Submitter : **Mr. Jonathan Thompson** **Date: 08/21/2007**

Organization : **Sand Hill Bone**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

I am writing on behalf of myself, Dr. Susan Ott, & Jeff Finn PA-C

GENERAL

" We appreciate the opportunity to review some of CMS decision-making process as it contemplates changes to the Stark self-referral regulations.
" While CMS does not make specific proposals with regard to some of the self-referral provisions, we would like to submit comments and clarifications.

ANTI-MARKUP PROVISION

" The fiscal and ethical integrity of the Medicare program is a goal shared by all those who participate in it.
" CMS decision to focus on the billing of diagnostic tests of one physician or group where the diagnostic test is performed by someone other than a full time employee is appropriate.
" CMS approach of paying the less of the Medicare fee schedule amount, actual charges, or the charges of the physician performing the diagnostic test is inherently reasonable
" However, we do request that CMS ensure that the calculation of payment level under the anti-markup provision place no new administrative burdens on the billing physician or group.

IN-OFFICE ANCILLARY EXCEPTION

" We strongly challenge some of the characterizations articulated in this section of the proposed rule.
" CMS refers to hundreds of letters from physical therapists and occupational therapists that the in-office ancillary services exception encourages physicians to create physical and occupational therapy practices. CMS does not elaborate any further on the propriety or harm of this activity.
" The advantages of physician owned physical and occupational therapy practices to physicians, therapists and, most importantly, patients are well understood.
" These practices give patients more places to choose from to get physical therapy services. In some cases, it may be more convenient for patients to obtain therapy at their physicians offices than have to travel somewhere else to get them.
" In addition, some patients may feel more comfortable knowing that their therapists and physicians are working together at the same location.
" We request that CMS elaborate on its concerns in this area, acknowledging that the number of letters received on a subject is not always indicative of the gravity of the issue or need for correction.
" We also request that CMS engage in discussions with stakeholders on this issue given the obvious importance of physician expertise, patient needs, clinical quality, and the appropriate use of Medicare resources in the area of physical therapy.
" A drastic change to this exception would be harmful to patient ability to access necessary care in an appropriate and convenient setting with the oversight of their treating physician.

ALTERNATIVE CRITERIA FOR SATISFYING CERTAIN EXCEPTIONS

" We commend CMS on its attempt to bring rationality to the strict enforcement of inadvertent form violations of the self-referral regulations.
" However, we also believe that CMS should amend the proposal so as not to be so unilateral on the part of CMS.
" Surely CMS can preserve its authority, while simultaneously ensuring that those that are subjected to this rule and exception are able to access the benefits of it.

Submitter : Lisa Pic **Date:** 08/21/2007

Organization : Lisa Pic

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)
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,

Lisa C. Pic CRNA
9508 S. 27th Street
Bellevue, NE 68147

Submitter : **Dr. Dale Friesen** **Date: 08/21/2007**

Organization : **Lawrence Anaesthesia, P.A.**

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.

Dr. Dale W. Friesen, M.D.

Submitter : **Miss. Lisbeth Kovach** **Date: 08/21/2007**

Organization : **Cleveland Clinic**

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.

Lisbeth Kovach

Submitter : Dr. Michael Lange **Date:** 08/21/2007

Organization : Lawrence Anaesthesia, P.A.

Category : Physician

Issue Areas/Comments

GENERAL

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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.

Dr. Michael D. Lange, M.D.

Submitter : Dr. Dan Roelofs **Date:** 08/21/2007

Organization : Lawrence Anaesthesia, P.A.

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

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Dr. Dan O. Roelofs, DDS

Submitter : Dr. John Lindsey **Date:** 08/21/2007

Organization : Lawrence Anaesthesia, P.A.

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

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Thank you for your consideration of this serious matter.

Dr. John D. Lindsey. M.D.

Submitter : Dr. Kortnee Sorbin **Date:** 08/21/2007

Organization : Dr. Kortnee Sorbin

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Dr. Tom Nique **Date:** 08/21/2007

Organization : Lawrence Anaesthesia, P.A.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Dr. Tom A. Nique, M.D.

