CMS-1385-P-8089

**Submitter :** Dr. Nicolai Hansen **Date:** 08/27/2007

**Organization :** Dr. Nicolai Hansen

**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.

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.

This will also increase your cost as the additional Physician visit will now be billed to you. You will also have the additionala doctors refering more to MRI to cover themselves. Knowing that the patient will be being treated by a DC they will want to limit their liability.

**Submitter :** **Ms. Karyn Karp** **Date: 08/27/2007**

**Organization :** **California Association of Nurse Anesthetists**

**Category :** **Health Care Professional or Association**

**Issue Areas/Comments**

**Background**

Background

August 26, 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 am writing to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule (72 FR 38122, 7/12/2007) Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. 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.

1. AANA has previously informed CMS that 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.

2. This proposed rule reviews and adjusts anesthesia services for 2008. Most Part B provider 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.

3. The proposed CMS 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 33% below 1992 payment levels (adjusted for inflation).

4. America s 36,000 CRNAs provide 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services. CRNAs are the predominant anesthesia providers to rural and medically underserved America; Medicare patients and healthcare delivery in the U.S. depend on nurse anesthesia services. The availability of anesthesia services depends upon fair Medicare payment for these providers.

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,

Karyn Karp, CRNA, MS
President-Elect
California Association of Nurse Anesthetists

CMS-1385-P-8090-Attach-1.DOC

#8090

August 26, 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 am writing to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS' proposed rule (72 FR 38122, 7/12/2007) Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. If adopted, CMS' proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.

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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,

Karyn Karp, CRNA, MS
CANA President-Elect

**Submitter :** cynthia houck **Date:** 08/27/2007

**Organization :** cynthia houck

**Category :** Nurse Practitioner

**Issue Areas/Comments**

**Coding-- Additional Codes From 5-Year Review**

Coding-- Additional Codes From 5-Year Review

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

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. 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.

Cynthia Houck, CRNA

**Submitter :** Dr. eugene solod

**Date:** 08/27/2007

**Organization :** Dr. eugene solod

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

#8092



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

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

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

**Submitter :** **Dr. Kevin Speight** **Date: 08/27/2007**

**Organization :** **Carolina Anesthesiology**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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

Dear Ms. Norwalk:

I support the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am gladl that CMS has recognized the 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 Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for those insured through Medicare putting patients at risk of not being able to get care. This is becoming a huge problem for hospitals and groups that serve our nation s seniors. It is also putting a burden on the businesses and individuals who have to pay higher rates for anesthesia services in what has become a cost-shifting measure to keep anesthesia departments viable. This is an unsustainable system in which anesthesiologists and nurse anesthetists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this 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 $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 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.

If you have questions please call me.

Sincerely,

Kevin L. Speight MD
kspeight@triad.rr.com
cell 336-442-6798

**Submitter :** **Dr. Richard Riley** **Date: 08/27/2007**

***Organization :*** ***Little Rock Chiropractic Clinic***

**Category :** **Chiropractor**

**Issue Areas/Comments**

**GENERAL**

GENERAL

The proposal of eliminating a chiropractor ability to refer to a radiologist for clinically indicated radiographs is ill conceived. This once again puts under burden on the medicare beneficiary and only increases Medicares expenses. Thank you.

**Submitter :** Mr. Thomas Smith **Date:** 08/27/2007

**Organization :** FANA/AANA

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**Background**

Background

I wish to ask you to please fully fund CRNA reimbursement. The shortage of nurses is epidemic and to not fund CRNAs makes it less attractive to recruit nursese plus you will have a preference for MDAs in training and harm CRNA teaching programs. There is a great shortage of CRNAs already and we in Florida have stepped up to the plate and are now educating over 400 a year. This will destroy careers and programs. Please fully fund CRNAs for their services. It would help dramatic\ally to stop spending monies on non citizens.
Thank you.
Yours truly,
Thomas Smith ARNP,CRNA and
Roxane Smith, R.N.

**Submitter :** **Dr. Ronald Knuth** **Date: 08/27/2007**

**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.

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. Thomas Osterman **Date:** 08/27/2007

**Organization :** Dr. Thomas Osterman

**Category :** Health Care Professional or Association

**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 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. Thomas Osterman Jr.
Chiropractic Physician

**Submitter :** Dr. Christopher Cole **Date:** 08/27/2007

**Organization :** Anesthesia Consultants of Indianapolis

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1385-P-8100-Attach-1.WPD

CMS-1385-P-8100-Attach-2.WPD

#8110

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** Mrs. Leela Seaveno **Date:** 08/27/2007

**Organization :** Mrs. Leela Seaveno

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am a CRNA in Arkansas (one of the lowest mc reimbursement states in the USA). We need to be fairly reimbursed for caring for the ever growing Medicare population. The 8.7% decrease imposed this year hurt.
Please make things fair again

**Submitter :** Mr. Drew Forhan **Date:** 08/27/2007

**Organization :** ForTec Medical Inc

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1385-P-8102-Attach-1.DOC

#8102

August 23, 2007

Dr. Donald Romano
Centers for Medicare & Medicaid Services
Center for Medicare Management
C4-25-02
7500 Security Blvd.
Baltimore, Maryland 21244

Dear Mr. Romano,

I am writing on behalf of ForTec Medical, Inc. to express our strong support for the proposed Medicare regulations that were published on July 2, 2007. We are encouraged by your proposals knowing that they have the potential to return the fair market nature and integrity that this sector of healthcare is now lacking.

