Submitter : **Herbert Silver** **Date: 08/25/2007**

Organization : **Herbert Silver**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a practicing physical therapist and I support the Stark Legislation as it was originally written for the following reasons:

1. Physician owned physical therapy practices (POPTS) do not enhance the quality of the physical therapy provided.
2. POPTS effectively decrease access to physical therapists
3. POPTS, by design (not necessarily by intention) decrease the long term skills of physical therapists.

To support these statements, I offered the following:

In a market based system, one of the hallmarks is competition. Based on my experience, physician owned practices (POPTS) effectively decrease competition. Personally, I have seen the practice for which I work lose 30% of our business TWICE literally overnight, when large orthopedic practices in my area opened their own physical therapy practices (one group has 70 surgeons and another has around 15 practicing physicians). We decreased our staff and number of clinics by ? (13 employees to 7, 6 clinics to 3 clinics). If the result were better quality of care for a better price, I would have no legitimate argument. The fact, not only from patients but from physicians, is that the care is not the same quality as what is provided at least in our clinics. The reason is simple: if I were to work in a POPTS, I would not have to enhance my skills in any way in order to have new referrals patients are seen by PTs in a POPTS due to a financial incentive to the referring physician. In contrast, the only way I have been able to keep practicing is to offer a superior product. I am referred difficult cases, ones that have failed in the POPTS facilities, as well as clients without insurance, poorly paying insurance, insurance that will not pay for PT at a POPTS and Medicare patients that can not be seen at one large POPTS because they do not comply with Medicare rules. Essentially, the POPTS cherry pick their patients and I may get to see those they can t treat or don t want to treat for various reasons. If the quality were better at a POPTS, I certainly would not be in business because I offer no financial incentive to the physician for the referral. Even so, staying in business has been dramatically more difficult than it was prior to the return of POPTS.
As a result of POPTS, I have observed a relative decrease in private practices at the same time, because of an aging population and an increasing population, demand for PT services has increased. Competing services offered by massage [therapists], chiropractors, personal trainers are opening up at much greater rates than physical therapy practices (even though a PT license requires 6 years of college level training, the restrictions placed on PTs are much greater than any of these other providers). The combined forces of physicians owning PT practices, practice acts that limit access to PTs and diminishing health care dollars available for our services create a perfect storm that has already harmed our profession and no doubt will continue to harm our profession. Of all of these factors, I have seen the most harm resulting from POPTS although the restrictions in practice act's offer almost as great a barrier to our services.

CMS-1385-P-7925-Attach-1.DOC

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Further evidence of decreasing access has come to me recently by way of a comment from a physician (who actually participates in a POPTS) that "almost all of the private practices [he] once referred to have closed". The PTs have gone to competing POPTS or moved out of the area because of the loss of jobs and this physician can no longer refer to them (in a POPTS, the physician owner must see the patient before the PT can treat them so this physician would have to refer to the competing physician group). Other physicians have told me of "in house" reprimands they have received for referring to my practice. I have also been told by physicians that even though they had been told we provided a superior service, they owned their own PT and would not refer to our service. A podiatrist told me 3 years ago that he was opening a PT practice to "enhance [his] bottom line". After 2 years, he realized that the service was inferior (and the profit was not sufficient) and he closed the PT practice. Referrals have increased from that physician from 0 to between 1 and 3 referrals A DAY (this has been an exception, the actual closing of a POPTS, although I have been told by other physicians the profits hardly justify them continuing the administrators are determined to make them profitable).

But what of physicians that don't own a POPTS?—they must refer long distances in some cases because of the relative lack of private practices or refer to a competing physician (or, the most likely scenario, they don't refer to PT at all—practice pattern surveys support that physician do not refer to PT as much as they should). The other scenario is that when PT is not suggested, the patient will seek "alternative care"—chiropractors, massage, personal trainers, athletic trainers, etc. This is fine, except for the fact that only physical therapists with equal to or much greater levels of training than any of these providers have much greater restrictions place on accessing them (requirements for physician referrals).

Finally, consider what these "market forces" do to the skills required to practice physical therapy. In my practice, since I am a sole practitioner, I must make sure that I have superior skills—that is my ONLY competitive advantage. I am not involved in a large corporate PT practice that may have exclusive access to certain patients through insurance contracts; I offer no financial incentives for referral as is found in a POPTS; I am forced to provide the best quality intervention. This is as it should be, but given the difficulty in providing these services through the combined presence of POPTS and restrictive practice acts, this is not enough to grow a business—businesses must be in an environment where they can grow or they fail; the present situation is far too restrictive for adequate growth. Long term, PTs will become more like commodities as they no longer are required to compete on skill but merely provide an inferior service. If PTs are not allowed to compete on a level playing field, other less trained providers will continue to encroach on the skilled services we provide and the profession will fail.

