Submitter : **Ms. Jessica Morgan** **Date: 08/24/2007**

Organization : **Evergreen Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing to express my concern regarding the in-office ancillary service arrangements that have impacted the delivery of quality physical and occupational therapy.

The "in-office ancillary services" exception has created a loophole which has resulted in many physician-owned arrangements that provide substandard PT and OT services.

Physicians are in a position to refer Medicare beneficiaries to in-office PT and OT services in which they have a financial interest. There is an inherent financial incentive to overutilize services under the in-office ancillary services exception.

Therapy treatments are repetitive in nature. Patients receiving outpatient PT and OT can just as easily return to a therapy clinic as to the physician office.

Thank you for considering these comments and eliminating this "in-office ancillary services".

Sincerely,

Jessica Morgan, MS, PT

Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems
Administrator-Designate
Cntrs. for Medicare and Medicaid Svcs.
U.S. Dept. of Health & Human Services
Attention: CMS-1385-P
RE: Physician Self-Referral Issues

CMS-1385-P-7619-Attach-1.DOC

#7621

Mr. Kerry N. Weems
Administrator-Designate
Cntrs. for Medicare and Medicaid Svcs.
U.S. Dept. of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018
RE: Physician Self-referral issues

FREEDOM
PHYSICAL THERAPY
SERVICES, S.C.

Dear Mr. Weems:

I am a physical therapist who has worked in private practice in Milwaukee, Wisconsin for 8 years. I would like to comment on the July 12th proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception.

The company for which I work takes pride in seeking out and hiring very well-educated, experienced therapists who provide exceptional care. With declining reimbursement and limited visits with both Medicare and other insurers it has become increasingly difficult financially, for us to provide the high level of patient care our patients are used to. To compound the problem, we have physician groups reaping the financial rewards of referring patients to therapy practices they own instead of therapy practices that may provide superior and more cost-effective care. This is possible due to the "in-office ancillary services exception" to the Stark Law, as physical therapy is currently considered a "designated health service (DHS)". In some cases, these patients are not even being seen by PT's, but instead by PTA's and ATC's under the physician's direction. This is illegal under Physical Therapy laws and needs to stop.

Generally speaking, physical therapy services are provided on a repetitive basis. That said, it is no more convenient for the patient to receive PT services 2-3 times per week in the physician's office than to attend an independent physical therapy location. Furthermore, physician-direct supervision is not necessary to administer physical therapy services. In fact, an increasing number of physician-owned physical therapy clinics are using the reassignment of benefits laws to collect payment in order to circumvent "incident-to" requirements.

Thank you for your consideration of my comments. I hope these comments have helped to highlight the abusive-nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

Sincerely,

A Concerned Physical Therapist in zip code 53004

Submitter : Mr. Alex Chown **Date:** 08/24/2007

Organization : Black River Falls Emergency Medical Service

Category : Local Government

Issue Areas/Comments

Ambulance Services

Ambulance Services

The proposed rule CMS-1385-P includes provisions that BRF EMS feels are unnecessary. The requirement for separate forms for the receiving hospital, relative of the patient, and ambualnce crew to sign when a patient is unable to is a duplication of paperwork. The ambulance crew and the receiving hospital already sign the Patient Care Report (PCR) which indicates the time, date, and name of hospital receiving the patient. To add another document is just a waste of resources and only adds another possibility of omitting a required form for payment. Our reimbursement for services is already so low that it barely covers our cost of providing the service. We have prided ourselves on being self sufficient and relying only on user fees for our service to survive. If our compensation continues to be cut for technical reasons, our service may be forced to go on the tax roll and rely on local property owners to subsidize our much needed service. Our medical assignment form already includes a place for someone to sign on behalf of the patient in the event the patient is unable to sign. I feel this form is sufficient documentation along with a completed PCR.

A. Brad Chown
EMS Division Chief
Black River Falls EMS

Submitter : Dr. Dean Muscarella **Date:** 08/24/2007

Organization : Muscarella Chiropractic

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

It is absolutely unacceptable to limit the ability of a chiropractor to get radiographs ordered for the purposes of diagnosis and demonstration of a subluxation and not have the radiographs paid for under medicare. These proposals are clearlly politically driven and have no clearly logical explanations other than medical domination of the medicare system without regards to what is best for patients. What about those people that do not want to see a medical practitioner and only want to see a chiropractic doctor? Why shouldn't they have that choice? Freedom of choice is what this country is founded on and there is no excuse for the removal of these choices under government policies. We all pay taxes and should have a say in who we can see when we are covered by our own tax dollars for medical purposes. I am sure that this is unconstitutional. It is no wonder congress at this time has a low approval rating. Everything about this is unfair and unjust. Clearly the people that have written this are thinking of their own gain and not the freedom of choice we should be guarunteed under our United States Constituition. This is uncalled for!

