneration as is deserved and reasonable for physical therapy services (Principle 7). The Guide contains specific prohibitions against placing one's own financial interest above the welfare of individuals under his/her care (7.1.B), as well as overutilization of services (7.1.D). The Guide also requires physical therapists to disclose to patients/clients if the referring physician derives compensation from the provision of physical therapy (7.3). The AMA, like APTA, rejects the conflict of interest inherent in referral for profit. The AMA Council on Ethics and Judicial Affairs (CEJA) has said that, "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients,"[17] and that, "physicians should not refer patients to a health care facility which is outside their office practice and at which they do not directly provide care or services when they have an investment interest in that facility."[18] The latter statement could be interpreted to prohibit referral to physical therapy practices in which a physician has an investment interest when he/she does not directly provide care or services to the referred patient.

Legal and Regulatory Prohibitions. Real and potential conflicts of interest among physicians with financial interests in entities to which they refer were recognized by members of Congress in the 1980s. The correlation between financial ties and increased utilization was the impetus for Congress to enact the "Stark I" law in 1989,[19] preventing Medicare from paying for clinical laboratory services if the referring physician had a financial interest in the facility. In 1993, Congress enacted the "Stark II" law, which expanded the list of services to which the laws applies to include physical therapy services[20] Specifically, the law states that if a physician or a member of a physician's immediate family has a financial relationship with a health care entity, the physician may not make referrals to that entity for the furnishing of designated health services (including physical therapy services) under the Medicare program, unless an exception applies. After the law was enacted, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) issued final regulations implementing the law on January 4, 2001.[21] Unfortunately, bowing to physician interests, the agency wrote rules that enable physicians to structure their practices in order to furnish physical therapy in their offices (so-called "incident to" services discussed previously) without violating the law.

Conclusion

Recognizing the incongruity of POPTS and APTA's Vision 2020 that embraces the autonomous practice of doctorally prepared professionals, the inherent conflicts of interest existing within POPTS, the loss of the patient/client's right to choice of provider, and the increased cost to society identified resulting from POPTS, the American Physical Therapy Association reaffirms its decades-long position of opposition to physician-owned physical therapy services. APTA supports legislative and regulatory measures at the state and federal levels to ban physician ownership of physical therapy services. These efforts include sponsoring efforts to strengthen state practice acts to prohibit POPTS—and gaining direct access to Medicare patients.

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[5] *Progress Report.* 1985;14(7):5.
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[7] The Online Ethics Center for Engineering and Science at Case Western Reserve University. Available at http://onlineethics.org/glossary.html. Accessed July 23, 2004.
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[10] APTA House of Delegates. APTA Vision Sentence for Physical Therapy 2020 and APTA Vision Statement for Physical Therapy 2020 (HOD 06-00-24-35). American Physical Therapy Association. 2000. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_I/GOALS_AND_MISSION/HOD_06002435. Accessed January 7, 2005.
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[12] Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California workers' compensation system as a result of self-referral by physicians. *NEJM.* 1992;327:1502-1506.
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[16] APTA Ethics and Judicial Committee. Guide for Professional Conduct. American Physical Therapy Association. 2001. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_4/GUIDEFORPROCONDUCT. Accessed January 7, 2005.
[17] AMA Council on Ethics and Judicial Affairs. Current Opinions. American Medical Association. Available at http://www.ama_assn.org/ama/pub/category/2498.html. Accessed November 23, 2003.
[18] American Medical Association Council on Ethics and Judicial Affairs. Current Opinions E-8.03 Conflicts of Interest: Guidelines and E08.02 Conflicts of Interest: Health Facility Ownership by a physician. Available at http://www.ama-assn.org/ama/pub/category/2498.html. Accessed November 23, 2003.
[19] Omnibus Budget Reconciliation Act of 1989, Pub L No. 101-329, Section 6204.
[20] Omnibus Budget Reconciliation Act of 1993, Pub L No. 103-66, Section 13562.
[21] 66 *FR* 855 (Jan 4, 2001) (codified at 42 CFR Parts 411 and 424).

American Physical Therapy Association
The Science of Healing. The Art of Caring.℠
www.apta.org

Submitter : **Dr. Peter Brandrup** **Date: 08/18/2007**

Organization : **U.S. Army**

Category : **Federal Government**

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.