Founded in 1988, ForTec Medical, Inc. leases surgical lasers to hospitals throughout the US on a per case basis. Historically a "non-physician owned" business model, ForTec has built its' business by providing cutting edge quality surgical lasers and skilled technician support to its customers.

While ForTec welcomes healthy competition, we have seen a dramatic proliferation of physician owned laser LLC's over the past three years. We now find ourselves competing against our former customers in what has become an unfair and anticompetitive market. The fact that physicians; exercise control over the patient, have access to our pricing structure, and improperly influence the hospital's purchasing decisions are a few of the factors that have led to ForTec's inability to compete fairly. On a larger scale, these facts have led to today's anticompetitive market.

Our experience has confirmed the following:

1. Financial motivation is driving treatment choices. While options exist for treatment of diseases, physician ownership of equipment plays a key role in influencing what the patient will ultimately be prescribed. The greater the utilization of his/her equipment, the larger will be the financial return on investment.

2. Steerage is driven by physician's potential financial gain. We know of instances where hospitals that chose to honor equipment contracts have 'lost' patients to competing facilities. In other words, physicians have steered patients to alternative facilities who were willing to engage with their LLC medical equipment company.
3. Over utilization exists as created by practices that, due to ownership, use treatments that yield lower efficacy outcomes. This trend often creates the need to retreat patients adding additional cost burdens to our healthcare system.
4. Physicians pressure hospitals to use their LLC despite not being the low cost provider. These bully tactics further contribute to escalating healthcare costs.

Without adoption of CMS's proposed regulatory changes, ForTec may be forced to allow physician ownership of our company simply as a means of survival. Furthermore, if left unchecked these scenarios will grow exponentially with LLC's forming around multitudes of surgical equipment across all surgical specialties.

We understand that this is an ongoing battle and in fact we have already learned of strategies being developed to circumvent the new proposed regulations if adopted. One such strategy includes a "cross ownership" business model in which LLC "A" would deliver laser cases to the investors of a separate LLC "B", and visa versa. Another includes where physician groups might simply try to re-characterize their "per service" rentals as block leases. CMS should be clear that any such scheme or "testing of the waters" will not be tolerated.

Finally, CMS needs to assert that any arrangement that involves rentals or leases of equipment and technical support will be considered as "performing" the DHS for the purposes of the definition of "entity".

We fully expect that many of the physician owned ventures and lobbies will seek to delay the implementation by claiming disruption to clinical services. In our experience, there are numerous independent businesses ready to service and purchase these assets and take over contracts without creating interruption of services.

We commend and applaud CMS's efforts to close these loopholes which are not in the best interest of the patient. Clinical efficacy, not financial gain, should be the motivating factor in patient care. The newly proposed regulations will reinstate balanced competition, fair market pricing, and help to reduce healthcare costs.

Respectfully Submitted,

Drew C. Forhan
President & CEO

**Submitter :** **Dr. Samuel Amari,Jr** **Date: 08/27/2007**

**Organization :** **Kenoza Chiropractic Offices**

**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

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.Samuel J. Amari,Jr.
89-93 Kenoza Avenue
Haverhill,MA 01830

**Submitter :** Dr. David Beck **Date:** 08/27/2007

**Organization :** Dr. David Beck

**Category :** Physician

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

A decision not to cover X-rays referred by a Chiropracor does not make any sense. It is not going to save any money. It will just end up costing more. If you want to save money you will change the regulations and allow Chiropractors to do what we are trained to do, specifically take and interpret X-rays.

If Chiropractors can not refer X-rays to a radiological facility then Medical Doctors should also be restricted. If the Government wants to discriminate against Chiropractic physicians then any rules regarding patient care should apply to all physicians. The only ones who really get hurt are the patients.

Medicare patients experiencing pain will usually seek help from a Chiropractor before going to a Medical doctor. An MD will only treat their condition with medication which will only cost Medicare more for the pills and put the patient at a health risk due to a reaction to the medications. Their health care decision should be respected by the US Government and covered by their health insurance. The U.S. has been notably one of the worst countries in the world for health care. CMS-1385-P is another step in the direction of making the U.S. health care even worse.

**Submitter :** Mrs. Barb Wieland **Date:** 08/27/2007

**Organization :** Michigan Heart, P.C.

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

Michigan Heart, P.C. is a cardiology practice that serves 8 cities and approximately 66,000 patients per year. On behalf of Michigan Heart, I would like to ask CMS to refrain from eliminating payment for color flow Doppler. I want to emphasize that we do not use color flow Doppler for every echo procedure, and when we do, it entails additional sonographer and physician time. Thank you for the chance to submit a comment.

**Submitter :** **Dr. Ranita Donald** **Date: 08/27/2007**

**Organization :** **American Society Of Anesthesiologist**

**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

Ranita R. Donald M.D.
Assistant Professor
Dept of Anesthesiology & Perioperative Medicine
Medical Collage of Georgia
Augusta, GA. 30912

**Submitter :** **Dr. gary freeman** **Date: 08/27/2007**

**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)

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Thank you for your consideration of this serious matter.