There is a reason our code of ethics in Georgia prohibits "fee splitting" as a means of gaining referrals (which essential is what a POPTS is, a fee splitting arrangement). The South Carolina Board chose to enforce this restriction and prohibits any more PTs working in a POPTS--the expense realized in enforcing this rule, apparently in the hundreds of thousands of dollars, is prohibitive in most states. A level playing field where

we are allowed to compete on the skills and service we provide is required. POPTS work against the profession financially, professionally and ethically. A profession is defined by its independence. POPTS take that independence away.

Submitter : **Dr. Robert Lee** **Date: 08/25/2007**

Organization : **Sumter Urological Associates**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

My partners and I are in a small southern town with one hospital. We provide PSA determinations and CT services to our patients through our office. We do so at a significant savings over the hospital charges and can do so in a timely manner which benefits the quality of our patients health and finances. I feel that the proposed changes to the Stark rules go entirely too far in their attempts to prevent fraudulent abuses. My large medicare population definitely benefits from our services and charges. Please do not ruin this for my patients and my practice.

Sincerely, Robert E. Lee, MD

Submitter : **Dr. Srikanth Patankar** **Date: 08/25/2007**

Organization : **New Jersey Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

I am writing to express my strong support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am glad that CMS has finally accepted that anesthesia services have been undervalued, and that the agency is now taking steps to increase the relative value assigned to anesthesia services.

A payment disparity for anesthesia care was created when the RBRVS was instituted, mostly due to undervaluation of anesthesia work compared to other physician services. Medicare payment for anesthesia services does not cover the cost of caring for our senior citizens, and is creating a system in which anesthesiologists are being forced away from areas with high Medicare populations.

The RUC recommended that CMS increase the anesthesia conversion factor to compensate for an estimated 32 percent work undervaluation-. This is a step toward correcting the undervaluation of anesthesia services that has persisted for many years. I am glad that the Agency has accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

To ensure continued access to medical care provided by anesthesiologists, it is important that CMS follow through with the proposal in the Federal Register by implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this matter.

Srikanth Patankar, MD

New Jersey Anesthesia Associates
Florham Park, NJ
August 25, 2007

Submitter : **Dr. Patrick Cho** **Date: 08/25/2007**

Organization : **Dr. Patrick Cho**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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When the RBRVS was instituted, it created a huge payment disparity for anesthesia 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. David Bartlett** **Date: 08/25/2007**

Organization : **Anesthesiologists Associated**

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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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. Frederick Mayer **Date:** 08/25/2007

Organization : Dr. Frederick Mayer

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, which 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 be eliminated. I am writing in strong opposition to this proposal.

I do not use x-rays to diagnose subluxation , but to help rule out "red flags" for manipulative therapy and to determine treatment options. X-rays also help determine the need for further diagnostic testing or referral to the appropriate specialist for diagnosis and treatment.

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, and duplication of services, prior to referral to the radiologist. With fixed incomes and limited resources seniors may choose to forgo X-rays and treatment. If diagnosis is delayed, conditions that affect a beneficiary s quality of life, or that are life threatening, may not be discovered. It is the patient that will ultimately suffer as a result of this proposal.

I strongly urge you to table this proposal.

Submitter : Mr. David Aguilar **Date:** 08/25/2007

Organization : American Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

As stated by Dr. Richard G. Brussard...
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 : **Mr. adam kuz** **Date: 08/25/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Health Care Provider/Association**

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,

Adam Kuz, SRNA, RN, BSN
138 Birchwood Dr.
Troy, MI 48083

CMS-1385-P-7932-Attach-1.PDF

#7932

August 20, 2007

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

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

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Sincerely,

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Dr. Jeffrey Toubin** **Date: 08/25/2007**

Organization : **Southwest Urology Associates**

Category : **Physician**

Issue Areas/Comments

Impact

Impact

Dear Mr. Kuhn,

I am a urologist practicing in Dallas, Texas. My practice is located in South Dallas and has a large Medicare population. The proposed Medicare changes would have an adverse affect on the majority of my patients, as in-office procedures would be limited.

I do a lot of in-office procedures, such as TUMT, cysto, etc. that keep my patients out of the hospital and off expensive medications. I also refer patients for radiation therapy and work closely with radiation oncologists to treat patients effectively and efficiently. The proposed changes will make it difficult, if not impossible, for me and other urologists to continue to treat Medicare patients. This will result in substandard care for the elderly population, as they will not be able to afford the medical care they deserve and expect.

A growing number of physicians are no longer seeing new Medicare patients or any Medicare patients at all because of the strict CMS guidelines.