CPT Peter Brandrup
WBAMC Ft. Bliss, Tx

Submitter : Mrs. Suzanne Wester **Date:** 08/18/2007

Organization : AANA

Category : Other Practitioner

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

Suzanne Wester, CRNA
189 Azalea Chase Dr.
Suwanee, GA 30024

Submitter : Mrs. Cynthia Struick **Date:** 08/18/2007

Organization : AANA

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
RE: CMS 1385 P (BACKGROUND, IMPACT)
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Sincerely,

Cynthia Struick
CRNA
Hillsborough, NC 27278

Submitter : **Dr. Kenneth Cheng** **Date: 08/18/2007**

Organization : **University of Rochester 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

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. Larry Ydens** **Date: 08/18/2007**

Organization : **Dr. Larry Ydens**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

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Thank you for your consideration of this serious matter.

Sincerely

Larry Ydens MD
Albuquerque, NM

Submitter : **Mr. Thomas Nolan** **Date: 08/18/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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? 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).

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Sincerely,

Thomas J. Nolan, CRNA
765 Upper Ridge Road
Bridgton, ME 04009

Submitter : **Date: 08/18/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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. In these situations, physicians 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 furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutilization of physical therapy services under the Medicare program, and enhance the quality of patient care.

Submitter : Dr. Donna Kucharski **Date:** 08/18/2007

Organization : Rhode Island Society of Anesthesia

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Please support these changes as the American Society of Anesthesia has recommended for continued quality care for all CMS patients!

Donna Kucharski, MD

Submitter : **Mrs. Pamela Bouley** **Date: 08/18/2007**

Organization : **Mrs. Pamela Bouley**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

Sincerely,

Pamela Bouley, CRNA
211 Millstone Dr.
Apt. T
Florence, SC 29505

Submitter : Mr. christopher hoeman **Date:** 08/18/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Sincerely,

Christopher Hoeman, CRNA
135 lake street
Middleton, MA 01949
978-774-5465

Submitter : Dr. Erin McCallum **Date:** 08/18/2007

Organization : Dr. Erin McCallum

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To whom it may conocern: I am a physical therapist, practicing in a hospital-based out-patient facility. I am strongly opposed to the loop-hole in the Stark laws that allows for physicians to refer patients to thier own physical therapy practices in their office. This is a classic example of a kickback, and encourages inappropriate use of physical therapy visits, due to the doctors receieving monetary benefit from sending the patient there. I have seen many cases where a patient needs therapy, and the physician tells them that they want the patient to go to their therapy clinic. They do not tell the patient that they have a choice, which they do, and the patient, who usually does not know better, agrees to whatever the doctor says. This is especially true with the elderly, Medicare patients, because they ususally have the most faith in whatever their doctor tells them. This is only one way that the doctors take advantage of their role as medical advisor. I have also seen patients referred to phyician owned practices for visits that were not neccessary, such as pre-op strengthening on someone who is in really good shape, or a crutch training visit on someone who already knows how to use crutches. This is a waste of the patient's time and Medicare's money. I am strongly opposed to Physician-owned therapy practices(POP), and I think Medicare should be too. If you take the first step, other insurances will follow. Physicians have been allowed to self-refer for too long. I know of one patient who was referred by their orthopedic surgeon to a POP for therapy, and the patient went for one month, only to receive a bill in the mail after that month, stating that they owed $800. The patient's insurance was not in-network at this POP, but no one told the patient. He though he had to go to that clinic because his doctor told him to. This is unethical and should be illegal. I hope that you will consider removing the loop-hole allowing physicians to self-refer for therapy services. Thank you.

Submitter : **Miss. Staci Sinex** **Date: 08/18/2007**

Organization : **Miss. Staci Sinex**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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Sincerely,
Staci Sinex

Submitter : **Mr. Barry Honcoop** **Date: 08/18/2007**

Organization : **RiverCity Anesthesia**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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August 18, 2007

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

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

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Sincerely,

Barry Honcoop, CRNA

5509 N. Timber Rim Dr
Spokane, WA 99212

Submitter : **Damian Brant** **Date: 08/18/2007**

Organization : **Damian Brant**

Category : **Nurse**

Issue Areas/Comments

Background

Background

I am a Junior SRNA student at the University of Maryland, Baltimore, MD

CMS-1385-P-6501-Attach-1.TXT

#6501

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the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Damian Brant
19010 Mediterranean Drive
Germantown, MD 20874

Submitter : Mr. David Thiot **Date:** 08/18/2007

Organization : Mr. David Thiot

Category : Other Health Care Professional

Issue Areas/Comments

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Submitter : **Dr. Sarah Bodin** **Date: 08/18/2007**

Organization : **Wake Forest University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely, Sarah G. Bodin, M.D.