Submitter : **Dr. John McCall** **Date: 08/24/2007**

Organization : **Dr. John McCall**

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.

John E McCall MD
Professor of Anesthesiology and Pediatrics
University of Cincinnati

Submitter : **Mrs. Barbara Kancso** **Date: 08/24/2007**

Organization : **Portsmouth Anesthesia Associates**

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 : **Miss. Heather Hopkins** **Date: 08/24/2007**

Organization : **Portsmouth Anesthesia Associates**

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 : **Mrs. Lisa Nelson** **Date: 08/24/2007**

Organization : **Portsmouth Anesthesia Associates**

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 : **Mrs. Rebecca Luck** **Date: 08/24/2007**

Organization : **Portsmouth Anesthesia Associates**

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 : **Mrs. Leah Anderson** **Date: 08/24/2007**

Organization : **Portsmouth Anesthesia Associates**

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. ANDREW PETRELLA **Date:** 08/24/2007

Organization : CITRUS ORTHOPAEDIC AND JOINT INSTITUTE

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

While we as a physician owned practice understand the debate and the financial impact that it has had on therapist owned practices, we must ask CMS to look at this from a global perspective.

The first question to be addressed is cost to the Medicare program and fiscal integrity. Can a correlation be made between an increase in physician owned therapy practices and Medicare outpatient therapy expenditures? A particular individual groups gain or loss should not play a factor in government decisions and regulations.

The next question CMS needs to concern itself with is, Does the quality of care differ in either circumstance? We can hypothesize that a closer proximity to the physician provides better care but I realize that we can all reference situations whereby the care was inadequate in either ownership situation. There are circumstances where physicians have been negligient in the hiring of proper staff to provide therapy services as well as therapist owned practices where there was a lack of communication between the ordering physician and the therapist and protocols were not followed appropriately. Additionally we can all site examples where the physician increased referrals due to his ownership but we can also remember the therapists who gained a lot thru giving lavous gifts to physicians. The bottom line is that integrity can be compromised regardless of ownership.

It is the foundation of America that a free market with little government intervention provides the best outcomes. I ask that CMS remain neutral on a self fulfilling request that physician owned therapy groups be banned. Let s let the market, competition and supply and demand determine who can manage and run these care facilities. Patients will not continue in subpar therapy practices. They will demand better care. Regardless of ownership, practices will be forced to compete at higher levels. Since an increase in physician ownership we have seen competition lead to increases in individual therapists salaries. This was actually a positive for many therapists whose passion was providing care without embarking on the business risks and responsibilities. Physician owned therapy practices also incur higher salary costs due to more stringent supervision rules. Stand alone outpatient facilities only require therapists general supervision of therapy assistants (whose salaries are half those of PTs and OTs). Thus you have assistants essentially running practices alone. However, CMS requires physician owned practices to have a PT or OT directly supervise therapy assistants for Medicare patients. The APTA has already crippled physician practices via this arena. Perhaps this is why they are in a better bargaining position for commercial insurance contracts. Increased
competition has also led to more bargaining for insurance contracts including Medicare replacements. With these lower reimbursements, and higher therapy staffing costs (due to both competition and CMS supervision regs) we have seen many physician practices lose these insurance contracts to their therapy owned counterparts.
CMS do not change the In Office Ancillary Exception, let s let patient demand and competition determine the best owners not personal interests.

Physician Self-Referral Provisions

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CMS do not change the In Office Ancillary Exception, let s let patient demand and competition determine the best owners not personal interests.

Submitter : **Ms. Lisa Rountree** **Date: 08/24/2007**

Organization : **Portsmouth Anesthesia Associates**

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 : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would like to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. The Potential for fraud and abuse exists whenever physicians are able to refer to their own practices offering physical therapy services. Physicians who own practices that provide physical therapy have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. By eliminating physical therapy as a designated health service furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutilization of physical therapy services under the Medicare program, and enhance the quality of patient care.

I have personally received referrals from physicians that own their own physical therapy practices when the patient they send to me is a "VIP" patient or one of their friends. All of their "other" patients are referred to thier own physical therapy practice. Telling me that my clinic gives better care and has better out-comes as comparred to the physician owned clinic.