Submitter : **Date: 08/21/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am opposed to any changes in these policies as:
1. Policies in place currently have the ability to prevent abusive behavior.
2. In-office availability of service provides for continuity of care and higher quality outcomes.
3. In-office service are easier to access.
4. In-office service often are at lower cost to the patient to utilize when consideration is given for patient travel time, easier access to service locally and lower administrative cost due to few claims processing issues.
5. Physicians are faced with ever increasing costs of doing business. Continuing to reduce in-office ancillary services would have a negative economic impact on physicians and lead to further reductions in access to patient on Medicare and Medicaid due to the need for physicians to maximize income from higher paying patients to meet expenses.
6. Evidence from insurance carriers that we deal with shows that patients treated in an integrated environment have lower cost and better outcomes.
7. Markets that are competitive always have lower costs. Reducing competition by restricting in-office ancillary services will lead to higher cost as supply decreases.

Again, I am against any changes to the present in-office ancillary servise provisions as it relates to PT/OT and imaging.

Submitter : Mr. Michael Sorbin **Date:** 08/21/2007

Organization : Mr. Michael Sorbin

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Dr. John Breth **Date:** 08/21/2007

Organization : University of Kansas Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Date: 08/21/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern:

As a physical therapist in private practice, physician owned physical therapy practices have affected the number of referrals to our clinic. There are two physician groups in the area that have their own physical therapy practices. Since these practices opened, the referrals to my clinic have dramatically decreased, dropping by more than 27%.

These physician owned physical therapy offices were set up not for lack of quality physical therapy in the area but to generate additional cash flow for the doctors. It is a conflict of interest when you control the number of patients to your own physical therapy business. If you want to increase your bottom line, you send additional patients. You can not be objective as to who receives physical therapy and who does not.

I am supporting that physical therapy be removed from the in-office ancillary service exception to the federal physician self referral laws.

Thank you.

Submitter : **Date: 08/21/2007**

Organization :

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Joseph Labriola, DC

Submitter : Dr. Anthony Kovac **Date:** 08/21/2007

Organization : University of Kansas 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
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Thank you for your consideration of this serious matter.

Submitter : Dr. Cameron Burrup **Date:** 08/21/2007

Organization : Anesthesia Associates of New Mexico

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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Thank you for your consideration of this serious matter.

Submitter : Dr. Jana Goldsich **Date:** 08/21/2007

Organization : Dr. Jana Goldsich

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
P.O. Box 8018
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Submitter : Dr. peter hild **Date:** 08/21/2007

Organization : Dr. peter hild

Category : Physician

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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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.

Submitter : Ms. Beverly Lynch **Date:** 08/21/2007

Organization : Orthopaedic Surgeons of New Jersey

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

GENERAL

? We appreciate the opportunity to review some of CMS decision-making process as it contemplates changes to the Stark self-referral regulations.
? While CMS does not make specific proposals with regard to some of the self-referral provisions, we would like to submit comments and clarifications.

ANTI-MARKUP PROVISION

? The fiscal and ethical integrity of the Medicare program is a goal shared by all those who participate in it.
? CMS decision to focus on the billing of diagnostic tests of one physician or group where the diagnostic test is performed by someone other than a full time employee is appropriate.
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? However, we do request that CMS ensure that the calculation of payment level under the anti-markup provision place no new administrative burdens on the billing physician or group.

