Submitter : **Ms. Catherine Schilling** **Date: 08/20/2007**

Organization : **Ms. Catherine Schilling**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Aug 20, 2007

To: CMS
From: Cathy Schilling, PT
RE: in-office ancillary services

I am a physical therapist and have been in practice for 27 years, 18 of which has been in private practice in the greater Manchester area. Over that time I have worked diligently to develop an excellent reputation for quality patient care both in technical expertise and nurturing care. I have enjoyed the development of collegial professional relationships with many of the Doctors in the area and have worked hard to provide their patients with the most up to date information and care, always referring back to the Doctor for medical decisions. I have served as a resource for my community often referring to the medical and orthopedic practices in our area as the need has arisen.

Recently, due I believe to the fact that the same MD s I have developed relationships with are now in a referral for profit relationship, there has been an eroding of my position in the community. Friends are told that the therapist that the surgeon recommends happens to be at the facility where the MD has ownership. Patients that I refer to orthopedists that I have worked with for years are strongly encouraged to attend therapy at the same facility. Acquaintances at church have been told that the only good therapists are at the facility where the MD has ownership. The abuses of that system are more and more blatant. Patients are being told that the MD wants them to be in a facility where he can keep a better eye on their progress. This is despite the fact that the MD is miles away and does not see patients at the PT facility.

Specifically, a friend of mine had a total hip replacement for degenerative changes. When her surgery went without a problem, she asked to have her PT with me. She was told that that would be OK, but he would really prefer to have her seen at his own facility. My friend did not want to argue with the physician, feeling that it might jeopardize her care, and had her rehab at the alternate site. The problem is not that this site does not provide good therapy or that their care was sub-par, it is rather that patients are being denied choice for rehab.

I had a patient who I was seeing on a referral from a primary care MD with a diagnosis of shoulder pain. Upon thorough evaluation and through the progression of treatment it was discovered that there was more than likely also cervical disc involvement. I referred the patient back to the primary care who then referred the patient to a neurosurgeon and eventual discectomy. Even though I had documented and correctly diagnosed the patient she was asked to go to the physician owned PT facility.

MD s in this area have ownership in PT clinics, brace companies, and out patient surgery clinics. The hand is in all pockets. Stark regulations had protected Medicare patients until the local MD s realized that they could bypass the safeguard by having the patients non-owner primary care physician refer them to the orthopedic MD s PT clinic. Patient care and choice are now dependant only on the good will and ethics of the clearly corruptible referring physician.

Sincerely,

Catherine F. Schilling PT

Submitter : **Mr. William Helton** **Date: 08/20/2007**

Organization : **Mr. William Helton**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
William Helton

Submitter : **Miss. Elizabeth Helton** **Date: 08/20/2007**

Organization : **Miss. Elizabeth Helton**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.
Kind Regards,
Elizabeth Helton

Submitter : **Dr. Shawn Carson** **Date: 08/20/2007**

Organization : **Dr. Shawn Carson**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Sincerely,
Shawn Carson, M.D.

Submitter : **Sussette Robinson** **Date: 08/20/2007**

Organization : **Sussette Robinson**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physical therapy should not be used in the office by the physician.
Some patients have told me that certain Doctors are doing ultrasound,
e-stim in their offices and charging under physical therapy. A nurse or a technician has been doing these proceedures. These modalities may be used incorrectly and cause damage to the patient.
Physical therapy should not be used as an ancillary services in physicians offices when there is not a physical therapist administering the services.

Submitter : **Dr. Janet Wendeln** **Date: 08/20/2007**

Organization : **Anesthesia Consultants of Indianapolis**

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
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P.O. Box 8018
Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Deanna Dalia** **Date: 08/20/2007**

Organization : **Dr. Deanna Dalia**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Sincerely,
Deanna Dalia, M.D.

Submitter : **Dr. Don Raithel** **Date: 08/20/2007**

Organization : **Dr. Don Raithel**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Sincerely,
Don Raithel, M.D.

Submitter : Mrs. SONIA SLABA **Date:** 08/20/2007

Organization : ANESTHESIA CONSULTING SERVICES

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,
SONIA SLABA CRNA 4434 E EAGLES LANDING WICHITA KS 67220

Submitter : **Dr. Joy Crossman** **Date: 08/20/2007**

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

Thank you for your consideration of this serious matter.