The "referral for profit" to physician owned physical therapy clinics should not be allowed.

Thank you for the consideration of these comments,

KC, Physical Therapist

OKlahoma City, Oklahoma

Submitter : **Ms. Jennifer Cantillo** **Date: 08/24/2007**

Organization : **Portsmouth Anesthesia Associates**

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
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Thank you for your consideration of this serious matter.

Submitter : Dr. Joseph Restivo **Date:** 08/24/2007

Organization : NEOCS

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Echocardiography consists of 2D imaging and color flow Doppler for evaluation of different cardiac and medical diagnoses. Color flow Doppler involves additional time and skill on the part of both the sonographers and the physicians interpreting these studies. Bundling the two modalities together would be a mistake and would be unfair to the above mentioned parties in terms of fair reimbursement for the additional time and skillset required to perform color flow Doppler on patients when indicated. I hope that CMS will reconsider the impact of this proposal on the quality of future patient from both the perfomance and interpretation of echocardiography perspectives. Thank you for you consideration in this matter.

Submitter : **Albright Joseph** **Date: 08/24/2007**

Organization : **Albright Joseph**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing to request that physical therapy services be removed as a DHS permissible under the in-office ancillary exception of the federal physician self-referral laws. I believe there is the potential for fraud and abuse whenever physicians are able to refer Medicare beneficiaries for physical therapy services in which they have financial interest. These physicians have an inherent financial incentive to refer their patients to these offices and to overutilize those services for financial reasons. The 'in-office ancillary services' exception has created a loophole that has resulted in an expansion of physician owned practices across the U.S. Because of Medicare referral requirements, physicians have a captive referral base of PT patients in their offices, thus providing the opportunity for abusive referral. By eliminating physical therapy as a DHS furnished under the in-office ancillary services exception, CMS would reduce overutilization of PT services and enhance the quality of patient care.

Submitter : Dr. TERRY KERBS **Date:** 08/24/2007

Organization : Dr. TERRY KERBS

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

To not allow any reimbursement for an x-ray that may be viewed by a chiropractor is extremely poor quality of care for the very people we are caring for. The x-ray is the most simple, cost effective way to allow the first look at the possibility of disease. 80 % of tests done by M.D. are to rule out x,y, or z, without any regard for what actually may be going on. Many conditions and diseases that patients have are first noted by their chiropractors, and then referred to the M.D.'.s It would be a severe blow to our seniors, as well as a costly mistake, to not allow medical reimbursement.

Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The "in-office ancillary services" exception of Stark II was designed to prevent limitations in quality and timeliness of patient care. However, in most cases this exception is used to allow physicians who own a physical therapy practice to profit by referring patients, some who are appropriate, some who are not appropriate for skilled physical therapy care, to their own facility. This completely defeats the purpose of Stark II, which was created to prevent inappropriate physician profit from patient misfortune. When the spirit of this law is limited by an exception designed to improve the quality and timeliness of patient care, this brings about concerns regarding the validity of the law and its ability to protect the rights of patients and other consumers.

Submitter : **Caroline Snooks** **Date: 08/24/2007**

Organization : **Lahey Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the 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 Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
__Caroline E Snooks, CRNA_____
Name & Credential
__11 Joyce Rd_____
Address
_Framingham, MA 01701_____
City, State ZIP

Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

CMS please stop the continued praetice that allows Physicians to make financial gains from self referals. It is simply wrong and adds to the massive cost to the health care system. As a physical therapist I seen the miss use as both a professional and a patient.

In my profession, I have witness MDs ask, no insist, that a patient attend their MD owned referal for profit Physical Therapy clinic when a closer operation of better quality is more easier for the patient to attend. When the patient attended their therapy session- it was a mass operation in which the operation had no respect for the profression and allowed significant periods of time during the patient's treatment go unsupervised in an effort to simply see more patients. When the treating PT was asked why there are so many patients and so few PTs, the response was simply- "The Doctor just tells me to see as many people as I can, but the pay is good so I deal." Disgusting.

As a patient, I took my son to see an Ortho after he broke his arm. After the cast was removed, the xray showned a cleanly healed fracture site, but my son made a comment that now he some stiffness in his elbow. The first think the MD said was he wanted to head down the hall to get a 'quick' MRI- completely unneeded and I said so, it was simply stiffness after being in a cast for 5 weeks.