IN-OFFICE ANCILLARY EXCEPTION

? We strongly challenge some of the characterizations articulated in this section of the proposed rule.
? CMS refers to hundreds of letters from physical therapists and occupational therapists that the in-office ancillary services exception encourages physicians to create physical and occupational therapy practices. CMS does not elaborate any further on the propriety or harm of this activity.
? The advantages of physician owned physical and occupational therapy practices to physicians, therapists and, most importantly, patients are well understood.
? These practices give patients more places to choose from to get physical therapy services. In some cases, it may be more convenient for patients to obtain therapy at their physicians offices than have to travel somewhere else to get them.
? In addition, some patients may feel more comfortable knowing that their therapists and physicians are working together at the same location.
? We request that CMS elaborate on its concerns in this area, acknowledging that the number of letters received on a subject is not always indicative of the gravity of the issue or need for correction.
? We also request that CMS engage in discussions with stakeholders on this issue given the obvious importance of physician expertise, patient needs, clinical quality, and the appropriate use of Medicare resources in the area of physical therapy.
? A drastic change to this exception would be harmful to patient ability to access necessary care in an appropriate and convenient setting with the oversight of their treating physician.

ALTERNATIVE CRITERIA FOR SATISFYING CERTAIN EXCEPTIONS

? We commend CMS on its attempt to bring rationality to the strict enforcement of inadvertent form violations of the self-referral regulations.
? However, we also believe that CMS should amend the proposal so as not to be so unilateral on the part of CMS.
? Surely CMS can preserve its authority, while simultaneously ensuring that those that are subjected to this rule and exception are able to access the benefits of it.

Submitter : Mr. James Armentrout **Date:** 08/21/2007

Organization : Mr. James Armentrout

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a Physical Therapist that has been in practice for 10 years. I have seen in that period of time growing abuse of the Stark Law. I have seen a trend of more physicians opening up their own physical therapy clinics. Unfortunately when physicians have a vested interest in a physical therapy clinic, I have noticed they tend to refer solely to their own clinic. They also rarely, if ever, disclose to their patients that they own the clinic or that the patient has a choice to go wherever they want. Since patients typically will do whatever their physician recommends, their freedom of choice to go where they want for their physical therapy is being taken away. This strongly impacts the physical therapy clinics that are not physician owned since in most states it is required to have a physicians referral for physical therapy. The free market competition is being taken away. Many clinics are struggling and going out of business because the referral sources are not sending anymore patients since they have no financial profit from clinics they do not own. Another trend I have noticed is many of these clinics have 1-2 physical therapists on staff and the rest of the staff is support staff/techs. By doing this they keep costs down and increase profit margins, but are committing fraud by billing for physical therapy services that are being carried out by non-licensed staff. Finally, the patients I have treated over the years that have gone to physician owned clinics have commented that the care "was not very good" and they went for a high number of visits. The more patients that physicians can refer to themselves, the more visits that they can see these patients the more money these physicians will make.

I ask that you take this information into consideration and make changes to the Stark Law to allow a free market competition. This will also help with the overall expense to the government every year with physical therapy services. Our aging population will continue to grow and be in need of physical therapy, but we must act now to make the changes needed to give these patients the choice to find the best care in their area that will not lead to over utilization and an excessive expense to the government.

Sincerely,

James Armentrout, MS, PT, CFMT, Cert. MDT
Physical Therapist

Submitter : Ms. joanne hart **Date:** 08/21/2007

Organization : Ms. joanne hart

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I feel that rehab (PT) patients should have the right to go to physician office rehab facilities. This allows for their personal physician to monitor their process more closely as the therapists and physician can customize a program for the patient. Also, it allows more free competition, and as an individual this can result in a lower cost to me. Why wouldn't the government want to provide the ability for convenience of multi-places to get a health care service at perhaps a more competitive rate?

Submitter : Dr. James Ross **Date:** 08/21/2007

Organization : Cardiology Associates, PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Coding--Additional Codes From 5-Year Review. 72 Federal Register 38122. Payment for Doppler flow studies as part of the echocardiogram should not be discontinued. Payment is required as reimbursement for the physician's time to read the Doppler study, the tech's time to do the study, and for the cost of buying the Doppler equipment.