Submitter : **Dr. Scott Maxwell** **Date: 08/18/2007**

Organization : **Affiliated Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Scott Maxwell

Submitter : Mr. Wayde Blumhardt **Date:** 08/18/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

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As a member of the American Association of Nurse Anesthetists, I write to support the CMS proposal to boost the value of anesthesia by 32%. This increase in Medicare payments is important for several reasons: Medicare currently under reimburses for anesthesia services. Studies by 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.

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As CRNAs are the predominant anesthesia care providers to rural and medically underserved America, I believe this to be a very important proposal not only for CRNAs, but also for the many millions of people who rely on our services.

Thank you very much for your consideration in this matter.

Sincerely,

Wayde Blumhardt CRNA ARNP
179 Hampshire Rd
Waterloo, Iowa 50701

Submitter : **Dr. Shihyen hsu** **Date: 08/18/2007**

Organization : **scpmg**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Leslie V. Norwalk, Esq.
Acting Administrator
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Submitter : Mr. Jeff Thurman **Date:** 08/18/2007

Organization : MTSA

Category : Other Health Care Provider

Issue Areas/Comments

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Sincerely,

Jeff Thurman, RN,BSN,SRNA

Submitter : Michael J. Alexa **Date:** 08/18/2007

Organization : Michael J. Alexa

Category : Other Health Care Professional

Issue Areas/Comments

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Submitter : Dr. Philip Lutz **Date:** 08/18/2007

Organization : Montclair anesthesia associates, P.C.

Category : Physician

Issue Areas/Comments

Background

Background

As a practicing anesthesiologist, I have found that the care for seniors is getting harder and harder. Due to the ridiculously low pay,at an hourly rate of what averages out to be about $64.00/hour for an anesthesiologist. or $ 16.00/Unit, it is difficult to find quality anesthesiologists. I am actually in fear of finding appropriate care for myself and my family as we age. I request that you support the small increase in anesthesia reimbursement for medicare patients

Submitter : **Mrs. Bethany Taylor** **Date: 08/18/2007**

Organization : AANA

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,
Bethany Taylor, CRNA
Hoboken, NJ

Submitter : **Mrs. Nadia Mihaljcic** **Date: 08/18/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

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

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

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

Sincerely,

Nadia C. Mihaljcic SRNA
224 W. Dryden St. #219
Glendale, CA 91202

Submitter : **Mrs. Starr Cartrett** **Date: 08/18/2007**

Organization : **Mrs. Starr Cartrett**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

Starr Cartrett, CRNA

Name & Credential

8354 Glen Aspen Dr.

Address

Las Vegas, NV 89123

City, State ZIP

Submitter : Dr. John Steriti **Date:** 08/18/2007

Organization : Dr. John Steriti

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.

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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.

John Steriti, M.D.

Submitter : **Mr. David Derrick** **Date: 08/18/2007**

Organization : **Mr. David Derrick**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Ms. Norwalk:

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

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David Derrick

Submitter : Mr. Thomas Evans **Date:** 08/18/2007

Organization : Eclipse Anesthesia Services PLLC

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

As a business owner and member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services. This is especially important for rural areas that are mostly supported by CRNA and and a high percentage of Medicare patients. This is essential for the continued well being of the anesthesia profession.

Submitter : Mr. David Rettler **Date:** 08/18/2007

Organization : Mr. David Rettler

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

Submitter : Julie Sanchez **Date:** 08/18/2007

Organization : Julie Sanchez

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#6517

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. Carla Levi-Miller** **Date: 08/18/2007**

Organization : **Sheridan Healthcorp.**

Category : **Physician**

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.

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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. Carl Sanchez **Date:** 08/18/2007

Organization : Medical Anesthesia Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#6519

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

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

Submitter : **Dr. Carl Sanchez** **Date: 08/18/2007**

Organization : **Medical Anesthesia Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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Thank you for your consideration of this serious matter.

Sincerely,
Carl Sanchez, MD

Submitter : **Mrs. Julie Sanchez** **Date: 08/18/2007**

Organization : **Mrs. Julie Sanchez**

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.

Sincerely,
Julie Sanchez

Submitter : **Juanita Sanchez** **Date: 08/18/2007**

Organization : **Juanita Sanchez**

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.