Sincerely,
Joy Crossman, M.D.

Submitter : **Dr. Ellen Roberts** **Date: 08/20/2007**

Organization : **University of Nebraska Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
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Sincerely,
Ellen Roberts, M.D.

Submitter : **Dr. Candice Montzingo** **Date: 08/20/2007**

Organization : **University of Nebraska Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Sincerely,
Candice Montzingo, M.D.

Submitter : **Dr. Franklin Cobos** **Date: 08/20/2007**

Organization : **University of NE Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Franklin V. Cobos II, MD
Anesthesiology

Submitter : Mrs. **Date:** 08/20/2007

Organization : Mrs.

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
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Sincerely,

Tamara Vaught, RN, BSN, SRNA
Address
1263 E. Rowland
Madison Heights, MI 48071
tlvaught@oakland.edu

Submitter : **Dr. James Janszen** **Date: 08/20/2007**

Organization : **Dr. James Janszen**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Sincerely,
James Janszen, M.D.

Submitter : **Dr. James Mosher** **Date: 08/20/2007**

Organization : **Dr. James Mosher**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Sincerely,
James Mosher, M.D.

Submitter : **Dr. Reginald Julien** **Date: 08/20/2007**

Organization : **GBAA**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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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,
Reginald Julien

Submitter : **Miss. Diana Hunt** **Date: 08/20/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

This increase in Medicare payment is important for several reasons.

First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other 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,

Diana C. Hunt, SRNA
50 South 4th Street #306
Memphis, TN 38103

Submitter : Mrs. Susan Neumeyer **Date:** 08/20/2007

Organization : Sheboygan Orthopaedic Associates

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Our five man orthopaedic practice owns in-office physical therapy.

We feel that our patients that use our facility have better outcomes. We are able to provide the convenience of one-stop medical care. Better communication between the physicians and the in-office therapists exists because as questions come up during treatment, the MD can walk down the hall and address any issues promptly.

I believe that referrals are not made to our physical therapy department simply because we own it. Often patients are given home exercise programs instead. One of our physicians continues to utilize the hospital therapists for some of his surgical procedures because he has established a rapport with those therapists, and he believes that is in the best interest of the patient.

I truly believe that our physicians do order physical therapy only when it is indicated. In addition, no patient is forced to use our facility.

Please don't make it illegal for physicians to own in-office physical therapy practices. This would not be in the best interest of our patients.

Thank you.

Submitter : **Mr. Chad Reuter** **Date: 08/20/2007**

Organization : **University of Minnesota Graduate School**

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)and a student of Nurse Anesthesia at the University of Minnesota, 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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? 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,

CHAD REUTER RN, SRNA
2879 Edison Street NE, Unit E
Blaine, MN 55449

Submitter : **Dr. Sumit Katyal** **Date: 08/20/2007**

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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.

This is extremely important for our speciality as we have continued increasing costs. Thank you

Sumit Katyal

Submitter : **Mrs. Janelle Tepper** **Date: 08/20/2007**

Organization : **AANA**

Category : **Other Health Care Provider**

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,
_____Janelle C. Tepper, SRNA_____
Name & Credential
3704-21st Ave S., Minneapolis, MN 55407
Address

City, State ZIP

Submitter : **Mr. Samuel Mugford** **Date: 08/20/2007**

Organization : **SWAC Anesthesia, PC**

Category : **Nurse 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:

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Sincerely,

Samuel A Mugford, MSN, CRNA
Name & Credential
6005 Natchez Dr.
Address
Corpus Christi, TX 78414
City, State ZIP

Submitter : **Mrs. Brittany Wellborn** **Date: 08/20/2007**

Organization : **Sumter Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

This provision is sure to lead to a decline in the quality of therapy services for the consumer. Overutilization of services is imminent.