Submitter : Mr. David Schwytzer, CRNA **Date:** 08/21/2007

Organization : KyANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 21, 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:

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,

David Schwytzer, CRNA
PRESIDENT, KENTUCKY ASSOCIATION OF NURSE ANESTHETISTS
7004 NEW BERN COURT
Prospect, KY 40059-9668

Submitter : Dr. Paul Friedman **Date:** 08/21/2007

Organization : DermSurgery Associates

Category : Health Care Professional or Association

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

It is inappropriate to subject 17311 and 17313 to the multiple procedure reduction rule for repairs performed on the same day as the Mohs procedure or for multiple Mohs lesion excisions performed on the same day. Following are some concerns regarding the proposed changes to the Medicare 2008 Fee Schedule:

" This proposal will negatively impact Medicare beneficiaries access to timely and quality care and application of the Multiple Procedure Reduction Rule will not likely generate significant cost savings and may paradoxically increase the cost of providing care to these patients.

" By removing the exempt status of the Mohs codes. Medicare beneficiaries access to timely and quality care will be effected. Application of the proposed rule to a second tumor treated on the same day will mean that reimbursement for the second procedure does not cover the cost of providing the service. This will affect Medicare beneficiaries disproportionately, since the incidence of skin cancers peaks in Medicare-age patients, who are most likely to have multiple tumors.

" Patients who are immuno-suppressed from organ transplantation, cancer chemotherapy, infection or other diseases are at significantly higher risk for skin cancers and often have multiple tumors. Many of these patients are also Medicare beneficiaries. These immuno-suppressed patients are not only at higher risk for cancers but also at higher risk for potential metastases and possibly death from skin cancers, especially squamous cell carcinoma.

" When Mohs procedures are performed with higher-valued repairs such as flaps or grafts, application of the MPRR to the Mohs codes will result in reduced reimbursement for Mohs that doesn t cover the cost of the procedure. Likewise. for lower-valued repairs such as intermediate and complex layered closures. which are the most commonly performed repairs, reduced reimbursement will not cover the cost of the repair.

" Because of the dual components of surgery and pathology associated with each Mohs surgery procedure, there is no gain in effic encies when multiple, separate procedures are performed on the same date, making application of the reduction inappropriate.

Submitter : Jonathan Nugent **Date:** 08/21/2007

Organization : Jonathan Nugent

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am strongly encouraging the elimination of physical therapy services from in-office ancillary services. The ability of a physician to self-refer for financial profit is ripe with opportunities for fraud and abuse as well as limiting the individuals option to seek the physical therapist of his/her choice. Indeed, OIG audits discovered alarming rates of fraudulent billing within physician-owned physical therapy practices. This practice reflects negatively on the entire physical therapy profession. Furthermore, many physicians do not follow APTA guidelines and use unlisenced and unqualified staff to deliver services under a standard protocal. Finally, the significant proliferation of physician-owned practices has driven many excellent physical therapists out of business and left other therapists with little options except to work for a physician.

Submitter : Dr. John Goeders **Date:** 08/21/2007

Organization : Dr. John Goeders

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. Pablo Motta **Date:** 08/21/2007

Organization : Cleveland Clinic Foundation

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.

Pablo Motta, MD

Submitter : Ms. Jan Dueringer **Date:** 08/21/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 20, 2007
Ms. Leslie Norwalk, JD

Dear Ms. Norwalk:
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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.
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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.

Submitter : Mrs. Sandy Armstrong **Date:** 08/21/2007

Organization : OhioHealth

Category : Nurse

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Mr Weems,
My mother saw a physician for her painful knee. He recommended physical therapy and scheduled her initial evaluation appointment while she was still in his office. She asked if she could go see our neighbor (physical therapist) that works in a PT facility close to our home. He told her no, that he wanted her to "stay in his system". She felt she had to follow his insturctions because he was her doctor.
When she told me about the appointment. I told her to cancel the PT evaluation. When she called to cancel it, she learned that he OWNED this clinic that he insisted she go to. We still cancelled the appointment and took her to our neighbor's facility. Our neighbor told us that his office was refusing to send her a copy of the physical therapy prescription, stating that my mom was supposed to be attending therapy at the doctor's PT office.
I think it is fradulent that this physician can intimidate patients like my mother in this way. His clinic was not close to our home or convenient for her to drive to. His clinical decision was motivated by making money on her therapy, not what was best for my mother. She was not permitted to make her own decision about where she attended therapy.
PLEASE close the loophole that allows physicians to practice this way. Patient care is getting lost while physicians are allowed to pad their own pockets with ancillary service.
Sincerely,
Sandy Armstrong, RN