**Submitter :** Dr. Steven Lewis **Date:** 08/27/2007

**Organization :** Whitehall Chiropractic Office

**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.

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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,

Steven Lewis, D.C.

**Submitter :** **Mark Parsons** **Date: 08/27/2007**

**Organization :** **Mark Parsons**

**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,

Dr. Mark A. Parsons

**Submitter :** Mrs. Nancy Ratzlaff **Date:** 08/27/2007

**Organization :** Midwest LifeTeam

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**Ambulance Services**

Ambulance Services

see attached letter

CMS-1385-P-8110-Attach-1.TXT

#8110

August 27, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

**Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008.**

Dear Ms. Norwalk:

Our organization provides emergency ambulance services to the communities which we serve. The proposed rule would have a severely negative direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. In addition, we believe this proposed rule will inappropriately provide incentives to seek signatures from patients who are in need of medical care and under mental duress. Additionally, this proposed rule would have a negative impact on wait times in the emergency room impacting our operations and the operations of emergency rooms throughout the country. We therefore urgently submit comments on ills of the proposed rule.

In summary, here are the points we would like you to consider:

- Beneficiaries under duress should not be required to sign anything;
- Exceptions where beneficiary is unable to sign already exist and should not be made more stringent for EMS;
- Authorization process is no longer relevant (no more paper claims, assignment now mandatory, HIPAA authorizes disclosures);
- Signature authorizations requirement should be waived for emergency encounters.

We understand that the proposed rule was inspired by the intention to relieve the administrative burden for EMS providers. However, the "relief" being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and the hospitals and would result in shifting the payment burden to the patient if they fail to comply with the signature requirements at the time of incident. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for emergency ambulance services.

Current Requirement

When the beneficiary is physically or mentally incapable of signing, the industry has been following the requirements listed in the CMS Internet Only Manual, Pub. 100-02, Chapter 10, Section 20.1.2 and Pub. 100-04, Chapter 1, Section 50.1.6(A) (3) (c). These sections allow for a representative of the ambulance provider or hospital to sign on behalf of the beneficiary when the patient is unable to sign, document that the beneficiary was unable to sign, the reason and that no one could sign for the beneficiary.

The proposed rule directly conflicts with the existing rule. It requires that the provider representative sign **contemporaneously** with the transport and **seek an additional signature** from the hospital in the event a patient is unable to sign.

**BENEFICIARY UNDER DURESS SHOULD NOT BE REQUIRED TO SIGN ANYTHING**

Emergency ambulance providers have no admission department and no registration desk. The same individuals responsible to providing medical care and transportation to the hospital are also responsible for fulfilling the administrative functions. All EMS encounters are emergency in nature and medically necessary ambulance transports in particular are stressful events on patients.

CMS has recognized this modified its rules for obtaining Advance Beneficiary Notice and Acknowledgement of HIPAA Privacy Notices, creating exceptions that do not require ambulance crews to interrupt their care to seek a signature from a patient under their care.

In fact, CMS has deemed that all emergency encounters put the patient under great duress. Under such duress, patients would sign anything in order to get the care they require. Therefore, any signature obtained in an emergency situation cannot be relied upon.

Yet the proposed rule is so burdensome on ambulance crews that they will have every incentive to obtain a patients signature even though the patient is under mental duress. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

**EXCEPTIONS WHERE BENEFICIARY IS UNABLE TO SIGN ALREADY EXIST AND SHOULD NOT BE MADE MORE STRINGENT FOR EMS**

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. The proposed exception essentially mirrors the existing requirements that the beneficiary is

unable to sign and that no authorized person was available or willing to sign on their behalf, while adding additional documentation requirements. Therefore, we believe that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed sub-division (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, we do not object to the requirement that an ambulance provider obtain documentation of the date, time and destination of the transport. Nor do we object to the requirement that this item be maintained for 4 years from the date of service. However, we do not see any reason to include these in the Regulation, as they are already required and standard practice.

The Proposed Rule would add a requirement that an employee of the facility, i.e. hospital, sign a form at the time of transport, documenting the name of the patient and the time and date the patient was received by the facility. Our organization **strongly objects** to this new requirement as:

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

We also strongly object to the requirement that ambulance providers or suppliers obtain this statement from a representative of the receiving facility *at the time of transport.* Since the proposed rule makes no allowances for the inevitable situations where the ambulance provider makes a good faith effort to comply, but is ultimately unable to obtain the statement, we believe this requirement imposes an excessive compliance burden on ambulance providers and on the receiving hospitals. Consider what this rule requires—the ambulance has just taken an emergency patient to the ER, often overcrowded with patients, and would have to ask the receiving hospital to take precious time away from patient care to sign or provide a form. Forms such as an admission record will become available at a later time, if CMS wants them for auditing purposes in addition to the trip transport that will already include date, time and receiving facility.

**AUTHORIZATION PROCESS IS NO LONGER RELEVANT (NO MORE PAPER CLAIMS, ASSIGNMENT NOW MANDATORY, HIPAA AUTHORIZES DISCLOSURES)**

Purpose of Beneficiary Signature

a. Assignment of Benefits -The first purpose of the beneficiary signature is to authorize the assignment of Medicare benefits to the health care provider or supplier. However, assignment of covered ambulance services has been mandatory since April 2002. Furthermore, 42 C.F.R. §424.55(c), adopted November 15, 2004 as part of the Final Rule on the Physician Fee Schedule (67 Fed. Reg. 6236), eliminated the requirement that beneficiaries assign claims to the health care provider or supplier in those situations where payment can only be made on an assignment-related basis. Therefore, the beneficiary's signature is no longer required to effect an assignment of benefits to the ambulance provider or supplier.