The sweeping changes to the Stark regulations go far beyond what is necessary to protect the Medicare program from fraud and abuse. The rules should be revised to only prohibit those specific arrangements that are not beneficial to patient care.

Thank you for your consideration.

Jeffrey C. Toubin, M.D., F.A.C.S.
jctmd@hotmail.com

Submitter : **Mr. Charles Hanson** **Date: 08/25/2007**

Organization : **UCAA**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

August 25, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

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Sincerely,

Charles E. Hanson, CRNA
282 Walnut Grove Rd.
Livingston, TN 38570

Submitter : **Dr. Jeff Unruh** **Date: 08/25/2007**

Organization : **Dr. Jeff Unruh**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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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.

Submitter : **Mrs. Julie Unruh** **Date: 08/25/2007**

Organization : **Mrs. Julie Unruh**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Mrs. Irene Unruh** **Date: 08/25/2007**

Organization : **Mrs. Irene Unruh**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Steven D'Sa** **Date: 08/25/2007**

Organization : **Cleveland Clinic**

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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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.

As an anesthesiology resident physician who is in the beginning stages of my training, I am especially hopeful that this proposal is passed as I will be entering practice at a time when senior citizens will constitute a significant portion of the population. I am excited to have the opportunity to provide excellent anesthesia care for our nation's seniors, and I believe that the increased funding from Medicare would improve my ability to provide such care.

Thank you for your consideration of this serious matter.

Sincerely,

Steven D'Sa, M.D.
Resident Physician, Class of 2010
Division of Anesthesiology, Cleveland Clinic

Submitter : Dr. Martin Bress **Date:** 08/25/2007

Organization : Dr. Martin Bress

Category : Physician

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

I urge you to reevaluate the placement of San Benito County in area 99.The recent GAO report gives more up to date data regarding the cost of medical practice here in Hollister. We have been a medically under served area since my arrival in 1973 in the National Health Service Corps. The low Medicare rates (and correspondingly low private insurance rate which are keyed to Medicare) are hampering our ability to recruit and retain physicians. If your option 3 were calculated with up to date figures it would put San Benito in a new locality with Monterey & Santa Cruz. Currently Medicare reimbursement in nearby Santa Clara County (20 miles) is about 25% higher giving a significant incentive for physicians to leave Hollister for Gilroy and thus perpetuate our status as chronically under served. Needless to say this has an adverse effect on our local hospital and our entire health care delivery system. Please do not rely on old data which does not reflect our true cost of business.

Submitter : Dr. Jared Gruhl **Date:** 08/25/2007

Organization : Dr. Jared Gruhl

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

X-rays are an indispensable tool used by chiropractors every day. Limiting our ability to reimburse patients for X-rays taken by another professional would only serve to hamper our ability properly serve our patient base.
I am against any proposed legislation that would make it more difficult for chiropractors to use X-rays taken by other professionals, or that would stop payment for such services through the Medicare/ Medicaid programs.
Thank you.

Submitter : **Mrs. MaryAnn Ophals** **Date: 08/25/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

? 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, MaryAnn Ophals CRNA

Submitter : Mrs. TRACY CURTIN **Date:** 08/25/2007

Organization : Mrs. TRACY CURTIN

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:
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Sincerely,

TRACY CURTIN, CRNA
905 SANDY BEACH CIRCLE
ST. AUGUSTINE, FL 32080

Submitter : **Dr. Lori DeVeuve** **Date: 08/25/2007**

Organization : **Dr. Lori DeVeuve**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Changing the reimbursement for
radiographs not done by the treating doctor would adversely affect many patients in our small community. Even the MD offices no longer do x-ray in-house. We all refer out to the radiology clinics associated with the local hospital. This will significantly slow down the time frame in which a patient could obtain an x-ray, increase the cost to insurers, and possibly put patient care in jeopardy.

Submitter : **Dr. Glenn Mann** **Date: 08/25/2007**

Organization : **Dr. Glenn Mann**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Paul Mattson** **Date: 08/25/2007**

Organization : **South Park Ambulance District**

Category : **Local Government**

Issue Areas/Comments

Ambulance Services

Ambulance Services

Reference CMS-1385-P
The requirement to obtain documentation from the receivng facility for patients unable to sign will place an unnecessary burden on emergency medical service providers. The reality of over-burdened, short staffed emergency departments will make such a rule almost impossible for individual emergency medical technicians to comply with. Treatment of the patient will (and must) be the priority. In the real world of emergency medicine who (physician, nurse) is going to take the time to routinely provide such documentation? Documentation that will not directly benefit the receiving facility. Limited response resources will have to be out of service for extended periods of time to obtain such documentation. Further degrading available response resources. The documentation submitted with the bill from the transport agency should be confirmed with the bill from the receiving hospital. That process would more than clearly demonstrate the transport and treatment requirements. This proposed rule will further impact the already limited reimbursement available for providers of 911 emergency care. Emergency care must be rendered and adequately compensated. The anticipated growth in patients requiring emergency response and covered by Medicare must be recognized. This proposal does nothing to further the goal of a high quality emergency medical response system.