Submitter : Dr. Carmen Fernandez **Date:** 08/21/2007

Organization : Fernandez Orthopedics PA

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

SCHEDULE PROPOSED RULE: STARK PROVISIONS

8/15/07
GENERAL
" We appreciate the opportunity to review some of CMS decision-making process as it contemplates changes to the Stark self-referral regulations.
" While CMS does not make specific proposals with regard to some of the self-referral provisions, we would like to submit comments and clarifications.

ANTI-MARKUP PROVISION
" The fiscal and ethical integrity of the Medicare program is a goal shared by all those who participate in it.
" CMS decision to focus on the billing of diagnostic tests of one physician or group where the diagnostic test is performed by someone other than a full time employee is appropriate.
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" However, we do request that CMS ensure that the calculation of payment level under the anti-markup provision place no new administrative burdens on the billing physician or group.

IN-OFFICE ANCILLARY EXCEPTION
" We strongly challenge some of the characterizations articulated in this section of the proposed rule.
" CMS refers to hundreds of letters from physical therapists and occupational therapists that the in-office ancillary services exception encourages physicians to create physical and occupational therapy practices. CMS does not elaborate any further on the propriety or harm of this activity.
" The advantages of physician owned physical and occupational therapy practices to physicians, therapists and, most importantly, patients are well understood.
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" We also request that CMS engage in discussions with stakeholders on this issue given the obvious importance of physician expertise, patient needs, clinical quality, and the appropriate use of Medicare resources in the area of physical therapy.
" A drastic change to this exception would be harmful to patient ability to access necessary care in an appropriate and convenient setting with the oversight of their treating physician.

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" We commend CMS on its attempt to bring rationality to the strict enforcement of inadvertent form violations of the self-referral regulations.
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Therapy Standards and Requirements

Therapy Standards and Requirements

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8/15/07
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Submitter : Dr. Ardaman Nanda **Date:** 08/21/2007

Organization : Midwest Cardiovascular Consultants, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

The performance of an color flow doppler is important for appropriate patient management requiring additional time for the technician to perform the procedure as well as the additional physician time to interpret the study. Therefore, the above has a significant impact on the bottom line regarding patient care and practice expenses.

Ardaman Nanda, M.D.

Submitter : Mr. **Date:** 08/21/2007

Organization : Mr.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist who has been in private practice in NY and NJ since 1997. In that time, I have had the opportunity to treat and speak with thousands of patients, in and out of the medicare system, with regards to various changes in the healthcare system. We provide a significant value in our services to patients in that we make every effort to make the patients self reliant, accountable for their self care and independent in function as soon as they can safely do so.
The 2 comments that I hear most often from patients is that we provide 'true individualized physical therapy' as opposed to a one size fits all rehab program.
Second is that they were able to limit the number of visits as compared to prior experiences.
Lately, however, patients have not even had the opportunity to test out our services because of an increase of physician owned physical therapy practices.
Physicians who own physical therapy practices, or who employ PT's in their facility, will not allow patients to go elsewhere for their care.
In the past 7 months alone, I have had more than 12 incidences where a physician either witheld a referral, threatened that they will not follow up with the patient if they go outside the physicians office for therapy,or provide services such as 'free massages' camouflaged as physical therapy. all for financial gain for the doctor.
While we can argue who provides 'better' therapy or medically appropriate therapy, we cannot argue that if a patient requests to go to a specific physical therapist because of a recommendation, prior experience, or simply geographical convenience, they should be allowed to do so.
Because of medicare referral requirements, physicians have a captive referral audience of patients in their office. Patients are never given the opportunity to be evaluated by independent practitioners.
Physical therapists are highly educated and trained in identifying musculoskeletal dysfunctions. Almost all of the recent graduates are earning doctoral degrees and many past graduates are continuing their education at the doctorate level. Physician direct supervision is not needed to administer physical therapy. New York State became the 43rd state in the union to allow direct access to physical therapists for 10 visits or 30 days, whichever is least, where patients can eliminate the time and expense of going to their pcp to simply get a referral for physical therapy. An increasing number of physician owned physical therapy clinics are using the reassignement of benefits laws to collect payment in order to circumvent 'incident - to' requirements.