The simple fact is there is no need for MDs to have the ability to profit off of their ablity to refer needed services. There is documented evidence that utilization is highter when a MD has a finacial interest in an ancillary service. Why? Simply beeasue they get paid to refer more! If the drug companies gave financial reward for writing more of on specific drug, it would be a kickback. Yet we allow the MDs to give kickbacks to themselves.

For the sake of the patients and the future of healthcare please put an end to ablity for the MD to profit off of the ability to write a prescription.

Submitter : **Ms. Emily Collar** **Date: 08/24/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Please support the revisions to payment policy for physician fee schedule docket CMS-1385-P. CRNA's provide an invaluable service all over the country providing excellent, much needed anesthesia care and deserve to be reimbursed for their time and experience they bring to the table with every case. Thank you for your support of this measure. Emily Collar, CRNA

Submitter : **Dr. Sam Fenner** **Date: 08/24/2007**

Organization : **Dr. Sam Fenner**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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.

Samuel Fenner

Submitter : **Dr. james scirotto** **Date: 08/24/2007**

Organization : **scirotto chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-7642-Attach-1.DOC

7642

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,
Dr. James V. Scirotto
4969 Rte. 51 North
Belle Vernon, PA 15012
724.379.4000

Submitter : **Date: 08/24/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Last year my doctor recommended treatment of my neck and back with physical therapy. He suggested the physical therapy facility on premises. I felt uncomfortable with this request and asked him to provide the names of physical therapy facilities in which his patients found the highest rate of successful treatment.

Perhaps some doctors look out for the patient s best interest in referring a physical therapy facility; however that was not my experience. It is my experience that many patients, especially elderly patients, accept their doctors advise unconditionally. If I had not requested additional facilities, I would not have received the information necessary to make an informed choice regarding physical therapy.

Based on my experience I feel that it is a conflict of interest when physicians supply physical therapy services in-house. I urge CMS to remove physical therapy as a service permissible under the in-office ancillary services exception of the federal physician self-referral laws.

Submitter : Ryan Gaynor **Date:** 08/24/2007

Organization : Ryan Gaynor

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Physicians are routinely using in-office ancillary services exception to the Stark Law, as physical therapy is currently considered a designated health service (DHS). In many cases these physicians are providing so called physical therapy without a physical therapist and are using less qualified individuals like PTA's, ATC's or even unprofessional staff. Also an increasing number of physician-owned physical therapy clinics are using the reassignment of benefits laws to collect payment in order to get around incident-to requirements.

Clearly the spirit of the law and the reason the law was written are being neglected by these physicians. These physicians are breaking the law in terms of how the Stark Law was originally written and taking advantage of their own patients for their own financial benefit. The excuse of convenience is unfounded here as it is just as easy for a patient to go anywhere 1-3 times a week as it is to the doctor. The idea that the physician needs to supervise is silly as our profession already has direct access. It is so clear that these corollaries need to be taken out or re-written I cannot imagine what the argument would be to keep them, unless of course it is that the BMW may be repossessed without it!

Submitter : **Dr. Anna Rodecki** **Date: 08/24/2007**

Organization : **Dr. Anna Rodecki**

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, Anna Rodecki, D.C.

Submitter : Dr. Michael Morgan Jr. **Date:** 08/24/2007

Organization : Sterling Family Chiropractic

Category : Chiropractor

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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 rule out pathology. I am writing in strong opposition to this proposal.

In some cases the patient clinically will require an X-ray 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,

Michael S. Morgan, Jr., D.C.

Submitter : **Dr. Peter DeFranco** **Date: 08/24/2007**

Organization : **Dr. Peter DeFranco**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

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.

You have no idea how many patients lives I have been able to save because this rule has been in place. Please do not eliminate this valued clinical option for my patients.

Sincere,

Peter DeFranco DC

Submitter : **Dr. Melanie Bober** **Date: 08/24/2007**

Organization : **Dr. Melanie Bober**

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

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

Sincerely,

Melanie Bober, D.C.

Submitter : **Dr. Les Peterson** **Date: 08/24/2007**

Organization : **Dr. Les Peterson**

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

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

Sincerely,

Les Peterson, D.C.

Submitter : **Mrs. Theresa Kerr** **Date: 08/24/2007**

Organization : **Mrs. Theresa Kerr**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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.