Thank you for this opportunity to express my views.

Paul C. Mattson
District Chief
South Park Ambulance District
Fairplay, Colorado.

Submitter : **Dr. Creig LOBDELL** **Date: 08/25/2007**

Organization : **St. John's Hospital**

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.

Creig Lobdell

Submitter : **Dr. Rainer Vogel** **Date: 08/25/2007**

Organization : **Dr. Rainer Vogel**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

I am very concerned about the projected payment cuts for pain physician specifically. Overal pain remains a poorly solved issue and with decreased pain less pain physician will provide much needed care. I think Medicare should require ABMS specialty board certification in order to prevent substandart of care and unnecessary procedures.

Submitter : Dr. Stephen Tannenbaum **Date:** 08/25/2007

Organization : Uromedix

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The present self-referral provisions that we live with and work under already restrict and confound our efforts to provide care and own the means to provide that care. The proposed increase in that burden is just not neccessary. No other business in this country has to work around so many legislative hurdles and it's time the legislators turn their attention to something that will really help the citizens of this country.

Submitter : **Dr. Howard Spinowitz** **Date: 08/25/2007**

Organization : **University Anesthesia Consultants**

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 : **Ms. kimberly yeh** **Date: 08/25/2007**

Organization : **ACI**

Category : **Nurse**

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. Mark Lynch** **Date: 08/26/2007**

Organization : **Dr. Mark Lynch**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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,
Mark P. Lynch DC

Submitter : **Ms. Patricia Bartels** **Date: 08/26/2007**

Organization : **Ms. Patricia Bartels**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The current Stark II rules have allowed for the potential for fraud and abuse whereby physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest.

I have been a physical therapist for 20 years, 7 of those years working in private practices owned by physical therapists and 13 years working for the Veteran's Administration.

Physical therapists and physical therapists assistants under the supervision of physical therapists are the only practitioners who have the education and training to furnish physical therapy services. In instances where services are provided by unqualified personnel there is an inherent risk of harm to the patient.

The current rule allows for a loophole whereby physicians are able to employ physical therapists and physical therapist assistants and refer to these providers. My experience, hearing from patients who have been seen in physicians' practices, is that they are told to "go across the hall for physical therapy". They are not told that they can take their prescription for physical therapy anywhere that they want. Medicare beneficiaries should be allowed a choice of providers for the medical services that they require and this arrangement deprives them of that choice.

It is sometimes difficult for a physical therapist owned practice to compete with a physical therapy practice owned by a large physician group. They typically have much larger budgets for advertising and recruitment. These physician owned practices don't contribute to the growth of the practice of physical therapy in terms of support of our professional association that provides money for research and who is working to educate all physical therapists and physical therapists assistants to use evidence based practice.

At times in these physician owned practices there is pressure, to include services that may not be the best practice for a specific neuro-musculoskeletal problem but that add to the patient's bill and thus the physicians profit. A study conducted by the State of Florida, showed that physician-owned physical therapy services provided 43% more visits per patient than did non-joint venture physical therapy facilities.

In some areas of the state, physician-owned physical therapy practices have come to predominant and make it difficult for a physical therapist to set up a practice. It's difficult to compete when the referring source refers to themself.

These abusive arrangements should be prohibited. One solution would be to allow direct access for physical therapy services under the Medicare program. Direct access would allow patients the right to obtain treatment from a licensed physical therapist where and when he or she chooses without requiring a referral. This direct access is within the state practice act provisions for physical therapists.

For years the U.S. Army has eliminated mandatory referral and physical therapy services are directly accessible to the patient. Forty-four states allow physical therapists to evaluate patients without a referral. Medicare patients should be allowed the same access to physical therapy services.

Thank you for the opportunity to comment on this important issue.

Submitter : **Dr. Thomas Mawn** **Date: 08/26/2007**

Organization : **Thomas J, Mawn Urology**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Office based proceedures are far less costly than the same proceedure performed in a hospital.

Submitter : **Dr. Joel Fugleberg** **Date: 08/26/2007**

Organization : **ACA**

Category : **Physician**

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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Sincerely,

Dr. Joel Fugleberg,DC

Submitter : Dr. Elizabeth Kautz Koch **Date:** 08/26/2007

Organization : Mountain Spring Chiropractic Center, Inc.