Thank you kindly for allowing me the opportunity to express my experience of the changes and impact that physician owned physical therapy offices have had on our patients and our community. Lets end this potential for fraud and abuse close the loopholes in the physician self referral, and improve the quality of patient care.

Sincerely,
Mark

Submitter : Mrs. Jennifer Milam **Date:** 08/21/2007

Organization : Mrs. Jennifer Milam

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see Attachment

CMS-1385-P-6966-Attach-1.DOC

#6966

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

Re: "TECHNICAL CORRECTIONS"

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

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

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

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

Sincerely,

Jennifer Milam
2302 N. Chelsey Ct.
Orange, CA 92867
(714)227-8569

Submitter : Dr. Meagan Bouse **Date:** 08/21/2007

Organization : Dr. Meagan Bouse

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Now, 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 - particularly as medicare patients tend to be the most complex and medically challenging patients to care for, 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 very much for your consideration of this serious matter.

Submitter : Dr. Robert Westergan **Date:** 08/21/2007

Organization : Jewett Orthopaedic Clinic, P.A.

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The advantages of physician owned physical and occupational therapy practices to physicians, therapists and, most importantly, patients, are well understood. Patients may feel more comfortable knowing that their therapists and physicians are working together in the same location. A drastic change to this exception would be harmful to patients as it limits the ability for patients to access necessary care in an appropriate and convenient setting with the oversight of their treating physician.

Submitter : Mrs. Cheena Kapoor-Cantlie **Date:** 08/21/2007

Organization : Cleveland Clinic

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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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.

Cheena Kapoor-Cantlie

Submitter : Ms. Marilyn Schneider **Date:** 08/21/2007

Organization : Fairview Hospital

Category : Individual

Issue Areas/Comments

GENERAL

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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.

Marilyn F. Schneider

Submitter : Mr. G Robert Rozic **Date:** 08/21/2007

Organization : Cleveland Clinic

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

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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.

G Robert Rozic

Submitter : Dr. Timothy Melson **Date:** 08/21/2007

Organization : Dr. Timothy Melson

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SeeAttachment

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.

CMS-1385-P-6972-Attach-1.DOC

Submitter : Dr. Jeffrey Lu **Date:** 08/21/2007

Organization : University of Utah

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Sincerely,
Jeffrey Lu, MD
Professor

Submitter : Dr. Sarah Clauss **Date:** 08/21/2007

Organization : Children's National Medical Center

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

To CMS:

I am writing regarding the proposed change to eliminate CPT 93325 and bundle this code into other CPT codes. As a cardiac specialist caring for pediatric patients / adults with congenital heart disease, this is of particular concern to me because:

I do not believe the appropriate process has been followed with respect to this change. After significant interaction and research between the RUC and the appropriate specialty societies (in this case The American College of Cardiology and the American Society of Echocardiography), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that the list of above echo codes be bundled as well with the 93325.
This new code is fully expected to address any outstanding issues relative to Medicare utilization of 93307, and has been analyzed at length by appropriate national medical societies, the CPT editorial panel, and the RUC. However, as a result of this proposed regulatory action by CMS, we are faced with resolving, in an accelerated timeframe of less than two months, an issue that directly impacts a distinctly non-Medicare population namely, pediatric cardiology practices and which is normally addressed over a multi-year period. Further, because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