   CMS recognized this in the Internet Only Manual via Transmittal 643, by adding Section 30.3.2 to Pub. 100-04, Chapter 1. As a result, the beneficiary signature is no longer needed to assign benefits of covered ambulance services.

b. Authorization to Release Records - The second purpose of the beneficiary signature is to authorize the release of medical records to CMS and its contractors. However, the regulations implementing the HIPAA Privacy Rule, specifically 45 C.F.R. §164.506(c) (3), permit a covered entity (e.g. an ambulance provider or supplier) to use or disclose a patient's protected health information for the covered entity's payment purposes, without a patient's consent (i.e. his or her signature). Therefore, federal law already permits the disclosure of medical records to CMS or its contractors, regardless of whether or not the beneficiary's signature has been obtained.

Signatures Not Required for ABN's for Emergency Transports

The Third Clarification of Medicare Policy regarding the Implementation of the Ambulance Fee Schedule states that Advanced Beneficiary Notifications only be issued for non-emergency transports. The ABN's which require beneficiary signature "may not be used when a beneficiary is under great duress" which would include emergency transports. Would not the requesting of a Medicare Beneficiary's signature for any other reason during an emergency transport be less duress?

Signature Already on File

Almost every covered ambulance transport is to or from a facility, i.e. a hospital or a skilled nursing facility. In the case of emergency ambulance transports, the ultimate

destination will always be a hospital. These facilities typically obtain the beneficiary's signature at the time of admission, authorizing the release of medical records for their services *or any related services*. The term "related services", when used by hospitals and SNFs, can mean more than only entities owned by or part of the facility. The term already includes physicians providing services at the facility. We believe that ambulance transport to a facility, for the purpose of receiving treatment or care at that facility, constitutes a "related service", since the ambulance transports the patient to or from that facility for treatment or admission. Therefore, we believe a valid signature will be on file with the facility. Additionally, for those transports provided to patients eligible for both Medicare and Medicaid, a valid signature is on file at the State Medicaid Office as a product of the beneficiary enrollment process.

Electronic Claims

It is also important to note that, as a result of section 3 of the Administrative Simplification Compliance Act and the implementing regulations at 42 C.F.R. §424.32, with very limited exceptions (e.g. providers or suppliers with less than 10 claims per month), ambulance suppliers must submit claims electronically. Thus, the beneficiary does not even sign a claim form. When submitting claims electronically, the choices for beneficiary signature are "Y" or "N". An "N" response could result in a denial, from some Carriers. That would require appeals to show that, while the signature has not been obtained, an alternative is accepted. As a result, many Carriers allow a "Y", even though the signature was not actually obtained, if one of the exceptions is met.

While this may be a claims processing issue, since you are now looking at the regulation, this would be a good time to add language indicating that the signature requirement will be deemed to be met if one of the exceptions to the requirement exists.

Program Integrity

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

**SIGNATURE AUTHORIZATIONS REQUIREMENT SHOULD BE WAIVED FOR EMERGENCY ENCOUNTERS.**

Conclusion

Based on the above comments, it is respectfully requested that CMS:

- Amend 42 C.F.R. §424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that "good cause for ambulance services is demonstrated where paragraph (b) has been met and the

ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported".

- Amend 42 C.F.R. §424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
- Amend 42 C.F.R. §424.36(b) (5) to add "or ambulance provider or supplier" after "provider".

In light of the foregoing, we urge CMS to forego creating a limited exception to the beneficiary signature requirement for emergency ambulance transports, especially as proposed, and instead eliminate the beneficiary signature requirement for ambulance services entirely if one of the exceptions listed above is met.

Thank you for your consideration of these comments.

Sincerely,

Nancy Ratzlaff, Director of Billing Services
Midwest LifeTeam
P.O. Box 780887
Wichita, KS 67278
(316) 749-4726
nratzlaff@midwestaviation.com

**Submitter :** **Date: 08/27/2007**

**Organization :**

**Category : Chiropractor**

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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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,

Jordan M. DeGrazia D.C.