Sincerely,
Juanita Sanchez

Submitter : Mr. KIMO DANIELSEN **Date:** 08/18/2007

Organization : ON SITE PHYSICAL THERAPY SERVICES

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I HAVE BEEN A LICENSED PHYSICAL THERAPIST IN TENNESSEE FOR THE PAST 12 YEARS. OVER THE YEARS I HAVE MET MANY, MANY PATIENTS WHO DO NOT FEEL OR REALIZE THAT THEY HAVE A CHOICE IN WHERE THEY RECEIVE PHYSICAL THERAPY SERVICES. THIS IS ESPECIALLY TRUE OF PATIENTS WHOSE PHYSICIAN HAS A FINANCIAL INTEREST IN A PHYSICIAN OWNED PHYSICAL THERAPY PRACTICE. PATIENTS ARE LED TO BELIEVE THAT THEY MUST GO TO THE PHYSICIANS' PHYSICAL THERAPY CLINIC IN ORDER FOR THE PHYSICIAN TO REMAIN INVOLVED IN THE RECOVERY PERIOD. I HAVE BEEN TOLD BY MANY PATIENTS THAT HIS / HER PHYSICIAN INSISTED WHERE THEY GO FOR THERAPY AND WAS VERY RELUCTANT TO FORWARD THE PRESCRIPTION TO THE PATIENT'S CLINIC OF CHOICE. I HAVE MET PATIENTS WHO FELT FORCED TO DRIVE ACROSS TOWN TO THE PHYSICIAN OWNED PRACTICE BECAUSE THEIR DOCTOR TOLD THEM WHERE THEY NEEDED TO RECEIVE THERAPY. EVEN THOUGH THE PATIENT HAD SEVERAL PHYSICAL THERAPY CLINICS NEAR THEIR HOME. I HAD ONE LADY WHO WAS SO ANXIOUS ABOUT DRIVING THAT SHE FINALLY COMPLAINED AND REFUSED TO COMPLETE HER THERAPY. IT WAS ONLY THEN THAT HER DOCTOR "RELEASED HER TO GO TO ANOTHER THERAPY CLINIC."

FURTHER, I PREVIOUSLY SERVED AS A DIRECTOR FOR A LARGE OUTPATIENT PRACTICE. SINCE THE OPENING OF A PHYSICIAN OWNED PT CLINIC, I WITNESSED A SHARP DECLINE IN REFERRALS. THE BIGGEST DECLINE WAS WITH PATIENTS WHO HAD PRIVATE INSURANCE! THE REFERRALS WE DID RECEIVE WERE PATIENTS WHO HAD MEDICAID / TENN CARE OR MEDICARE.

AS AN INDEPENDENT PRIVATE PRACTICE OWNER, I HAVE HAD SEVERAL RETURN PATIENTS WHO TOLD ME THAT THEY HAD TO INSIST THAT THEY WERE GOING ELSEWHERE FOR THERAPY. THANKFULLY, THESE PATIENTS HAD SEEN ME PRIOR AND I EDUCATED THEM THAT THEY HAD A CHOICE AS TO WHERE THEY RECEIVED THERAPY.

IT IS OBVIOUS TO ME THAT PHYSICIAN OWNED PHYSICAL THERAPY PRACTICES ARE MAKING A HUGE PROFIT BY SELF REFERRING. THEY ARE ALSO TRYING HARDER TO HOLD ON TO PATIENTS WITH PRIVATE INSURANCES AND BEING INDIFFERENT TO THOSE WHO HAVE MEDICAID / MEDICARE. AGAIN, THEY ARE NOT GIVING PATIENTS A CHOICE AS TO WHERE THEY CAN RECEIVE PHYSICAL THERAPY. WHILE THEY MIGHT HAVE A LIST OF OTHER PROVIDERS ON FILE, THEY ARE LEADING PATIENTS TO THEIR OWN PRACTICES. THEY TRY TO JUSTIFY THEIR SELF REFERRAL BY MAKING IT SEEM THAT THEIR PRACTICE CAN BE MORE CLOSELY MONITORED, THEIR THERAPIST ARE MORE SPECIALIZED, OR THAT THEY WILL MORE INVOLVED IN THE REHAB PROCESS.