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I am opposed to this change - eliminating reimbursements to non-treating physicians for XRs ordered/requested by chiropractors. I do not have XR in my office and depend on my patients' PCPs to get the films for me so I can safely treat Medicare patients. First, I need to rule out pathology. The older a patient gets, the greater the chances are that there is a medical condition. Secondly, I need to see the patient's spine on XR so I know what type of adjustment technic, if any, is appropriate to perform.

This "correction" on your part will lead to lack of correction for my patients; i.e., patients will not be able to get the appropriate, and by any study I've seen done, cost-effective care that their structures need.

Also, my senior patients come to me because they understand that structure affects function. They are also disgusted with their PCPs not listening to them and the PCPs only answer is throwing a drug at their symptoms, adding to the existing large and complicated chemical soup they are already ingesting. These patients want to be well without more medication, which is possible IF I GET THE XRs I NEED.

For lower health-care costs, you must not make this "technical correction."

Submitter : **Dr. Jonathan Colter** **Date: 08/26/2007**

Organization : **Dr. Jonathan Colter**

Category : **Federal Government**

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

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Sincerely,
Dr. Jonathan Colter

Submitter : **Dr. Louis Pau** **Date: 08/26/2007**

Organization : **The Pain Center of Kansas**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Kerry Weems
Administrator Nominee
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1385-P

Dear Mr. Weems:

I would like to thank you for the opportunity to comment on the Proposed Rule CMS-1385-P, Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008 (the Proposed Rule) published in the Federal Register on July 12, 2007 As requested, I have limited my comments to the issue identifiers in the Proposed Rule.

As you may know physician offices and ambulatory surgery centers are important sites of service for the delivery of interventional pain services. After having experienced a severe cut in payment for our services in 2007, interventional pain physicians are facing additional proposed cuts in payment; cuts as much as 7.8% to 19.8% in 2008 alone. This will have a devastating affect on my and all physicians ability to provide interventional pain services to Medicare beneficiaries. I am deeply concerned that the continued underpayment of interventional pain services will discourage physicians from treating Medicare beneficiaries unless they are adequately paid for their practice expenses. I urge CMS to take action to address this continued underpayment to preserve Medicare beneficiaries access.

The current practice expense methodology does not accurately take into account the practice expenses associated with providing interventional pain services. I recommend that CMS modify its practice expense methodology to appropriately recognize the practice expenses of all physicians who provide interventional pain services. Specifically, CMS should treat physicians that list interventional pain or pain management as their primary Medicare specialty designation, as interventional pain physicians for purposes of Medicare rate-setting. This modification is essential to ensure that interventional pain physicians are appropriately reimbursed for the practice expenses they incur.

The cost to start up an interventional outpatient office is ENORMOUS. The x-ray shielding of the procedure (fluoroscopy) suite alone cost $10,000. The cost of an adequate fluoroscope (specialized x-ray machine to visualize spine and bone structures) to correctly perform procedures is $184,965. (Usually, interventional physicians will have two fluoroscopes because the need for a back up fluoroscope if the first fluoroscope should malfunction.) The hourly charge for the repair of fluoroscopic and ultrasound equipment is $150/hour. Parts for the fluoroscope are very expensive. The replacement of a used/refurbished image intensifier for the fluoroscope is $30,000 - $40,000. An ultrasound machine to correctly perform nerve block procedure costs $87,709. The fluoroscope compatible procedure table starts at $14,000, and we usually require two procedure tables. A radiofrequency generator costs $23,000 - $29,000. The single use, disposable radiofrequency ablation needles cost $18.95 each, and I typically will use 3 5 needles per radiofrequency session. These needles are not reimbursed by Medicare.Medical billing and transcription cost cost usually averages $4,000 - $6,500 per month. These are the basic minimum equipment needed to start an Interventional Pain office, not including office space rental, insurance, staff salaries and benefits, medications and medical supplies.

In comparison to anesthesiologist performing procedures in hospitals, there are no costs for the anesthesiologist associated with performing the procedures. The hospital based anesthesiologists are reimbursed for performing the procedures without any overhead of medical equipment and staffing.

Your attention in this matter is greatly appreciated. Sincerely,

Louis Pau, M.D
921 SW 37th St.
Topeka, KS 66611
785-235-9100

Submitter : **Dr. Frank Lizzio** **Date: 08/26/2007**

Organization : **Dr. Frank Lizzio**

Category : **Chiropractor**

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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Sincerely,
Frank S. Lizzio,D.C.