Submitter : **Ms. Laura Ford** **Date: 08/20/2007**

Organization : **Ms. Laura Ford**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Ms. Kathi Bindeman, CRNA **Date:** 08/20/2007

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 (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,
Kathi Bindeman, RN,MSN, CRNA

Submitter : **Ms. Nicole Schmidt** **Date: 08/20/2007**

Organization : **Oakland University**

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 an associate 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,
Nicole Schmidt SRNA
40615 Ruggero Clinton Twp MI 48038
Oakland University Rochester MI

Submitter : Dr. Ken McMahon **Date:** 08/20/2007

Organization : Dr. Ken McMahon

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am against physician or any other healthcare worker being able to refer patients to their own 'in house' services, and thereby generate profit from it. I have friends and former patients go to be seen by a physician and be referred to physical therapy. However, when these people asked to go to my clinic they were told that they had to go to their (the physicians) in house physical therapy. The physician then went on to tell the person/s that they would not refer them to therapy, if they did not come to their in house physical therapy clinic. This has happened on more than one occasion.

Physician referral for profit is dangerous and runs up health care costs. We now have in house physical therapy centers with primary care physicians, who formerly, never even used physical therapy. However, they see physical therapy as a way to generate revenue. This is not very wise healthcare policy.

Please remove physical therapy from the 'in-house ancillary services' exception to the federal physician self-referral laws.

Sincerely,

Ken McMahon, PT, DPT

Submitter : **Michelle Burque** **Date: 08/20/2007**

Organization : **Michelle Burque**

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:

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Sincerely,

_Michelle Burque, SRNA_____
Name & Credential
_3312 E 125th St._____
Address
_Burnsville, MN 55337_____
City, State ZIP

Submitter : **Dr. Steven Herling** **Date: 08/20/2007**

Organization : **North American Partners in Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Steven Herling, DO
North American Partners in Anesthesia

Submitter : Mrs. Erica Gillard **Date:** 08/20/2007

Organization : Dearborn Physical Therapy/Advanced Physical Therap

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

8/20/07
Re: CMS-1385-P

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

I am concerned that patients will not get the care in my community that they need to prevent higher cost interventions, such as surgery or long term inpatient care.

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

Sincerely,

Erica Gillard

Submitter : **Date: 08/20/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please remove physical therapy from the "in-office ancillary services" exception to the federal physician self-referral laws. I feel this is doing a disservice to the physical therapy profession and to its clients. Some patients do not realize that they have an option of where to go for physical therapy if their physician has in house PT. They could be going to a clinic that has more specialized care or that is closer to their home. With so many physician offices plugging their own PT it makes you wonder are they doing it for the benefit of the patient or to pad their pocketbook?

Submitter : Dr. Jack Ansell **Date:** 08/20/2007

Organization : Boston Medical Center

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

See Attachment

CMS-1385-P-6716-Attach-1.DOC

#6716

August 20, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-1850

COMMENT TO: "Resource-Based PE RVUs"

File Code CMS-1385-P: Comments Related to Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008

SUMMARY: I am requesting that CMS reconsider the methodology that it uses for determining payment for G0248 and G0249 services in order to avoid the potential for abuse while, at the same time, ensuring fair compensating for legitimate providers of Home INR Monitoring services.

Dear Ms. Norwalk,

I wish to address this comment to CMS-1385-P Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008 (Proposed Rule) as it relates to the provision of Home INR Monitoring services (G-0248 and G-0249). I am writing to offer my opinion about this Proposed Rule as both a practicing Hematologist at the Boston University School of Medicine and as Founder of the Anticoagulation Forum (AC Forum). The AC Forum is a national network of anticoagulation clinics providers with a membership of over 3,000 health care professionals.

Over the past eight years I have written several letters to CMS - initially to recommend coverage of the INR home testing service for selected patients and later to suggest policies to ensure efficient implementation of and fair payment for this lifesaving service. I am writing today to express my concerns related to the payment methods used by CMS and a recommendation to ensure that all training services be performed on a face-to-face (rather than telephonic) basis.

1. **Payment Methods (G0248/G0249):** I believe that the current method that CMS uses to pay for INR monitoring equipment is inherently flawed. In previous communications I have expressed my opinion that the cost of the INR monitor should be paid for as Durable Medical Equipment or Medicare rather than the amortized cost as an equipment cost on a per test basis. I believe that the current payment method provides a financial incentive for non-physician providers of INR Monitoring services to mandate weekly testing in order to ensure that they fully recover the cost of the INR monitor. While, I believe that there is substantial evidence to support that weekly testing improves patient safety, I believe that

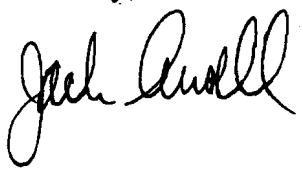
ultimately test frequency should be determined by the patient's treating physician for clinical reasons not the financial interests of a non-physician provider.