The surveys performed to set the work RVU s for almost all of the echo codes utilized specifically by pediatric cardiologists and adult cardiologists caring for patients with congenital cardiac abnormalities and affected by this proposed change were performed more than 10 years ago. As a result, particularly with respect to the 93325, the RVU s are reflective of a focus on the cost of the technology and not the advances in care that have been developed as a result of the technology. Particularly among those who care for this select group of patients, much needed new surveys would provide evidence that the work and risk components of the procedures that involve Doppler Color Flow Mapping have evolved to the point where the relative value of the procedures have shifted to a significantly greater work component and a lesser technology component.
This shift is reflected in the development of national standards such as those present in the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL) initiative to develop and implement an echo lab accreditation process. The focus of this initiative is on process, meaning work performed, and less so on the technology associated with the provision of echocardiography services. In 1997 there were specific echocardiography codes implemented in CPT for congenital cardiac anomalies to complement the existing CPT codes for echocardiography for non congenital heart disease. "The codes were developed by the CPT Editorial Panel in response to the American Academy of Pediatrics and the American College of Cardiology s request to delineate more distinctively the different services involved in assessing and performing echocardiography on infants and young children with congenital cardiac anomalies." (CPT Assistant 1997).

CPT Code 93325 describes Doppler color flow velocity mapping. This service is typically performed in conjunction with another echocardiography imaging study to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow velocities.

Submitter : Dr. Linda Reed **Date:** 08/21/2007

Organization : Dr. Linda Reed

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

SEE ATTACHMENT

CMS-1385-P-6975-Attach-1.DOC

#6975

Physical therapy, as a profession, has and will continue to evolve, producing therapists who have the expertise needed to assess dysfunction of the movement system, set an appropriate plan of treatment, deliver the treatment and continue to assess the progress of the patient to be sure the treatment is effective.

The movement system includes the musculoskeletal system [muscle, bone, soft tissue (tendons, ligaments, fascia)], neurological system, cardiovascular / respiratory systems including brain function, balance & equilibrium among others.

Physical therapy also has areas of specialty requiring further education. This includes women's health, neonatal, pediatrics, orthopedics, and other areas whereby the therapist is certified in their particular area of expertise.

The PT also has the ability to screen for conditions that would best be referred to another medical specialty through their extensive training in recognizing red flags or signs of pathology that would not fall under the auspice of the therapist's. The PT would then refer the patient to the appropriate medical specialty.

As a physical therapist practicing for 36 years and having continued my education from a bachelor's degree to a master's to a DPT [doctor of physical therapy] I feel I am able to offer patients the expertise they deserve with regards to any movement system dysfunction & to give them the chance they deserve to get better and enjoy their life to it's fullest, no matter how complicated their dysfunction may be.

A physician can offer their patients many options for treatment including medications. I wonder how the MD would feel if a PT told their patient they were the same as an MD because the PT gave the patient a bottle of OTC vitamins. M.D.s are medical doctors, NOT physical therapists.

Often, the required prescription sent to the PT from the MD has a dubious diagnosis such as shoulder pain or back pain, which is a symptom not a diagnosis. Many knowledgeable M.D.s do rely on the expertise of the PT to make the correct diagnosis causing the pain symptoms.

When a medical doctor or chiropractor tells a patient they will be receiving physical therapy, & has an untrained office worker give the patient a modality such as ultrasound, or electrical stimulation, the patient actually believes they have had real therapy. But nothing could be farther from the truth.

It is time physical therapy as a genre, be recognized as a specific area of medical expertise and require a licensed PT to provide such treatment. Any professional other than an actual PT providing treatments & calling it PT is misleading & short changing the patient population.

In one very egregious situation, I was working part time in an office as a so called "consultant". The doctor said he needed a real PT to do evaluations for certain patients he felt were in need of my expertise. I carried a small caseload of about 10 patients, 2 to 3 days/week.

A rubber stamp of my signature was created & phony evaluations created, phony SOAP notes, and hundreds of patients were billed for PT services under my license.

I started to get suspicious when I saw some of the documentation and questioned the doctor. His answers did not satisfy me so I called some of the major insurance companies and had them do an audit of billing on my license. As a result of their findings, I went to the FBI who in fact had been investigating this person. Eventually, he did 2 years in prison. My license wasn't the only license he did this to.