Submitter : **Dr. Frank Zavisca** **Date: 08/26/2007**

Organization : **LSU HSC Shreveport**

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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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: 08/26/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. len Probe **Date:** 08/26/2007

Organization : Dr. len Probe

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

What a scam. The inibility of the D.C. to refer to a radiologist shows that the ongoing conspiracy against Chiropractic is stronger than ever and that the Government is stepping up to help their medical brothern. Can you imagine that a Chiro can take X-Rays in his own office and is allowed to legally do so for the purpose of rendering a diagnosis to perform his service but that they are now not competent enough to even recommend to a patient that they need and X -ray and that it could be paid for even if they don't do it. You don't have to be a doctor to know when people need an x-ray. This does not make any sence what so ever and is a blatant assult on the Chiropractic profession. It has absolutely nothing to do with public safety or cost reduction. It is an attack by the Medical profession and is an obvious misuse of power. If anything Medicare should reimburse the Chiro for taking the X-ray. WE are usually cheaper than the hospital and faster. We dont make people wait unnecdlessly. Like an X-Ray is a major scientific breakthrough that we should fight over! Whoever proposed this should be investigated to see who paid them off and they should be exposed for the piece of garbage they are.

Submitter : Dr. Moody Makar **Date:** 08/26/2007

Organization : Cedars Sinai Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

my comment is about the underevaluation and underpayment of the Anesthesia by Medicare. We are losing a lot of residency programs because of this reason. Please, re consider the conversion factor. thanks

Submitter : Dr. Scott Helm **Date:** 08/26/2007

Organization : Kane Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Anesthesia services are among the most important, yet underappreciated of all medical services. The job of the anesthesiologist is nothing short of keeping patients alive and free of pain and discomfort during procedures which would otherwise be impossible to perform. We are pioneers in the field of patient safety---long before CMS placed any kind of emphasis on it. However, reimbursement for the anesthetic portion of a procedure significantly lags the reimbursement for the procedure itself. Because of our crucial role in patient safety, we deserve to be reimbursed at a higher level than other physicians who perform procedures or who function as diagnosticians. The training required to become an anesthesiologist is every bit as rigorous as the training of the proceduralists and diagnosticians with whom we work: college, medical school, internship, residency, and often subspecialty fellowships. It is a long and rigorous process---nobody will enter the field in the future if reimbursements do not begin to increase following the precipitous declines that have occurred in recent years. If this country's lawmakers truly care about the health and well being of our elderly population, then those physicians most responsible for our patients' safety before, during, and after surgical and other procedures need to be fairly reimbursed. Furthermore, as CMS embarks on its new policy of denying payment for 'avoidable complications' such as surgical site infections, it must be noted that anesthesiologists have been leaders in patient safety for years---far ahead of every other specialty in medicine. We have led all other fields in safety because we have always known it was the right thing to do. Our safety record, which we track ourselves, is on a par with the airline industry. If you would like this further substantiated, simply ask the founders of the Institute for Healthcare Improvement (IHI), Dr. Donald Berwick and Dr. James Reinersten. Anesthesia is second to none in safety. Also, in our unique role as peri-operative physicians, anesthesiologists have also willingly accepted responsibility and accountability over such issues as the prevention of surgical site infection----we have agreed to take ownership of antibiotic administration, close control of blood glucose, and close control of temperature during surgical procedures. Our willingness to do this (as opposed to many other proceduralists who prefer to stick to their ancient aneedotal methods, ignoring all current evidence put together by IHI) needs to be highlighted and supported by CMS. In short, the field of Anesthesiology deserves a much higher degree of compensation than many other fields----what we provide in terms of patient safety and prevention of the very type of 'avoidable complications' which CMS is hoping to stop is, without question, unequaled in any other field of medicine. However, up until now, it has been those in the procedural fields (surgery, endoscopy) and diagnostic fields (Pathology and Radiology) who have been much more generously rewarded. It is time for the tide to turn---anesthesiologists need to be quickly caught up to our proceduralist and diagnostician colleagues, and, I believe, we should exceed them. We, after all, are the physicians most in a position to prevent the types of complications which CMS now wants to see prevented. Believe me, in the future, this country needs its best and brightest to go into Anesthesiology for the sake of the health and well being of all of its citizens. This will only happen if our bright young minds see that they will be generously rewarded for entering the great and noble field of anesthesiology.

Thank you for your attention to this critical matter.

Dr. Scott Whitney Helm, M.D., Ph.D.
Chairman
Dept. of Anesthesiology
Kane Anesthesia Associates
Geneva, IL 60134

Submitter : **Dr. Randy Rosett** **Date: 08/26/2007**

Organization : **University of New Mexico School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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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.

Randy Rosett, MD
Associate Professor of Anesthesiology
Medical Director Outpatient Surgery
University of New Mexico
Albuquerque, NM 87102
505-272-2610

Submitter : Dr. James Higgins **Date:** 08/26/2007

Organization : Chiropractic Family Center of Brick

Category : Chiropractor

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

I am writing in strong opposition to the above proposal. While X-ray is not needed to detect Subluxation, it will be necessary in some cases to have an x-ray study to rule out "red Flags" and also determine diagnosis and treatment options. By limiting x-ray availability it will become more costly for the patient and if they forgo treatment due to finances, may prove dangerous if treatment is delayed or neglected due to limited funds.