Therefore, as an alternative to this approach, **I strongly recommend that CMS consider treating the entire cost of the monitor as a one-time upfront cost included in G0248.** Although, this will increase the payment rate for the one-time G0248 (initial training) code, it may very well result in a reduction in the ongoing G0249 (testing supplies) code in perpetuity.

2. **Training Issues (G0248)**: As the use of Home INR Monitoring has expanded in recent years, I have become aware of substantial differences in the approaches used for training new patients. Although, I believe that it was always the intent of CMS to require that G0248 services be conducted on a face-to-face basis, it has come to my attention that some providers may attempt to provide G0248 services via telephone or by simply providing the patient a DVD to review. In my professional opinion I do not believe that it is possible to properly train patients in Home INR Monitoring using these alternative methods. For this reason, **I strongly recommend that CMS ensure that the resource-based RVUs be based on face-to-face training and that the supporting procedures for this code clearly stipulate that payment for G0248 services will only be made for face-to-face trainings.**

I am requesting that CMS consider these comments in order to help reduce the potential for abuse while also fairly compensating legitimate providers. Doing so will ensure that CMS' initial policy objectives are met in the most efficient manner, with the greatest potential to improve the health outcomes of the beneficiaries we all serve.

Sincerely,



Jack E. Ansell, M.D.

Submitter : **Chad Hinton** **Date: 08/20/2007**

Organization : **Chad Hinton**

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,

Chad Hinton GRNA
111 Zircon Ln
Knightdale, NC 27545

Submitter : **Brenda Fahy** **Date: 08/20/2007**

Organization : **Brenda Fahy**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Brenda G. Fahy MD
Professor, Department of Anesthesiology
University of Kentucky

Submitter : Dr. philip eichenholz **Date:** 08/20/2007

Organization : northStar Anesthesia

Category : Physician

Issue Areas/Comments

Background

Background

This is critical to keep this area of medicine viable. At present it is underfunded and thus cannot continue.

Submitter : **Mr. Mark Gombotz** **Date: 08/20/2007**

Organization : **Select Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

August 16, 2007

Subject: Physician Self-Referral

Dear Mr. Weems:

My name is Mark Gombotz and I am a physical therapist working in a physical therapy practice in West Hartford, CT. In the last 5 years I have witnessed a tremendous explosion in the number of physician owned physical therapy practices which has created a referral for profit environment. I ask nothing more than a fair business environment in the best interest of the patient.

On this point I am sure that you have heard many different arguments from many different constituents. I would urge you to consider the evidence. Please look at the arguing points and determine their validity by source.

Referral for profit physical therapy services has caused higher healthcare costs for patients and insurance companies most notably Medicare. These arrangements generate more utilization and higher charges than do autonomous physical therapy practitioners. The evidence regarding referral for profit services is clear:

" According to a report by the Office of the Inspector General of the Department of Health and Human Services approximately 91 percent of physical therapy billed to Medicare by physicians in the first 6 months of 2002 did not meet Medicare requirements,1 This cost the Medicare program and its beneficiaries approximately $136 million.
" A study in the Journal of the American Medical Association revealed that visits per patient were 39% to 45% higher in physician-owned clinics when compared with therapist-owned clinics; revenue per patient was 30% to 40% higher in facilities owned by referring physicians.2
" The Florida Health Care Containment Board found that physician-owned physical therapy facilities provide 62% more patient visits per full-time physical therapist, when compared with non-physician-owned clinics. The patients referred had 43% more treatments when compared with non-physician-owned clinics.3

" A William Mercer study of workers compensation patients in California revealed that patients seen by physicians with ownership interest in physical therapy services received referrals for physical therapy 66% of the time; patients seen by physicians without ownership interest in physical therapy services were referred 32% of the time. This resulted in $233 million in services per year for economic rather than clinical reasons.4
" According to the Florida study, patient care may also suffer in physician-owned clinics. Both licensed therapists and non-licensed workers in physician-owned facilities spent less time with each patient. This may indicate a lower level of care. This study also found that assistants were substituted for licensed therapists more often in physician-owned facilities.5

As you can see this problem has a long history and is wide spread. I would like to thank you for your time and consideration on this issue.