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

Sincerely,

Theresa Kerr

Submitter : Dr. Victor Jack Youcha **Date:** 08/24/2007

Organization : Dr. Victor Jack Youcha

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Chiropractic benefits to the aging population are well understood. A large portion of elderly can benefit from appropriate chiropractic care. To remove reimbursement for radiography related to chiropractic care is irresponsible and ill conceived. Removal of this benefit will surely result in higher health care costs in the long run as well as make life more difficult for the elderly who depend on chiropractic.

Submitter : Dr. Gregory Mellon **Date:** 08/24/2007

Organization : American Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

In regards to CMS-1385-P my concern is the elimination of Chiropractors to be reimbursed for x-rays. If a patient of mine is 65 or older and say would develope lower back pain with radicular complaints of numbness and tingling and the objective examination needs to rule out medical criteria an x-ray is a vital component. This then requires myself to refer back to the medical doctor for an evaluation (x-tra medical costs for office visit) and then in all medical probability have an x-ray taken at the local hospital, and a raiologist fee for the reading (x-tra costs) and a possible referral back to this office to treat the patient conservatively.. How is this saving on medical costs?? This is just one scenario. Pleasc reconsider this proposal.

Gregory Mellon D.C.
Delaware, Ohio 43015

Submitter : **Ms. JoAnn Fawcett** **Date: 08/24/2007**

Organization : **Ms. JoAnn Fawcett**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

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.

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

Sincerely,

JoAnn Fawcett

Chiropractic Student

Submitter : Dr. Warren Landesberg **Date:** 08/24/2007

Organization : Dr. Warren Landesberg

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

re: proposed x-ray reimbursement repeal.

Isn't it about time the federal gov't stops with it's long history of bias against this profession. Isn't it time to stop nitpicking and looking after the welfare of it's citizens. If an x-ray is indicated it is for the patients best interest. They go to health providers for the best possible health care. The whole x-ray thing is a scam that should have been repealed a long time ago.

Government should set an example for encouraging quality care for all it's insureds. Once you stop doing your duty the money hungary scoundrels follow your lead. Get over it already!

Submitter : Dr. Jeffrey Wilder **Date:** 08/24/2007

Organization : Madison Chiropractic

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

It is my understanding that this policy change would decrease reimbursement of x-rays for Medicare recepients.

Our facility and our patients are vehemently opposed to such a reduction.

Many or most Medicare recipients are on a fixed income. They simply do not have excess funds to make up shortfalls when the Federal Government takes away benefits.

In addition, this provision is biased against chiropractic and against chiropractic patients. If the change is made, these patients would have an obvious financial disincentive to recieve chiropractic services vs. medical services.

Please do not allow this change to negatively impact our patients.

Thank you.

Submitter : **Dr. Ronald Farabaugh** **Date: 08/24/2007**

Organization : **Ohio State Chiropractic Association**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

The proposed rule eliminating the ability for a DC to refer to a radiologist for necessary x-rays is not rational, from a case management viewpoint or economic viewpoint. In this progressive period of interdisciplinary cooperation, why would we require a patient to incur the expense of a medical office visit for the sole purpose of the MD ordering an X-ray that the DC could have easily ordered. It makes no sense for Medicare to incur additional costs for an MD visit just to order an x-ray.

Submitter : **Dr. Todd Elsner** **Date: 08/24/2007**

Organization : **Advanced Wellness Solutions**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Dr. Todd M. Elsner
1105 Chesapeake Drive
Mansfield, TX 76063
PHONE: 817-657-5910
FAX: 682-518-7563
e-mail: drtodd72712@yahoo.com

August 24, 2007

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,

Todd M. Elsner, D.C.

Submitter : **Dr. John Gray** **Date: 08/24/2007**

Organization : **Dr. John Gray**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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 : **Date: 08/24/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I am a physical therapist, working in a private orthopedic office. I would like physical therapy removed from the "in-office ancillary services" exception to the federal physician self-referral laws. I have patients tell me, quite often, that it was "suggested strongly" to them, to have their physical therapy treatment provided to them at an office within their doctor's office suite. When they choose to select a facility of their choice, they have commented that they are treated differently when they return to their doctor's office for follow up visits. Many of these patients are elderly and feel pressured to go to their doctor's office because of this, not realizing that they have the freedom to choose from other facilities. I believe this situation can be rectified with the above change I have suggested. Thank you for your time.