Many patients have told me other horror stories of their experience in non-PT owned practices. It is clearly time to stop this potential for abuse and to recognize PT as the unique specialty it is, allowing only licensed physical therapists to perform and bill for physical therapy services.

Thank you !

Linda D. Reed DPT, MEd

Submitter : Dr. Michael womack **Date:** 08/21/2007

Organization : Resurgens Orthopaedics

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As an orthopaedic surgeon it is apparent to me that supervised rehabilitation therapy is a key adjunct in the treatment of many of my operative and non operative patients. The ability to provide in office Rehabilitaion/ Physical therapy services benefits the patient and the healthcare system in multiple ways. Specifically, such access improves convenience for the patient and decreases cost thru free market increased competition. The continuity of care/ quality of care are improved in that the treating physician is able to train the therapist in the desired protocols and techniques and more closely follow the patient's care. For example, our group has recently invested heavily in an electronic medical record system. All of our physical therapy sites are linked and all of our therapists input their progess reports directly into the EMR system at the actual encounter. The net result is that the physician is constantly updated on progess or problems and can better control the care. When the patient is unable to attend our rehab I rarely get a progress report or update prior to the next office follow up visit (many weeks). Thus the continuity of care and quality of care for the patient is effected. Finally- studies confirm that in office rehab facilites have superior Physical therapist to patient scheduling ratios. This translates to better direct time involvement between the patient and the therapist. To summarize, when free market competition is allowed to continue between tradition physical therpay establishments and between in office rehabiltiation therapy establishments the cost is reduced, the quality is improved and THE PATIENT derives maximum benefit and quality of care. Therefore, please support the continuation of in office physical therapy/ rehabilitiation services for our patients

Submitter : Dr. Charles Austgen **Date:** 08/21/2007

Organization : Dr. Charles Austgen

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Joel H. Mumford** **Date: 08/21/2007**

Organization : **Dr. Joel H. Mumford**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Joel H. Mumford, M.D.
221 Elm Hill Road
Springfield, VT 05156

Submitter : Dr. Hayden Hughes **Date:** 08/21/2007

Organization : UAB

Category : Physician

Issue Areas/Comments

GENERAL

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

Submitter : Dr. Stephen Siegel **Date:** 08/21/2007

Organization : Urology Specialists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am a private practice urologist with an office located in Middlebury, CT and service a wide catchment area. We are a group that has been around for 75 years and is a very well respected group of 7 physicians. We are proud to be able to offer our patients the wide variety of urologic care that they need. I am a partial owner in a joint venture LLC that owns a lithotripter and through this I am able to provide lithotripsy service to our patients.

It was not too many years ago that our closest option for shock wave lithotripsy was in the Bronx, NY, several hours away. Our patient population is older and this trip was near impossible, causing many patients to forgo an easy to recover from procedure and choosing a much more invasive procedure just so they could stay closer to home. Shock wave lithotripsy is certainly the gold standard in the treatment of many stones and having the service available in my town/my hospital has improved patient care without question. I serve on the medical advisory board of our LLC and meet each quarter to go over the performance of the machine, making sure that our patients are receiving the best possible results. Before out ability to invest in this LLC, I was not able to get this type of quality assurance feedback and was not able to quote accurate risks and benefits to my patients.

The under arrangement contracting would impact us in several ways. Right now we have the greatest access to the newest technology and I am afraid that by not having LLC's like ours we would not be sharing the costs of the machines with the hospitals and the benefit of bringing the machine around connecticut to the smaller hospitals will be lost.

A couple of questions still remain, are we a designated health service? American Lithotripsy vs Thompson states we are not. What are the services that are not dhs when performed outside of a hospital? Why are there concerns about overutilization? The only way this machine can be used is if a patient is found to have a stone, it is not a diagnostic tool.

There are many other concerns, but I hope that this letter shows you some. I appreciate you taking the time to read this and your consideration.

Respectfully
Stephen Siegel MD