**Submitter :** **Dr. Tom Hyland Robertson** **Date: 08/27/2007**

**Organization :** **Whole Chiropractic Healthcare, LLC**

**Category :** **Chiropractor**

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

CMS-1385-P.
THIS REVISION, IF INSTATED, WOULD LIMIT MY ABILITY TO SAFELY DIAGNOSE MY PATIENTS' CONDITIONS AND WOULD THUS COMPROMISE MY MEDICAL DECISION-MAKING AND RISK THE HEALTH OF MY PATIENTS. I am a chiropractor practicing in the state of Maryland and have actually been told for years by the major radiology clinics around Baltimore that they will NOT accept a referral from chiropractors because Medicare will not pay for it--essentially, only MDs or DOs have the ability to send a patient for radiologic studies. This is not a new thing, but it galls me that I have been misled for years and have essentially living under the revisions before they were officially revised. It also galls me that I have MORE TRAINING IN RADIOLOGY, BOTH IN INTERPRETING AND TAKING FILMS, THAN THE AVERAGE MEDICAL DOCTOR (based on curriculum comparisons, even without diplomate training), yet if this revision goes through, I won't be able to decide when my patients need an xray or an MRI, something that is often crucial to my diagnosis. I would like to know why chiropractors are not given the same priority as medical doctors in Medicare--PLEASE REVIEW THE CURRICULA AT VARIOUS CHIROPRACTIC SCHOOLS, ESPECIALLY NATIONAL UNIVERSITY, NORTHWESTERN U, NEW YORK CHIROPRACTIC COLLEGE, ETC. TO SEE THE AMOUNT OF RADIOLOGY TRAINING THAT ALL CHIROPRACTORS GET!!! At this point, chiropractors are already considered "second-class" healtheare providers in Medicare, being limited to only being paid for the Chiropractic Adjustment, not for examinations, office visits, physical therapy, etc, and this will relegate us even further to the rear of the field. It seems like such a backward step, especially considering the fact that the Pilot Program for Chiropractors, which was done to examine the cost-effectiveness of chiropractors using physical therapy modalities and acting as Primary Care Providers, hasn't even been evaluated yet.

Please stop this revision from happening.

**Submitter :** Edward Peashey **Date:** 08/27/2007

**Organization :** Canadochly Valley Ambulance Club

**Category :** Other Health Care Provider

**Issue Areas/Comments**

**Beneficiary Signature**

Beneficiary Signature

Abiliy to submit without beneficiary or representative signature is a welcome nad most needed change, since it is sometimes impossible to get a signature on emergency transports.

Proposed record keeping requirements pose no significant problem, but given the current level of activity in Hospital Emergency Departments, it will be nearly impossible to track down some one willing to sign a "receipt" for the patient, and at best would interfere with patient care for the patient who is unable to sign and likely to be in a life threatening situation.

We respectfuuly request the elimination of the need to obtain a signature at the hospital.

**Submitter :** Mr. Mike Wallace **Date:** 08/27/2007

**Organization :** Alamogordo Physical Therapy

**Category :** Physical Therapist

**Issue Areas/Comments**

**CAP Issues**

CAP Issues

I urge you to take action to provide a long term policy solution and pass legislation to remove the therapy cap and prevent harm to Medcare benificiaries needing rehabilitation services. A physical therapists ability to treat Medicare patients will be limited if you allow cuts in payments under the 2008 Medicare fee schedule to go into effect as scheduled on Jan 1. Please cosponsor HR 748/S.450 to repeal the therapy cap. Thank you

**Submitter :** Mr. David Bumgarner **Date:** 08/27/2007

**Organization :** Florida Board of Physical Therapy Practice

**Category :** State Government

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1385-P-8115-Attach-1.DOC

#8115


Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

August 22, 2007

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

Re: CMS-1385-P THERAPY STANDARDS AND REQUIREMENTS

Dear Sir or Madam:

The Florida Board of Physical Therapy Practice submits the following comments on the proposed rules changing the definition of "physical therapist" in Section 484, Title 42 of the Code of Federal Regulations. The proposed rules are part of the 2008 Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for Calendar Year 2008, found in Volume 72 of the Federal Register, published on July 12, 2007.

Under subsection (i)(B) and (ii)(B) of the proposed definition of "physical therapist" an applicant would need to have "passed the National Examination approved by the American Physical Therapy Association." We strongly suggest that CMS rely on state licensure and that the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist" be deleted from the final rule. At the very least, the Centers for Medicare and Medicaid Services ("CMS") should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We, along with all of the other state boards of physical therapy examiners, have already adopted a national qualifying exam for physical therapists, the National Physical Therapy Examination ("NPTE"). The Federation of State Boards of Physical Therapy ("FSBPT") develops and administers the NPTE in close collaboration with the state boards. Working together, we have developed a national passing score. The FSBPT has done an outstanding job of meeting our needs. Likewise, the NPTE has been a valuable tool in screening physical therapist applicants. Through the NPTE, we have been able to successfully filter applicants. In turn, we, as a licensing body, have been able to protect the public by ensuring that only qualified therapists are licensed to care for our citizens.

CMS should not usurp the states' function of licensing physical therapists and other professionals. Health care professional credentialing and licensing is a state function. Licensing and credentialing are the domain of the states. CMS' proposal would inappropriately transform a state function into a federal function. There is no justification for this action, and CMS should prevent it by removing the proposed rule.

CMS respects states' rights and state licensure for other health care professions, and it should continue to do so with respect to physical therapists. For example, CMS' regulations define a physician as a "doctor of medicine ...legally authorized to practice medicine and surgery by the State in which such function or action is performed." 42 C.F.R. § 484.4 (2006). Likewise, a registered nurse is defined as "a graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing." 42 C.F.R. § 484.4. establishing requirements that are different than what the states require for

Medical Quality Assurance
Medical Therapies/Psychology
4052 Bald Cypress Way Bin # C 05
Tallahassee, FL 32399-3255
(850) 245-7373

licensing Physical Therapists would be inconsistent with not only the rights of the states, but also CMS' own standards.