THIS PRACTICE OF SELF REFERRAL NEEDS TO STOP. IT IS NOT GOOD FOR PATIENTS. THEY DESERVE TO BE EDUCATED AND KNOW THAT THEY HAVE A CHOICE IN WHERE THEY RECEIVE PHYSICAL THERAPY. IN ADDITION, PATIENTS SHOULD NOT FEEL COMPELLED OR MADE TO FEEL GUILTY BY THEIR PHYSICIANS IF THEY HAVE A THERAPY CLINIC WHERE THEY WOULD LIKE TO RECEIVE THERAPY.

Submitter : **Dr. patricia davidson** **Date: 08/18/2007**

Organization : **american society of anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Submitter : **Dr. joseph sedutto** **Date: 08/18/2007**

Organization : **Dr. joseph sedutto**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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joseph sedutto md

Submitter : Dr. John Tretter **Date:** 08/18/2007

Organization : Slocum Dickson Medical Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am currently Board Certified in both Cardiology and Adult Echocardiography. In regards to bundling of payments of doppler studies,you need to be aware that dopplers are not routinely done with all echos. Also, doppler echo has become more complicated over the years, and indeed now with tissue doppler, trans valvular flow analysis, etc. and the ability to calculate various pressures within the heart it has become more time consuming for both the sonographer as well as myself. Do not bundle doppler with 2D/M mode doppler. Indeed, the payment both technical and physician should be increased.

Submitter : Mr. Jeffrey Woods **Date:** 08/18/2007

Organization : Active LIfe and Sports Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The Stark Laws were established to protect the interest of the patient. The patient must come first not the physicians wallets. How can an entrepreneurial Physical Therapist open a successful clinic when the majority of Physicians are opening clinics for themselves. We should follow in the steps of South Carolina and have physicians own physician groups and Physical Therapist's own PT clinics. They have no idea what we do, but they want our money. WE do no go to school for 7-8 years, in the hopes of owning our own clinic, then find out that we cannot because the physicians will not refer to us.

Please end the loophole in the stark referral laws. Let Physical Therapists be as successful as they can be

Submitter : **Mrs. Leanne Behny** **Date: 08/18/2007**

Organization : **Mrs. Leanne Behny**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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Sincerely,

Leanne P. Behny, CRNA, MSN

421 S. Monticello,

Winamac, IN 46996

Submitter : Dr. John Finn **Date:** 08/18/2007

Organization : Bay Area Heart Center

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Please reconsider the plan to reduce the reimbursement for the color doppler component of an echocardiogram. I am the Director of the Bay Area Heart Center Echo Lab (a group of 11 cardiologists) and I have 29 years experience in echocardiography. The performance of a color doppler exam requires additional technician and physician training and time to perform and it should NOT be a 'routine' part of all echocardiography exam---so it should be re-imbursed separately. Quality assurance and cost saving efforts would be better centered on mandating certification of technologists and physician interpreters and on tailoring exams (and payments) on specific 'tailored' echocardiographic exams---which has never been done before.
For example, an echocardiogram for 'chest pain' should consist of M-mode and 2 D (real time) but need not include pulsed doppler, color doppler,3D, strain imaging, etc. An exam for evaluation of a heart murmur should include the basic M-mode, 2 D but also now would include pulsed and color doppler---but not 3 D or strain imaging. An exam to evaluate the pumping function of the heart in a patient with heart failure would include M-mode, 2 D,pulsed doppler, TISSUE color doppler and strain imaging. An exam to evaluate congenital or complex valve disease or prosthetic heart valve function would also include 3 D imaging. THEN, for each of these defined diagnoses (CPT codes) the TYPE of echocardiogram would be specified and the payment defined. This would allow the physician to taylor the study ordered based on the diagnosis (also thereby defining the technitian and physician time needed to complete the study) and allow the payor to make different payments dependent on the study that was done.
Again, please re-consider the pending legislation that will exclude separate payment for the color doppler study. I fear that this will only encourage a decrease in the quality of patient care as many outpatient non-invasive labs will then 'tailor' the studies that they do so that the technician and physician time spent on each procedure will be less. I hope that working together our attempts will help us obtain control over cost while maintaining and expanding the quality of patient care. John Finn,M.D., FACC

Submitter : **Shannon Hagan** **Date: 08/18/2007**

Organization : **Shannon Hagan**

Category : **Nurse**

Issue Areas/Comments

Background

Background

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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

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

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

Shannon Hagan RN, BSN, CCRN
10635 Browns Farm Road
Woodstock, MD 21163

Submitter : **Dr. Michael Gosney** **Date: 08/18/2007**

Organization : **Dr. Michael Gosney**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Donna Gosney** **Date: 08/18/2007**