I strongly urge you to table this proposal. X-rays are an integral part of the treatment plan, ultimately the patient will suffer.

Submitter : Dr. Sundar Cherala **Date:** 08/26/2007

Organization : Fox Valley Pain Center

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

The proposed reduction in payments for physician services for pain management will negatively affect the care of the patients. At a time when the cost of providing care is escalating, cutting the payments for such needed services in the office setting makes our elderly more vulnerable to suffer with chronic pain conditions. I request you to reconsider this. Thanks

Submitter : Dr. Carol Szarko **Date:** 08/26/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-7968-Attach-1.DOC

#7968

Carol Szarko, M.D.
167 Spangsville Road
Oley, PA 19547
August 26, 2007

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

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Carol Szarko

Submitter : Mr. David Monahan **Date:** 08/26/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Re: CMS-1385-P (Background, Impact) Anesthesia services.

Thank you for considering significant improvement in CRNA reimbursement for Medicare cases. We perform 27 million cases per year, mostly in poor and rural areas, many of which would not be served without our presence. We embrace our commitment, and seek to continue serving. Fair reimbursement keeps CRNA services in these areas and attracts replacements for retiring practitioners.

Submitter : **Dr. William Blueter** **Date: 08/26/2007**

Organization : **Chestnut Hills Wellness Center**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

I am writing to inform the appropriate parties that I am strongly against the recommendation that patients no longer be reimbursed for X-rays taken by medical doctors or doctors of osteopathic medicine and used by a doctor of chiropractic to determine a subluxation. These x-rays, if needed, are integral to the overall treatment plan of Medicare patients. It is ultimately the patient that will suffer should this proposal become a standing regulation. It is well accepted in the medical and chiropractic professions (especially the radiology associations) that x-rays are often times needed for patients over the age of 50 to rule out possible pathology that could make chiropractic treatment contraindicated (such as tumors or severe osteoporosis). Please take my concerns into consideration before making a final decision.

Yours in Health,
Dr. Bill Blueter
President: Tri-County Chiropractic Association

Submitter : **Dr. Fred Rotenberg** **Date: 08/26/2007**

Organization : **Dr. Fred Rotenberg**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Barbara McNeil** **Date: 08/26/2007**

Organization : **McNeil Chiropractic Health Center**

Category : **Health Care Professional or Association**

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 me, as 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 (family physician, 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. Barbara L. McNeil, D.C.

Submitter : **Dr. leon graham** **Date: 08/26/2007**

Organization : **Dr. leon graham**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

8-26-07

Dear Ms. Norwalk,

I write to support the increase in anesthesia payments under the 2008 Physician Fee Schedule. There is a tremendous undervaluation of anesthesia services that was created when the RBRVS was instituted. This has had a disproportionate negative impact on anesthesiology. I appreciate your concern to this matter.

Sincerely

Leon Graham, M.D.

Submitter : **Dr. John Brenner** **Date: 08/26/2007**

Organization : **UT Health Sciences Center at San Antonio**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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.

-John R. Brenner, D.O.
Resident, Dept. of Anesthesiology
UTHSC-San Antonio

Submitter : **Richard D. Clarke** **Date: 08/26/2007**

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

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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,

Richard D. Clarke, CRNA
37833 37th Ave S
Auburn, WA. 98001

Submitter : **Dr. Tammy Lee** **Date: 08/26/2007**

Organization : **Upland Anesthesia Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Tammy B. Lee, D.O.

Submitter : **Dr. Michael Johnsen** **Date: 08/26/2007**

Organization : **Dr. Michael Johnsen**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Respectfully,
Michael W. Johnsen, M.D., Ph.D.
Board Certified Anesthesiologist

Submitter : **Dr. Laura Slauhgter** **Date: 08/26/2007**

Organization : **Anesthesia Medical Group of Santa Maria**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Submitter : Mrs. Linda Raynor **Date:** 08/26/2007

Organization : Fl Sports, Orthopedic, and Spine Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

This comment is to address the issue of physician / patient utilization and quality of care in the setting of therapist within the physician office setting. We are an Orthopedic practice that employs physical therapists with doctoral degrees. These therapists came to us from independent free standing rehab facilities. We had to teach them the Medicare "8" minute rule, grouping rules for Medicare members, and other basic guidelines that they were not required to do, or at least were not aware of, when they were practicing in their other facilities. Actually, some of the free standing therapy clinics they left incorrectly encouraged them to bill for more units than needed as they needed revenue.