Sincerely,

Mark Gombotz, PT, MBA

1 Physical Therapy Billed by Physicians, Office of Inspector General, Dept. of Health and Human Services, May 2006.

2Mitchell, J., Scott, E., Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics, Journal of the American Medical Association, 1992.

3 Joint Ventures Among Health Care Providers in Florida, State of Florida Health Care Cost Containment Board, 1991.

4Johnson, G., Swedlow, A., Medical Referral-for-Profit in California Workers Compensation, unpublished addendum to the authors 1992 article, based on course notes from their presentation of findings at a physical therapy symposium, January 1992.

5 Joint Ventures Among Health Care Providers in Florida, State of Florida Health Care Cost Containment Board, 1991

Submitter : **Mr. Timothy Gollaher** **Date: 08/20/2007**

Organization : **Mr. Timothy Gollaher**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Ms. Norwalk:

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Sincerely,

Timothy Gollaher, CRNA, MHS
4505 Quail Hollow Ct.
Fort Worth, TX 76133

Submitter : **Ms. Joyce Aultman** **Date: 08/20/2007**

Organization : **Ms. Joyce Aultman**

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

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Sincerely,

Joyce Aultman, CRNA, MS
Director of Anesthesia
Marshall Medical Center North
8000 Hiway 69
Guntersville, Al 35975

Submitter : Dr. David Bostwick **Date:** 08/20/2007

Organization : Bostwick Laboratories

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 15, 2007
Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial confliet of interest that compromises the integrity of the Medicare program.
Sincerely,

David G. Bostwick, M.D., M.B.A.
CEO and President

Submitter : **Dr. Janet Wendeln** **Date: 08/20/2007**

Organization : **Anesthesia Consultants of Indianapolis, LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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When the RBRVS was instituted, it created a huge payment disparity for anesthesia carc, 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,

Janet Wendeln, M.D.

Submitter : **Dr. Mark Manley** **Date: 08/20/2007**

Organization : **Dr. Mark Manley**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Sincerely,
Mark Manley, M.D.

Submitter : Mr. Larry R. Taylor **Date:** 08/20/2007

Organization : AANA

Category : Nurse 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

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Sincerely,

_____
Name & Credential
_____

Submitter : Ms. **Date:** 08/20/2007

Organization : Ms.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. weems
Administrator-Designate

ATTN: CMS
I would like to address the July 12th proposed 2008 pahysicl fee schedule rule surrounding physician self-referral and the "in-office ancillary services" exception. POPTS (physician owned physical therapy services) has had a negative impact in our community for at least 15 years. Our practice essentially suffered largely due to the fact that the local orthopedist in our area did not refer to us. Why would they!!! They benefited financially from referring their patients to their own clinics. Patients were many times confused- they had no knowledge that they could legally receive therapy wherever they wanted- but the doctors told them to go to a place across the street or down the hall. Many of the patients that wanted to come to us- said the doctors would many times say negative things about our clinic- trying to direct them to their own place. Feedback from many patients that did have therapy in the MD's office was that it lacked good care. They were just a number. Improvement was slow, questionable and patients were many times left frustrated.
In smaller medical offices the PT was not provided by an registered therapist but the medical assistant and/or nurse. After months of therapy and no improvement-the patient would finally be referred to a separate and independent physical therapist.
I had a patient (older male in his early 80's) that had a rotator cuff repair. His MD told him while in was in the hospital to continue his therapy at the "clinic". This PT clinic and the Ortho office share the same space. Long story short- the PT stretched the RC too much re-tearing the shoulder requiring a 2nd surgery. Patient was then referred to us.
We had several direct referrals from the insurance company (work comp) and I subsequently received calls from the doctors office asking us why we were treating the patient. They did not refer the patient to us. They were suppose to go to their office. I of course told them the INSURANCE company requested our clinic.