Organization : **Mrs. Donna Gosney**

Category : **Individual**

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

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Submitter : **Dr. Michael Gosney** **Date: 08/18/2007**

Organization : **Dr. Michael Gosney**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Acting Administrator
Centers for Medicare and Medicaid Services
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Baltimore, MD 21244-8018

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Submitter : **Date: 08/18/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

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Centers for M edicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Submitter : **Dr. Christopher Yeakel** **Date: 08/18/2007**

Organization : **Dr. Christopher Yeakel**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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P.O. Box 8018
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Thank you for your consideration of this serious matter.

Chris Yeakel, MD

Submitter : **Date: 08/18/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

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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.

Sincerely,

Phillip J. Mosca, M.D.

Submitter : **Merrill Parks** **Date: 08/18/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Ms. Norwalk:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Merrill Parks, CRNA
14814 Old River Drive
Scott, AR 72142

Submitter : Mr. John Pike **Date:** 08/18/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Submitter : **Mr. Matthew Kervin** **Date: 08/18/2007**

Organization : **Georgia Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

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

Dear Ms. Norwalk:

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

Sincerely,

Matthew W. Kervin, CRNA, MN
President, Georgia Association of Nurse Anesthetists
RR2, Box 148DD
Eastanollee, GA 30538

Submitter : **Dr. Penna Bui** **Date: 08/18/2007**

Organization : **Dr. Penna Bui**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Thank you for your consideration of this serious matter.

Submitter : Mr. DINO KATTATO **Date:** 08/18/2007

Organization : SRNA

Category : Other Health Care Provider

Issue Areas/Comments

Background

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Dino Kattato
47 S. Lake Ave
Apt. 1-G
Albany, NY 12203

Submitter : Mr. Curtis Watson **Date:** 08/18/2007

Organization : St. Vincent Hospital Green Bay Wisc.

Category : Nurse

Issue Areas/Comments

Background

Background

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

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Sincerely,

Curtis L. Watson C.R.N.A., Anesthesia Manager St. Vincent Hospital
835 South Van Buren Street
Green Bay Wisconsin 54307-3508

Submitter : **Dr. Brian Waltmann** **Date: 08/18/2007**

Organization : **North Fulton Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Sincerely,

Brian K. Waltmann, M.D.

Submitter : **John Schreiner** **Date: 08/18/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Sincerely,

John Schreiner, CRNA
W8976 Pine Crest Ln.
Shawano, WI 54166

Submitter : **Dr. Samuel Jacobson** **Date: 08/18/2007**

Organization : **Dr. Samuel Jacobson**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-6545-Attach-1.DOC

#6545

Center for Medicare Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244-8018

8/18/2007

http://www.hhs.gov/eRulemaking

Comments on CMS- 1385-P: Proposed 2008 Medicare Physician Fee Schedule Rule

Current Rules: In June of 2004, Congress passed law regarding shared facilities for separate medical practices in the same building. These rules, promulgated by CMS are the basis for the "Medical office building (MOB)" exemption for providing and billing for designated health care services (DHS) by physicians in the same office building.

Many physician practices have relied on these rules to plan and move forward on facilities as well as purchasing and leasing of equipment to provide these services for patients. These projects are very expensive and rely on extensive legal review of current rules and law. The current proposed rule, CMS- 1385-P puts the practicing physician in financial jeopardy and the Medicare patient in danger of loss of access to vital health care services and care.

The current state of Medicare's treatment of practicing physicians is difficult, to put it mildly. The E and M reimbursement barely covers overhead for most internists and internal medicine specialists. Most of these physicians have relied on in office ancillary DHS, including laboratory, ultrasound and X ray requiring the purchased services of pathologists and radiologists, to make ends meet. Many physicians acted on the 2004 MOB exemption and have taken on large, if not huge obligations to comply and to provide superior services for the patient. Is it fair to turn the current rules upside down?

Medicare patients are often frail and have difficult access to transportation. They consistently prefer to have DHS provided by their personal physician's practice where they are familiar to the staff and facility. Outside of the physician's office there is almost always a delay and often tests are not performed because patients have difficulty finding or getting to outside hospitals or IDTFs. These delayed or missed tests are a significant risk to the patient and increase the inefficiency and cost to Medicare.