Moreover, the federal government should not impose an additional burden on the states, particularly since its stated desire for a national examination is already satisfied and its other stated goals would not be better met by the burden it proposes to impose. The proposed unfunded mandate could result in the development of a second exam, which would create confusion and more work for the states, without benefit. Our resources are already limited and stretched.

In the preamble to the proposed regulations, CMS says that it is seeking uniformity. The fact of the matter is that uniformity and consistency across the nation and across provider settings already exists. State licensing requirements apply to physical therapists without regard to where they practice. All states accept CAPTE accreditation. All states accept the NPTE and have adopted the same passing score. No federal regulation is required.

In fact, the proposed regulations would likely defeat CMS' own goal of uniformity. If, for example, the APTA were to approve a different exam than the NPTE, which the regulations would permit it to do, physical therapists, patients, including Medicare and Medicaid beneficiaries and recipients, and others could face substantial confusion and interruption of service. As a state board of physical therapy examiners, we would continue to have authority to select an exam of our choice for licensing purposes. However, under the proposed rule, a physical therapist would have to pass a second exam approved by the APTA to qualify for Medicare reimbursement. Thus, patients might be forced to change physical therapists as they become Medicare or Medicaid eligible, and the current uniformity and continuity of standards across the country would be lost. Thus, the proposed rules undermine CMS' ambition for uniformity of standards.

CMS and the federal government should not empower an advocacy group, like the APTA, to establish an examination or any qualifications for professionals to provide healthcare services to patients. The APTA's mission is to advocate and promote the profession. As a licensing body, our mission is to ensure that physical therapists are qualified to provide physical therapy services and are authorized to do the work for which they are trained. The FSBPT, the organization to which we look for the national licensing exam, was created to eliminate, protect against and prevent the inherent conflict of interest that the APTA would have if it were to have authority over the examination and credentialing processes. Even the APTA recognized this conflict of interest problem two decades ago when it created the Federation of State Boards of Physical Therapy. CMS must not allow this conflict of interest to become a rule.

The Florida Board of Physical Therapy Practice strongly urges CMS to require only state licensure. Most importantly, CMS should remove the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist." At a minimum, CMS should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing, and licensing processes currently in place.

We appreciate the opportunity to comment on the proposed rules regarding physical therapist and physical therapy assistant qualification requirements.

Respectfully yours,

*David Bumgarner*

David Bumgarner, MPT, GCS,
Chair, Florida Board of Physical Therapy Practice

DB/cs

Medical Quality Assurance
Medical Therapies/Psychology
4052 Bald Cypress Way Bin # C 05
Tallahassee, FL 32399-3255
(850) 245-7373

**Submitter :** Mrs. vrinda hatti **Date:** 08/27/2007

**Organization :** AUM Physical Therapy, P.C.

**Category :** Physical Therapist

**Issue Areas/Comments**

**Physician Self-Referral Provisions**

Physician Self-Referral Provisions

Physical therapy is one of the highly specialized branches of medicine in current curative medical model dealing with chronic and acute muscular aches and pains. Physical therapy is, and should be preventative medicine and not only curative in nature. Prevention is one of the prime initiatives of Public Health Policy in curtailing healthcare costs.

With all due respect, I would like to ask CMS to review the precise instructions for referral to physical therapy. How often patients are referred to outpatient physical therapy with clear directives for home exercise program to prevent future episodes of chronic aches/pains? Do these instructions to physical therapist include patient education on posture/body mechanics to avoid deleterious effect of gravity on posture? This is important in understanding utilization of physical therapy services.

Depending on individual State laws & Regulations, to ensure safety of members, Medicare beneficiaries are required to have face-face encounter with physicians prior to implementing, or continuing outpatient physical therapy services. Precise treatment regimen should be included on the prescriptions to make sure encounter with physicians for referral to outpatient physical therapy is meaningful and fulfills required safety issue.

**Submitter :** **Dr. Andy Circelli** **Date: 08/27/2007**

**Organization :** **Dr. Andy Circelli**

**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,

Dr. Andy Circelli

**Submitter :** **Dr. Peter Billharz** **Date: 08/27/2007**

**Organization :** **Associated Anesthesiologists of Reno**

**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.

-Peter Billharz, MD

**Submitter :** **Dr. Nicholas Helmich** **Date: 08/27/2007**

**Organization :** **Helmich Chiropractic Clinic**

**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

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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,

Nicholas T. Helmich, DC

**Submitter :** **Dr. James Miles,Jr.** **Date: 08/27/2007**

**Organization :** **Dr. James Miles,Jr.**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

**Submitter :** **Dr. Laura Miles** **Date: 08/27/2007**

**Organization :** **Dr. Laura Miles**

**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 :** **Ms. Sydney Miles** **Date: 08/27/2007**

**Organization :** **Ms. Sydney Miles**

**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)

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Thank you for your consideration of this serious matter.

**Submitter :** **Ms. Paige Miles** **Date: 08/27/2007**

**Organization :** **Ms. Paige Miles**

**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.

CMS-1385-P-8124

**Submitter :** Kirk Harum **Date:** 08/27/2007

**Organization :** Kirk Harum

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-1385-P-8124-Attach-1.RTF

#8124

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.