It goes on and on. It is about greed- plain and simple. They want to make a quick and easy money and this is an avenue that is easy to target.

Please remove Physical Therapy from the "in office ancillary services".

Thank you for your time and consideration

Submitter : **Dr. Richard Cochran** **Date: 08/20/2007**

Organization : **Bostwick Laboratories**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 15, 2007
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Richard K. Cochran, M.D.
Medical Director, Phoenix, AZ

CMS-1385-P-6729-Attach-1.TXT

[redacted]
6729

August 15, 2007

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Richard K. Cochran, M.D.
Medical Director, Phoenix, AZ

Submitter : . **Date: 08/20/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The loop hole that allows physicians to offer in-office ancillary services needs to be closed. The whole idea of the Stark Laws is to eliminate profit or other types of compensation for referrals. A lot of different reasons have been presented by the physicians on why they want to own their therapy services. They state that there is improved communication, better continuity of care, improved treatments due to physicians being directly involved in the rehab program. All of the ideas presented by physicians on why they should owm their own rehab are a smoke screen. Good communication, continuity of care and a physician direct plan are necessary parts of any rehab program in the state of Indiana. The bottom line is that physicians want to own therapy services to make more money off of their patient's. Physicians can offer rehab facilities in their office and allow another company to own the practice and create all of the necessary componenets of a good rehab program, without them profiting of their refferals. This set up is ideal for the patient. It allows the patient to chose where they have rehab at, allows for competition in the market place, and limits the use of therapy services by a physician due to no secondary gains.
This loop hole needs to be closed as soon as possible. To protect patient's and insurance companies of fraud, to allow patient's to chose their healthcare options, and to protect the autonomy of the Physical Therapy profession.

Submitter : **Dr. William Glass** **Date: 08/20/2007**

Organization : **Bostwick Laboratories**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 15, 2007
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Sincerely,

William F. Glass, II, M.D.
Associate Medical Director

CMS-1385-P-6731-Attach-1.TXT

#67 31

August 15, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008." I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

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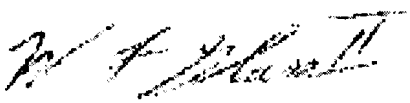
Sincerely,



William F. Glass, II, M.D.
Associate Medical Director

Submitter : Dr. Deloar Hossain **Date:** 08/20/2007

Organization : Bostwick Laboratories

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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Sincerely,

Deloar Hossain, M.D.
Associate Medical Director

CMS-1385-P-6732-Attach-1.TXT

#1732

August 15, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008." I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

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Sincerely,

Deloar Hossain, M.D.
Associate Medical Director

Submitter : **Dr. David Hull** **Date: 08/20/2007**

Organization : **Bostwick Laboratories**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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Submitter : **Date: 08/20/2007**

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a physical therapist practicing in the same community for an extended period, I have seen many changes in the healthcare environment. Once such change is the ease with which physicians may now own physical therapy practices and profit from them. I am totally opposed to this type of arrangement as it lends itself to abuses, which is why it used to be illegal. Medicare beneficiaries have a hard enough time managing the challenges of multiple health care issues arising later in life without the added challenge of trying to negotiate their way through a referral for profit situation. On many occasions we have experienced patients who want to come to us for rehabilitation but are told they must go to the physician's office, even if it is further for them to drive. We have had them pulled out of our care because the physician wanted to "more closely monitor" their status in their own facility, with the patient often never seeing the physician thereafter. And we have seen care take an exceptional length of time in these situations when ordinarily we would not have seen a patient for so long. We have also witnessed very poor outcomes for these patients as the quality of care provided is substandard, largely because the patient population is a "captive audience" of the physician and there is no competition. I believe it is wrong in any situation for a provider to profit from a referral, and it is wrong that CMS continues to allow physicians to profit so blantantly from the Medicare system by allowing this abuse to continue. Studies support the abuse to which I am referring, which encompasses so many areas: freedom of choice, poor outcomes, excessive cost, and added hardship to beneficiaries. I would ask that CMS please review its current stand and prohibit payment to physicians under such circumstances. Thank you.