As far as the potential for abuse from the current MOB exemption is concerned, the proposed rule will limit competition and provide a monopoly by pathologists and radiologists. The proposed rules seem tailor made to protect the income and control of radiology services and laboratory tests by these two specialties.

Who drives the utilization and expense of these DHS? I would like to provide some real life examples for your consideration.

The physician orders a chest X ray at an IDTF. A vague density is seen on the film (as a board certified pulmonologist, my review showed that this was clearly calcium in a healed rib fracture, i.e.; nothing!)

A CAT scan is requested by the radiologist and then ordered by the primary care physician (the radiologist is not available to review the films and in this climate of medical liability the doctor would be at risk if the CT is not ordered!) An incidental finding of a tiny 3mm nodule is found. The best care is rendered when the radiologist and ordering physician can review the findings together. This is almost impossible in an IDTF or an impersonal hospital based radiology department.

The current standard of care promulgated by the radiology societies is to follow a minimal abnormality such as this with serial CT scans at three-month intervals to assure stability for two years. Six to eight CT scans for nothing. Clearly, the radiologist is at least as responsible as the primary referring physician for driving utilization and cost in this common scenario.

As a pulmonologist, I perform bronchoscopy and often refer patients for surgery. Specimens are always sent to pathology (hospital only in my practice.) Although precise diagnosis is enhanced by the skill of the pathologist, sometimes expensive special stains are requested, not by the pulmonologist, but by the pathologist. I am concerned that the pathologist may in some instances recommend unnecessary procedures or special stains. Again, the cost and "referrals" are driven by the pathologist as are the procedures done by the radiologist.

There is a privately owned radiology company in South Florida that is currently being investigated by the OIG for fraud and abuse regarding recruitment of referring physicians. I suspect that there has really been no violation of Medicare rules, however, this is an example of a radiologist owned center possibly increasing the number and cost of procedures billed to Medicare.

These three real life examples show that eliminating competition and giving one specialty monopolistic control over laboratory and radiology procedures will only exacerbate the potential for abuse. Conversely, there is no data presented that a "per click" arrangement nor the employment of part time radiologists or pathologists have resulted in over utilization of services nor otherwise threatens program integrity.

The centralized medical office building (MOB) exception to the Stark law has made it more financially feasible for physicians working in separate practices in the same building to provide additional services to their patients. The expense of building out a clinical laboratory or imaging department, purchasing the needed equipment and hiring qualified staff that is prohibitive for a small practice becomes a manageable expense under the MOB exception where physicians can share these expenses. Physicians have been developing these arrangements in good faith and at great expense.

CMS is proposing to no longer allow per-click or per-use agreements which is a reversal from CMS current position. No data has been presented that "per click"

arrangements, or the employment of part-time radiologists or pathologists has resulted in over utilization of services or otherwise threatens program integrity.

The proposed anti-markup provision to the technical and professional component of diagnostic services specifically disallows operational costs incurred from part-time employment of a physician to provide the professional component of a diagnostic service. This defies logic. No serious argument can be made that a practice does not have legitimate expenses for scheduling and billing at the very least. The centralized medical office building (MOB) exception to the Stark law has made it more financially feasible for physicians working in disparate practices, but in the same building, to provide additional services to their patients. The expense of building out a clinical laboratory or imaging department, purchasing the needed equipment and hiring qualified staff that is prohibitive for a small practice becomes a manageable expense under the MOB exception where physicians can share these expenses. Physicians have been developing these arrangements in good faith, often after having obtained, at considerable expense, a legal opinion to help ensure that they remain in compliance with the rules and laws.

CMS is proposing to no longer allow per-click or per-use agreements which is a reversal from what CMS has so recently ruled. No data has been presented that "per click" arrangements, or the employment of part-time radiologists or pathologists has resulted in over utilization of services or otherwise threatens program integrity.

The proposed anti-markup provision to the technical and professional component of diagnostic services specifically disallows operational costs incurred from part-time employment of a physician to provide the professional component of a diagnostic service. This defies logic. No serious argument can be made that a practice does not have legitimate expenses for scheduling and billing at the very least.

CMS is concerned about the "existence of certain arrangements that we believe are not within the intended purpose of the physician self-referral rules, which permit physician group practices to bill for certain services furnished by a contractor physician in a "centralized building."