There are approximately 7,000 physicians practicing interventional pain management in the United States I am included in this statistic. As you may know physician offices, along with hospital outpatient departments and ambulatory surgery centers are important sites of service for the delivery of interventional pain services.

I appreciated that effective January 1, 2007, CMS assigned interventional pain and pain management specialties to the "all physicians" crosswalk. This, however, did not relieve the continued underpayment of interventional pain services and the payment shortfall continues to escalate. 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 anesthesiologists who list interventional pain or pain management as their secondary Medicare specialty designation, along with the 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.

## RESOURCE-BASED PE RVUs

### I. CMS should treat anesthesiologists who have listed interventional pain or pain management as their secondary specialty designation on their Medicare enrollment forms as interventional pain physicians for purposes of Medicare rate-setting.

Effective January 1, 2007, interventional pain physicians (09) and pain management physicians (72) are cross-walked to "all physicians" for practice expenses. This cross-walk more appropriately reflects the indirect practice expenses incurred by interventional physicians who are office-based physicians. The positive affect of this cross-walk was not realized because many interventional pain physicians report anesthesiology as their Medicare primary specialty and low utilization rates attributable to the interventional pain and pain management physician specialties.

The practice expense methodology calculates an allocable portion of indirect practice expenses for interventional pain procedures based on the weighted averages of the specialties that furnish these services. This methodology, however, undervalues interventional pain services because the Medicare specialty designation for many of the physicians providing interventional pain services is anesthesiology. Interventional pain is an inter-disciplinary practice that draws on various medical specialties of anesthesiology, neurology, medicine & rehabilitation, and psychiatry to diagnose and manage acute and chronic pain. Many interventional pain physicians received their medical training as anesthesiologists and, accordingly, clinically view themselves as anesthesiologists. While this may be appropriate from a clinically training perspective, their Medicare designation does not accurately reflect their actual physician practice and associated costs and expenses of providing interventional pain services.

This disconnect between the Medicare specialty and their practice expenses is made worse by the fact that anesthesiologists have the lowest practice expense of any specialty. Most anesthesiologists are hospital based and do not generally maintain an office for the purposes of rendering patient care. Interventional pain physicians are office based physicians who not only furnish evaluation and management (E/M) services but also perform a wide variety of interventional procedures such as nerve blocks, epidurals, intradiscal therapies, implant stimulators and infusion pumps, and therefore have practice expenses that are similar to other physicians who perform both E/M services and surgical procedures in their offices.

Furthermore, the utilization rates for interventional pain and pain management specialties are so low that they are excluded from Medicare rate-setting or have very minimal affect compared to the high utilization rates of anesthesiologists. CMS utilization files for calendar year 2007 overwhelming report anesthesiologists compared to interventional pain physicians and pain management physicians as being the primary specialty performing interventional pain procedures. The following table illustrates that anesthesiologists are reported as the primary specialty providing interventional pain

services compared to interventional pain physicians

| CPT Code | Anesthesiologists - 05 (Non-Facility) | Interventional Pain Management Physicians - 09 (Non-Facility) |
|---|---|---|
| 64483 (Inj foramen epidural l/s) | 59% | 18% |
| 64520 (N block, lumbar/thoracic) | 68% | 15% |
| 64479 (Inj foramen epidural c/t) | 58% | 21% |
| 62311 (Inject spine l/s (cd)) | 78% | 8% |

The high utilization rates of anesthesiologists (and their extremely low practice expenses) drive the payment rate for the interventional pain procedures, which does not accurately reflect the resource utilization associated with these services. This results in payment rates that are contrary to the intent of the Medicare system—physician payment reflects resources used in furnishing items and services to Medicare beneficiaries.

I urge CMS to make a modification to its practice expense methodology as it pertains to interventional pain services such that its methodology treats physicians who list anesthesiology as their primary specialty and list interventional pain as their secondary specialty designation as interventional pain physicians for rate-setting. This pool of physicians should be cross-walked to "all physicians" for practice expenses. This will result in a payment for interventional pain services that is more aligned with the resources and costs expended to provide these services to a complex patient population.

I urge CMS not to delay implementing our proposed recommendation to see if the updated practice expenses information from the Physician Practice Information Survey ("Physician Practice Survey") will alleviate the payment disparity. While I believe the Physician Practice Survey is critical to ensuring that physician services are appropriately paid, I do not believe that updated practice expense data will completely resolve the current underpayment for interventional pain services. The accurate practice expense information for interventional pain physicians will continue to be diluted by the high utilization rates and associated low practice expenses of anesthesiologists.

## II. CMS Should Incorporate the Updated Practice Expenses Data from Physician Practice Survey in Future Rule-Making

I commend CMS for working with the AMA, specialty societies, and other health care professional organizations on the development of the Physician Practice Survey. I believe that the survey data will be essential to ensuring that CMS has the most accurate and complete information upon which to base payment for interventional pain services. I urge CMS to take the appropriate steps and measures necessary to incorporate the updated practice expense data into its payment methodology as soon as it becomes available.

## III. CMS Should Work Collaboratively with Congress to Fix the SGR

**Formula so that Patient Access will be preserved.**

The sustainable growth rate ("SGR") formula is expected to cause a five percent cut in reimbursement for physician services effective January 1, 2008. Providers simply cannot continue to bear these reductions when the cost of providing healthcare services continues to escalate well beyond current reimbursement rates. Continuing reimbursement cuts are projected to total 40% by 2015 even though practice expenses are likely to increase by more than 20% over the same period. The reimbursement rates have not kept up with the rising cost of healthcare because the SRG formula is tied to the gross domestic product that bears no relationship to the cost of providing healthcare services or patient health needs.