Submitter : Dr. Deborah Josefson **Date:** 08/20/2007

Organization : Bostwick Laboratories

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 15, 2007
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Sincerely,

Deborah Josefson, M.D.
Associate Medical Director

Submitter : **Dr. Laura Michael** **Date: 08/20/2007**

Organization : **Bostwick Laboratories**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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Sincerely,

Laura Michael, M.D.
Associate Medical Director, Gastrocor

CMS-1385-P-6736-Attach-1.TXT

CMS-1385-P-6736-Attach-2.TXT

#6736

August 15, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008." I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

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Sincerely,

Laura E. Michael, DO

Laura Michael, M.D.
Associate Medical Director, Gastrocor

Submitter : **Dr. Olga Rosenblum** **Date: 08/20/2007**

Organization : **Bostwick Laboratories**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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Sincerely,

Olga Rosenblum, M.D.
Associate Medical Director

CMS-1385-P-6737-Attach-1.TXT

#6737

August 15, 2007

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Sincerely,

O Rosenblum

Olga Rosenblum, M.D.
Associate Medical Director

Submitter : Dr. Hillel Kahane **Date:** 08/20/2007

Organization : Bostwick Laboratories

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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Sincerely,

Hillel Kahane, M.D.
Medical Director, New York, NY

CMS-1385-P-6738-Attach-1.TXT

#6738

August 15, 2007

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Sincerely,

Hillel Kahane, M.D.
Medical Director, New York, NY

Submitter : Dr. Tita Lamm **Date:** 08/20/2007

Organization : Bostwick Laboratories

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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Sincerely,

Tita C. Lamm, M.D.
Associate Medical Director

Submitter : Dr. CHRISTOPHER LOMBARDI **Date:** 08/20/2007

Organization : AMERICAN SOCIETY OF ANESTHESIOLOGY

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

#6740

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 : Ms. Amber Carpenter **Date:** 08/20/2007

Organization : AC Physical Therapy PC LLC

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

It is important to maintain seperation between doctors offices and physical therapy offices for the protection of the consumer. Patient's should be referred to physical therapy with no secondary gain available to ensure appropriate referral patterns. Physical therapy practices are best owned, operated and managed by those who understand the practice of physical therapy best, the therapists themselves. If physicians own their practice, physical therapy practices, outpatient imaging, surgery centers etc etc there is no check and balance system in place to ward against price gouging for consumers and insurance companies. The power of practioners to impact the costs associated with health care must be considered when determining ability to own practices providing ancillary services. We should not continue to allow ancillary service provisions in physicians offices or physician owned ancillary services, hoping that no inappropriate referral or billing practices are occuring, rather steps must be made to protect the consumer, the insurance company and the proprietors of ancillary services. It is in the best interest of all but the physicians offices who wish to procure these anciallary services for profitability to prevent physical therapy practices to be owned by physicians.

Submitter : **Date: 08/20/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Patient receive better care in physician-owned physical therapy clinics as communication with the physician can be immediate such that appropriate rehab maneuvers can be performed and dangerous ones prevented. The government should not restict a patient's choice to be seen by any physical therapists, including those that work in physician owned clinics.

Submitter : **Dr. John Kasimos** **Date: 08/20/2007**

Organization : **Consultants in Pathology**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 6, 2007

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Sincerely,

John N. Kasimos, D.O., FCAP, FASCP FAOCP

Submitter : **Date: 08/20/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Mike Morel** **Date: 08/20/2007**

Organization : **Mr. Mike Morel**

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,

___Mike Morel CRNA_____
Name & Credential
___po349 Martin TN 38237_____
Address

_____
City, State ZIP

Submitter : **Dr. Leo Lu** **Date: 08/20/2007**

Organization : **Bostwick Laboratories**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 15, 2007
Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial confliet of interest that compromises the integrity of the Medicare program.
Sincerely,

Leo Lu, M.D.
Associate Medical Director

CMS-1385-P-6746-Attach-1.TXT

#6746

August 15, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008." I am a board-certified pathologist and a member of the College of American Pathologists. I practice in [include city, state of your primary practice area] as part of [include a description of your pathology practice, whether you are a solo practitioner or part of a 5-member pathology group and whether you operate an independent laboratory or practice in a hospital or other setting.]

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group's patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

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Sincerely,

Leo Lu, M.D.
Associate Medical Director