CMS is proposing to apply the anti-markup provision "irrespective of whether the billing physician or medical group outright purchases the PC or the TC, or whether the physician or other supplier performing the TC or PC reassigns his or her right to bill.... (Unless the performing supplier is a full-time employee of the billing entity)." In fact, there is no substantive difference between employing a fulltime physician (which enables the employer to keep the "mark up" on the professional component) and engaging a physician on a fair market basis on a part-time basis and billing globally (again enabling the price to keep the "mark up"). In either scenario, the program costs are the same. No data is presented to support the need for these restrictions, only a "concern" that abuse is possible.

The restrictions contemplated in CMS-1385-P leaves one with the impression that CMS has been influenced by a conflict between radiologists and pathologists as opposed

to physicians who actually treat the patients. Radiologists' fear of other physicians providing imaging services has led to a ramping up of rhetoric that has only one hoped for outcome for the radiologists – the elimination of healthy competition and monopolization of all imaging services. The goal of government should not be to protect the interests of radiologists and pathologists at the expense of all other specialties or, nor to determine by regulation what types of specialists may be employed (and to what extent – fulltime or part-time) by others in the absence of clear, compelling data that it is necessary to prevent program abuse. It is cruel and unjust to changing the already overly complex reassignment rules to preserve income levels for physicians who never see patients, all as part of a regulation that will REDUCE the compensation of those who actually treat the patients.

The current regulations promote competition

The Stark II, Phase II regulations published effective July 2004 contained specific, well-considered provisions to permit the sharing of facilities for ancillary services by practices located in the same building. Many physicians, acting in direct reliance on these regulations, have invested millions of dollars to establish these shared laboratory and imaging facilities as an alternative to more costly and complex formation of huge group practices. As intended, these shared facilities are both cost effective and convenient to patients, and many rely heavily upon the 2004 "physician in the group" and reassignment of benefits regulation. To change these basic concepts at this time, in the absence of clear data demonstrating the need for change, is unfair and unwise.

Anecdotal allegations about potential abuse are entirely unfounded, not supported by any data or other supportive information, and are not a proper basis to cause physicians across the country to re-incur legal fees to unravel relationships structured to comply with recent, well-considered regulations.

The cost effectiveness of shared ancillary facilities is obvious. Rather than duplicate capital expenditures for state-of-the-art technologies like PET scanners, high speed CT and MIR and duplicate operating costs for personnel and facilities that would be underutilized, shared facilities allow practices to offer the most current technologies and best trained personnel. Further, these shared facilities will enable physician practices to continue to offer these advantages even if the drastic fee reductions proposed over the next several years are fully implemented. Eliminating unnecessary overhead and expanding access to care should be goals of any efficient health care delivery system, including those financed by the CMS.

In view of the above, I request that CMS keep the present concept of purchased professional and technical services.

Continue the current concept of reassignment of benefits.

Additionally CMS should keep in mind that pathologists and radiologists are the most highly compensated of any specialty and that fairness to physicians who actually care for

patients is required. Therefore, prior to enacting these rules, CMS should review the potential for abuse with the present versus the proposed payment methodology for histology, pathology and laboratory services in that the pathologist has control over doing multiple expensive stains on the same specimen.

Likewise, CMS should review the potential for abuse by radiologists and IDTFs in the current versus the proposed changes.

My personal analysis is that with the proposed CMS- 1385- P, monopolistic radiology and pathology services will increase costs, decrease healthy competition and make appropriate tests inconvenient for Medicare patients. Along with declining Medicare reimbursement, the proposed rules potentially will limit access of Medicare patients to not only diagnostic testing, but for physician services as well. The current rules will, on the other hand, will not impact radiologists or pathologists adversely and will help preserve Medicare program integrety.

Keeping the current rules for the MOB exemption and purchased tests provide Medicare beneficiaries high quality choices for testing including those tests done in their own physician's office building. The proposed rules, I believe, will adversely affect Medicare beneficiaries by forcing many physicians to limit or cease caring for Medicare patients.

Keep in mind that many physicians, having relied on the current rules have already committed to leases and contracts with five or more years duration. Therefore, CMS needs to exempt projects in progress or delay implementation of rule 1385-P for at least five years.

In closing, CMS has high expectations for physicians to live up to the demanding rules already in place. I believe that CMS is obligated to abide by it's own policies on which physicians have relied on as a valid basis for legitimate projects in progress. Pulling the rug out from practicing physicians with 1385-P is, at this time unacceptable at best, and truly a threat to not only the physician; but to the Medicare patient, as well.

Yours truly,

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