Because of the flawed formula, physicians and other practitioners disproportionately bear the cost of providing health care to Medicare beneficiaries. Accordingly, many physicians face clear financial hardship and will have to make painful choices as to whether they should continue to practice medicine and/or care for Medicare beneficiaries.

CMS should work collaboratively with Congress to create a formula that bases updates on the true cost of providing healthcare services to Medicare beneficiaries.

***

Thank you for the opportunity to comment on the Proposed Rule. My fear is that unless CMS addresses the underpayment for interventional pain services today there is a risk that Medicare beneficiaries will be unfairly lose access to interventional pain physicians who have received the specialized training necessary to safely and effectively treat and manage their complex acute and chronic pain. We strongly recommend that CMS make an adjustment in its payment methodology so that physicians providing interventional pain services are appropriately and fairly paid for providing these services and in doing so preserve patient access.

Sincerely,

Kirk E. Harum, MD
700B McCarthy Blvd
New Bern, NC 28562

**Submitter :** Dr. Kyle Ervin **Date:** 08/27/2007

**Organization :** Dr. Kyle Ervin

**Category :** Chiropractor

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

#8125



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

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

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

**Submitter :** Dr. James Hollern **Date:** 08/27/2007

**Organization :** Hollern Chiropractic

**Category :** Chiropractor

**Issue Areas/Comments**

**Technical Corrections**

Technical Corrections

Abolish recommendation

**Submitter :** **Mrs. Linda Miles** **Date: 08/27/2007**

**Organization :** **Mrs. Linda Miles**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am of medicare age and having a more difficult time finding physicians who will take care of medicare patients. Please increase the anesthesia reimbursement to a reasonable level for their professional services. At this time their rates are less than mechanics charge in Oklahoma. Thank you for your consideration of this increase.

**Submitter :** **Mr. Robert Francis** **Date: 08/27/2007**

**Organization :** **Mr. Robert Francis**

**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 :** Dr. Tom Kuzma **Date:** 08/27/2007

**Organization :** Kuzma Chiropracic

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

I am writing in regards to the proposal to repeal chiropractic x-ray reimbursement for medicare and medicaid patients. I realize that you all are trying to reduce health care costs and limit the amount of services that you will cover as a government. This, however, is not going to be the answer. I do realize that there are a small percentage of chiropractors that believe that x-ray is not an important adjunct to delievering quality chiropractic care, but this is why I do not agree with them.

X-ray is the only way that a chiropractor or any health care provider can be sure that there is spinal misalignment. The picture also is important for us to determine which direction and vector is going to be the most effective at reducing the subluxation. I am aware that spinal x-ray is not enough to diagnose a subluxation, but it definitely is necessary for correcting underlying malpositions that can lead to advanced degeneration and more problems longterm. Also, a chiropractor that doesn't take x-rays is putting himself at risk for malpractice, because without looking at the x-ray the chiropractor could miss a fracture or any other condition that may be a contraindication to adjust, therefore injuring the patient further.

These are just a few of the reasons not to take this service away from medicare and medicaid patients. It is doing them a great disservice that will end up with increased medical costs in the long term. Chiropractic is a great preventitive service and if more of this country would be held more accountable for their own health, many of the health care problems would solve themselves.

Your friend in health,

Tom Kuzma D.C.

**Submitter :** **Date: 08/27/2007**

**Organization :**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

Brian Thyr, M.D.
Dept. of Anesthesiology
6401 France Avenue South
Edina, MN 55435

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

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

Thank you for your consideration of this serious matter.

**Submitter :** **Mr. James Miles** **Date: 08/27/2007**

**Organization :** **Mr. James Miles**

**Category :** **Individual**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

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Thank you for your consideration of this serious matter.

**Submitter :** **Michael Palsgrove** **Date: 08/27/2007**

**Organization :** **Michael Palsgrove**

**Category :** **Other Health Care Professional**

**Issue Areas/Comments**

**Background**

Background

August 27, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018
Baltimore, MD 21244 8018

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

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

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 D. Palsgrove, MS, CRNA
1497 W. Avon Blvd.
Avon Park, FL 33825

**Submitter :** **Dr. Laura Miles** **Date: 08/27/2007**

**Organization :** **Dr. Laura Miles**

**Category :** **Physician**

**Issue Areas/Comments**

**GENERAL**

GENERAL

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

**Submitter :** Dr. Joey Schroeder **Date:** 08/27/2007

**Organization :** Heartland Chiropractic Associates

**Category :** Physician

**Issue Areas/Comments**

**Chiropractic Services Demonstration**

Chiropractic Services Demonstration

Xrays, at times, are an integral part in assessing a patient in all forms of Health Care. In the Chiropractic profession, we are assessing the musculoskelatal system. We should have every opportunity to fully utilize the diagnostics procedures to give the geriatric patient the appropriate care.

**Submitter :** **Dr. David Petcu** **Date: 08/27/2007**

**Organization :** **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

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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.

Dr. David Petcu