Submitter : Dr. Dana Winchester **Date:** 08/24/2007

Organization : Winchester Chiropractic Clinic

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

X-rays, when needed, are integral to the overall chiropractic treatment plan of Medicare patients, and unfortunately in the end, it is the beneficiary who will be negatively affected by this proposed change in coverage. The current X-ray Medicare protocol has served patients well, and there is no clinical reason for this proposed change, said ACA President Richard Brassard, DC. If doctors of chiropractic are unable to refer patients directly to a radiologist, patients may be required to make additional and unnecessary visits to their primary care providers, significantly driving up the costs of patient care.

Submitter : **Dr. Peter C Chilian** **Date: 08/24/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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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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.

Respectfully submitted,

Peter C.Chilian, M.D.

Submitter : **Dr. Barbara Cook** **Date: 08/24/2007**

Organization : **Dr. Barbara Cook**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Greetings,

I am against the repeal of CMS1385P which provides for payment of diagnostic x-rays for medicare recepients when ordered by a Doctor of Chiropractic. The diagnostic x-rays when ordered are medically necessary and payment of such should continued to be paid whether ordered by a Chiropractor or MD. Forcing the patient to seek a "medical doctor" to order the x-rays will only increase medicare reimbursement in the long run and cost the patient additional delays in receiving necessary medicare care. Please do not repeal the payment of x-rays when ordered by a chiropractor.

Thank you,
Dr. Barbara Cook

Submitter : **Mr. Lawrence Bronstein** **Date: 08/24/2007**

Organization : **individual**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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,

Lawrence Bronstein

Submitter : **Date: 08/24/2007**

Organization :

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-7664-Attach-1.DOC

#7664.

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.

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

Sincerely,

Eric Putty D.C.
American Academy of Pain Management
American Board of Quality Assurance and Utilization Review

Submitter : Dr. John Giovanelli **Date:** 08/24/2007

Organization : John J Giovanelli DC PC

Category : Chiropractor

Issue Areas/Comments

TRHCA-Section 104: Physician Pathology Services

TRHCA-Section 104: Physician Pathology Services

I have been a practicing chiropractor for 19 years. I find a spinal fracture on average once every year. I have found cancer in several patients that either metastasized to the spine or was in adjacent soft tissue. Just last week I did a plain film radiograph of a 43 year old female who had agenesis of the posterior arch of the first cervical vertebra. I found a C1 vertebra with 3 fractures following a car accident after the ER AND orthopedic surgeon said the patient 'only had a sprain.'

The idea of limiting x-ray is the craziest proposal I have heard since starting my practice in 1988. I will continue to take x-rays because it is not only convenient for the patient, it is an absolute necessity.

Submitter : **Dr. David Price** **Date: 08/24/2007**

Organization : **Dr. David Price**

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.

I do not understand why CMS does not allow for xray reimbursement for xrays taken by a chiropractic physician, in the first place. But, then to propose that reimbursement not be made even if the diagnostic test is done by a radiologist or other "non treating" physician, seems even more unreasonable. Does CMS believe that referring the patient back to the primary treating physician and then having that physician arrange for xray evaluation, will save money? Indeed, it will necessitate payment for two more office visits - one to determine the need for the xray order, and the other for the follow up xray report to the patient by the primary care physician. And, all of this effort by CMS when in reality medicare will only pay for perhaps 12 to 20 chiropractic visits in a year (if the claims reviewer is in a good mood), and so this money outlay for treatment is only$300.00 to 500.00 in a year. They will end up spending $100.00 (20%) of this outlay for the two office visits in order to not have the chiropractor order or request the xray. This does not make fiscal sense.

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

Sincerely,

Dr. David Price

Submitter : **Dr. Robert Larsen** **Date: 08/24/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

/Users/relarz/Desktop/commentlettertemplate.doc

CMS-1385-P-7667-Attach-1.DOC

#7667

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.

Robert Larsen, MD

2004 University Park Drive
Sacramento, CA 95825

Submitter : Dr. Daniel Tarnowski **Date:** 08/24/2007

Organization : Wilson Family Chiropractic

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Regarding CMS 1385-P. I strongly oppose the proposed elimination of reimbursement to Medicare participants for X-Rays when ordered by a CHiropractor. For many Medicare patient's in the United States, Chiropractic treatment is the only non-drug treatment that provides safe and effective relief of age-related and arthritic conditions. As the number of Medicare participants continues to increase there will be an increased need for these services. Eliminating the reimbursement to Medicare patient's for X-Rays will force the patient to make additional visits to other doctors increasing the time, cost and hassle of health care which in the end will dramatically affect the patient.