I feel that we work hard to maintain quality of care and yet follow utilizaton guidelines. We do not keep our patients unnecessarily but neither do we discharge them too early. I feel that the APTA has their own financial agenda and prejudice that drives their aim to try and stop physicians from employing physical and occupational therapists. However, in a free market society, there should be opportunity for employment in all aspects of healthcare. I feel it would be a grave blow to the patients, who love to come to us because they feel a certain comfort knowing their doctor is easily available.

All facilities; hospitals, physician offices, and freestanding clinics, are subject to the same guidelines established by CMS. It is up to all entities to adhere to them, and it is not in CMS, physician, and even the APTA's best interest to purposely limit a patient's choices. I do not feel that poor utilization can be found just in a physician setting and as for what I have seen, poor utilization and cost containment can be found in the physical therapy facility that is independently owned and struggling to make ends meet on lower reimbursments from all healthcare insurances.

We must not limit the physician's ablity to offer patients convenient and effective choices, but rather we must strive to control costs and be responsible towards those that will be the Medicare recipents of tomorrow. I have survey after survey that attests to patient satisfaction with our treatment protocols and length of treatment time. One of the most common patient remarks is that they felt like they were getting personalized quality care and that the therapist and the doctor communicated about their case so that they could get better and do so more quickly.

I would urge CMS to adopt standards that make all therapists in all settings(hospital, physician office, independent clinic) strive for the same documentation and utilization goals and not to limit those settings where patients can receive good care.

Submitter : **Ms. Irene McLaughlin** **Date: 08/26/2007**

Organization : **Ms. Irene McLaughlin**

Category : **Individual**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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. David Corral** **Date: 08/26/2007**

Organization : **Valley Urological Associates**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1385 P
P.O. Box 8018
Baltimore, MD 21244 8018.

Dear Mr. Kuhn:

I am a urologist who practices in a group practice in Pittsburgh, Pa with a very large Medicare population. I am writing to comment on the proposed changes to the physician fee schedule rules that were published on July 12, 2007 that concern the Stark self-referral rule and the reassignment and purchased diagnostic test rules.
The changes proposed in these rules will have a serious impact on the way I
practice medicine and will not lead to the best medical practices. With respect to the in-office ancillary services exception, the definition should not be limited in any way. It is
important for patient care that urologists have the ability to provide pathology services in their
own offices. It is equally important to allow urologists to work with radiation oncologists in a
variety of ways to provide radiation therapy to patients. If the limitations in this proposal are enacted, I will not be able to provide my patients with the immediate diagnostic studies and therapeutic interventions that are needed by patients with kidney stones, cancer or other urologic diseases. The proposed under arrangement rule, will prohibit the provision of laser surgery commonly used to treat cancer, enlarged prostate and other conditions. Not providing these services will be severely detrimental to patient care and cause a serious hardship for my Medicare patients.
The sweeping changes to the Stark regulations and the reassignment and purchased diagnostic
test rules go far beyond what is necessary to protect the Medicare program from fraud and abuse.
The rules should be revised to only prohibit those specific arrangements that are not beneficial to
patient care.
Thank you for your consideration,
Signature

David A. Corral, MD, FACS
Valley Urological Group
dcorral@valleyuro.com
Ph: 412-741-8025
Fax: 412-741-2102

Submitter : Dr. SCOTT GILFORD **Date:** 08/26/2007

Organization : Dr. SCOTT GILFORD

Category : Chiropractor

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.

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,

Scott R. Gilford, DC

Submitter : **Mrs. Karen Giggetts** **Date: 08/26/2007**

Organization : **Mrs. Karen Giggetts**

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,
__Karen Giggetts CRNA_____
Name & Credential
_____3814 Endicott Place_____
Address
_____Springdale, MD 20774_____
City, State ZIP

Submitter : Mr. David Wagner **Date:** 08/26/2007

Organization : Mr. David Wagner

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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Submitter : **Mr. Odeed Geismar** **Date: 08/26/2007**

Organization : **Mr. Odeed Geismar**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-7985-Attach-1.DOC

7985

August 20, 2007

Office of the 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 Administrator:

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This increase in Medicare payment is important for several reasons.

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

_____
Name & Credential

_____
Address

_____
City, State ZIP

Submitter : **Dr. Rex Russell** **Date: 08/26/2007**

Organization : **Pinnacle Partners in Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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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.

As a physician on the front lines of caring for our nations citizens from all walks of life, it seems unjust to force myself and my colleagues to subsidize the increased cost of medical care occurring in the US by reducing payment for care to levels that do not cover overhead costs. These underpayments are essentially an additional tax burden on physicians. Indeed, there is a financial crisis as medical care costs increase, but any new taxes or subsidies to cover these costs should be distributed amongst all our citizens and residents as opposed to quietly targeted to overworked physicians.

Thank you for your consideration.
Rex Russell, MD