Submitter : Dr. William Pfeifer **Date:** 08/24/2007

Organization : Dr. William Pfeifer

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

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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,

Dr William Pfeifer
2901 Baranof Ave
Ketchikan, Alaska

Submitter : Dr. Jeffrey Riker **Date:** 08/24/2007

Organization : Dr. Jeffrey Riker

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

I hope that the Congress will seriously reconsider its current line of thinking regarding the potential repeal of reimbursement for Chiropractic referrals to a radiologist. If this revision becomes law, you will have done nothing more than remove a clinical tool that is currently at the disposal of every licensed Doctor of Chiropractic. Furthermore, you will frustrate and infuriate the Medicare population by now adding another step to the process of seeking and receiving timely and expeditous clinical care.

Submitter : **Dr. Prabhu Potluri** **Date: 08/24/2007**

Organization : **Dr. Prabhu Potluri**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Prabhu Potluri MD

Submitter : Dr. Vernon Temple **Date:** 08/24/2007

Organization : Dr. Vernon Temple

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

cms-1385-p
X-rays when utilized by the chiropractor are necessary to ensure public protection. Xrays allow the chiropactor to rule in or more importantly rule out the appropriate treatment options available in the D.C.'s office. Both education and scope of practice in all states allow for xray privelges and any attempt to restict the access of these by the chiropractor will be at the detriment of the patients. Please remove any restiction to xray access for the chiropractic physician.
Dr Vernon R Temple
Bellows Falls Vermont 05101
802 463 9522

Submitter : **Dr. Steven Wachs** **Date: 08/24/2007**

Organization : **Dr. Steven Wachs**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

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

Sincerely,

Submitter : Ms. cheryl tedrick **Date:** 08/24/2007

Organization : Ms. cheryl tedrick

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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

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

Submitter : **Dr. Frank Stiso** **Date: 08/24/2007**

Organization : **Dr. Frank Stiso**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

This proposal is discriminatory to chiropractic physicians and a supreme health hazard to the general public. When treating a chiropractic patient it is extremely important to analyze current X-rays to evaluate patient s condition and proper diagnosis, especially in the elderly. You would never allow a surgeon to operate blind! Certain diagnostic testing must be performed to make to accurate clinical decisions regarding patient care plans.

Without X-rays it would be impossible to determine contraindications for treatment, such as cancer, congenital anomalies, ankylosing spondylitis, DISH, soft tissue disorder, osteoporosis, fractures, bone spurs, advanced discogenic spondylosis...etc. The list goes on!

Chiropractic physicians are fully proficient in plain film radiograph imaging and have passed rigorous National and State examinations focusing on film reading, imaging and processing. The fact that you single out my profession and disallow X-ray reimbursement when performed by Doctors of Chiropractic is blatant discrimination. Now we can't even refer out to a Radiologist? That is absolutely ridiculous and will be challenged. Such a change in regulations would be colossal mistake. I urge you to abolish this proposal!

Submitter : Mr. Louis Sanchez **Date:** 08/24/2007

Organization : Mr. Louis Sanchez

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I've been working in healthcare for at least twenty years. I've witnessed patients agree to anything because their doctor told them to, or recommended them, so on and so forth. It just seems to me to be a very political way of doing things to hire family and friends as part of support staff or other specialty provider and then send work their way. Very much like this state is run. Corrupt and not in the best interest of the patients and citizens. I can't think of any other reason why a physician would want to subject themselves to the medicare population with all of its rules, regulations, guidelines audits etc., except to take advantage of a group of people assumed to not know any better. The medicare population is from the old school way of thinking that it must be okay if the doctor said so. I strongly urge the CMS to remove physical therapy as a DHS permissible under the in-office ancillary exception of the federal physician self-referral law. I would believe that a lot of unneccessary script writing and dx coding of non-existing problems would start to arise in order to keep that sort of cash cow flowing. Also, would it end there with just the medicare population? Or would it progress to other healthcare coverage policy holders of group health insurances such as the HMO's PPO's POS' etc.? In the defense of the physicians, perhaps they feel cornered into generating some revenue after having to deal with such high mal-practice insurance. In any event, medicare may not even be around for me when I'll need it. But regardless, I will do my own researching and referring out to providers thank you very, not my physician whom I've hired.

Submitter : **Dr. ROSSANO BALDASSARRA** **Date: 08/24/2007**

Organization : **PRIVATE PRACTICE**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Rossano M. Baldassarra, D.C.
696R White Plains Road
Scarsdale, NY 10583
Tel. (914) 722-0287
Fax (914) 722-0407
Email rbdc@verizon.net

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

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

Sincerely,

Thank you for your assistance. Contact the office with any questions.

Best regards,

Rossano M. Baldassarra, D.C.

Submitter : **Ms. Laura Higgins** **Date: 08/24/2007**

Organization : **Decatur Hand and Physical Therapy Specialists**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Mr. Weems;

I am writing this letter to express my concern regarding the in-office ancillary service arrangements that have impacted the delivery of quality physical and occupational therapy.

The "in-office ancillary services" exception has created a loophole which has resulted in many physician-owned arrangements that provide substandard physical and occupational services.

Physicians are in a position to refer Medicare beneficiaries to in-office physical and occupational services in which they have a financial interest. There is an inherent financial incentive to overutilize services under the in-office ancillary services exception.

In my 12 years experience as a Physical Therapist, I have heard many stories from patients that makes me sure the "in-office ancillary services" needs to be eliminated.

Many patients complained about an orthopedic surgeon who offered "Physical Therapy" in his office. The provider was often an athletic trainer, not a therapist, and was seeing multiple patients at the same time. In this setting, as well as other physician-owned cases, patients are often seen along with many other patients, therefore not providing quality care. They may be seen for more visits because the person seeing them is not able to truly see what they can or cannot do and because they just don't take the time to progress their home program.

As I specialize in an area of PT (Women's Health) and work with another specialist (Certified Hand Therapist), I strongly see the need for Medicare beneficiaries to be given choices from their physicians on who they can see for therapy. Although they may technically be able to go any Medicare provider, most people will take their doctor's advice, thinking the doctor is looking out for the patient's best interest. When there is financial gain for the physician, they may lose sight of the best interest of the patient. With the "in-office ancillary services" exception, patients may not be made aware of specialists who may give them the best care due to financial gains to be made by the physician. I am not even able to market myself to many offices like this because I am told "We have our own therapists and we always just send our patients there." Even though they don't offer women's health services or have a CHT, they won't even think about referring outside of their practice. This certainly is not an example of looking out for the patients, only their own financial gain.

In closing, please consider these comments and eliminate the "in-office ancillary services."

Sincerely,
Laura Higgins, PT

Submitter : Dr. Douglas Wiseman **Date:** 08/24/2007

Organization : Anesthesia Medical Consultants, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-7679-Attach-1.TXT

#7679

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. This is limiting access to care for Medicare recipients.

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,

Douglas F. Wiseman, MD
615 Cambridge Blvd, se
Grand Rapids, MI 49506

Submitter : Dr. Daniel Schlenger **Date:** 08/24/2007

Organization : Schlenger Chiropractic

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

It would be a dis-service to chiropractic medicare patients to eliminate reimbursement for X-rays. X-ray has been a standard of health care for nearly a century. Chiropractors have been well-trained in the use of X-ray for that entire time. It is not logical to classify this a non-covered service.

Submitter : Mrs. EVA CAMPAGNOLO **Date:** 08/24/2007

Organization : Mrs. EVA CAMPAGNOLO

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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.

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

Sincerely,

EVA CAMPAGNOLO

Submitter : **Mr. Michael Wray** **Date: 08/24/2007**

Organization : **AANA**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

Office of the 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 Administrator:

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,
Michael Wray, CRNA

Submitter : **Dr. Blanca Savans** **Date: 08/24/2007**

Organization : **Savans Chiropractic Clinic**

Category : **Chiropractor**

Issue Areas/Comments

Medicare Telehealth Services

Medicare Telehealth Services

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,

Submitter : Dr. AUDREY EGAN **Date:** 08/24/2007

Organization : Dr. AUDREY EGAN

Category : Health Care Professional or Association

Issue Areas/Comments

Technical Corrections

Technical Corrections

RE: file code CMS-1385-P
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Sincerely,
AUDREY J. EGAN, D.C.
SAN FRANCISCO, CA.

Submitter : Dr. Darrel Drumright **Date:** 08/24/2007

Organization : Dr. Darrel Drumright

Category : Physician

Issue Areas/Comments

Technical Corrections

Technical Corrections

In the state of MO chiropractic physicians are licensed as primary care doctors, this proposed rule will put undue hardship on Medicare recipients who choose a chiropractic physician as thier portal of entry doctor. There is no explainable reason for implementing this undue hardship other than the monopolistic ambitions of the Medics.
Please understand, passing this provision will create undue hardship on many of our elderly citizens.