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)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Ms. 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
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Thank you for your consideration of this serious matter.

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

Organization : Dr. J. Clayton 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

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Thank you for your consideration of this serious matter.

Submitter : **Mr. John Rogers** **Date: 08/27/2007**

Organization : **Mr. John Rogers**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Miss. Amanda Richardson** **Date: 08/27/2007**

Organization : **Palmer College of Chiropractic - Student**

Category : **Chiropractor**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Amanda Dee Richardson
Palmer College of Chiropractic Student

Submitter : **Mrs. Corinne Rogers** **Date: 08/27/2007**

Organization : **Mrs. Corinne Rogers**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

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

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Thank you for your consideration of this serious matter.

CMS-1385-P-8143

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

Organization : Integris Jim Thorpe Rehabilitation Hospital

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I would like to object to Physical Therapists being required to pass a national exam approved by the APTA. We already have a standardized national exam and then are licensed by the state as are other health care professionals. The APTA is a support organization and not a governing body for our profession, which makes their defining the national exam as well as credentialing process for foreign-trained therapists is a conflict of interest. The state boards are currently providing licensure effectively protecting their citizens against unqualified Physical Therapists. The proposed changes for Physical Therapy are unecessary and will require additional work for the state boards. Thank you for your consideration. Linda Helphrey PT

Submitter : **Dr. Hire Basavaraja** **Date: 08/27/2007**

Organization : **Dr. Hire Basavaraja**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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

Organization : **Mrs. Linda Miles**

Category : **Individual**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Sarah Smart** **Date: 08/27/2007**

Organization : **Ms. Sarah Smart**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Submitter : Dr. Thaddeus Ray **Date:** 08/27/2007

Organization : Iowa Orthopaedic Center

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Please consider patients, in regards to ASC use vs Hospitals for Pain procedure. Cost much less, less paper work= much happier patient

Submitter : Dr. William Gischia **Date:** 08/27/2007

Organization : Harbor Family Chiropractic Center PLC

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

I think your discrimination against a profession as helpful and safe as our speaks volumes about your motives and who lines your pockets. Pharmeceuticals Companies and the AMA, FDA, FTC and sleeping with government a disgusting display hippocracy and greed. You sicken me.

CMS-1385-P-8148-Attach-1.PDF

#8148

Nonsteroidal Anti-inflammatory Drugs (NSAIDs) and Chemoprevention of Breast Cancer

Randall Harris,[1] of Ohio State University, Columbus, Ohio, and colleagues presented very interesting results from a prospective study on the effects of anti-inflammatory agents in the chemoprevention of breast cancer in women enrolled in the Women's Health Initiative observational study. A total of 80,741 postmenopausal women (50-79 years of age) with no previous history of cancer (other than nonmelanoma skin cancer) were included, 1392 of whom developed breast cancer during the study as documented by pathologic exam. Average follow-up was 43 months. Use of anti-inflammatory agents and general medical histories were recorded at baseline and throughout the study.

Regular intake of 2 or more tablets per week of over-the-counter anti-inflammatory drugs (aspirin, ibuprofen, or other compounds) at standard doses (aspirin, 325 mg/dose; ibuprofen, 200 mg/dose) for 5-9 years was found to have a protective effect against the development of breast cancer, with an overall reduction in cancer risk of 21% (relative risk [RR] 0.79; confidence interval [CI], 0.60-1.04). **Protection was greater with longer use of the anti-inflammatory agent (28% risk reduction with a > 10-year use)** and when ibuprofen was used instead of aspirin (ibuprofen: RR, 0.51; $P < .04$; aspirin: RR, 0.79; $P < .06$).

Concomitant evaluation of other factors, including age, body mass, estrogen use, family history, parity and exercise, did not seem to modify the protective effect attributed to the anti-inflammatory agents. Of note, low-dose aspirin and the pain reliever acetaminophen were not effective in modifying breast cancer incidence.[1]

These new results seem to confirm previous data obtained in smaller trials by the same group,[2] who previously found a significant reduction in risk of breast cancer (RR, 0.66; CI, 0.52-0.83) in a case-controlled study of 511 breast cancer patients who used anti-inflammatory agents at least 3 times weekly for more than 1 year. Similarly, a 5-year follow-up of a cohort of 32,505 women in central Ohio had shown that incidence of breast cancer was inversely related to use of NSAIDs. Breast cancer rates were 50% lower in women using NSAIDs and 40% lower with regular doses of aspirin ($P < .05$).[3]

These are very intriguing results that might change the way we look at and implement chemoprevention of breast cancer. Are a couple of pills of ibuprofen or aspirin per week indeed good and enough for all? As noted by the authors of these studies, further analysis of the data and confirmatory trials are needed before any formal recommendation can be made for the general public. Although not frequently linked with high toxicities, daily or weekly use of NSAIDs may be associated with toxic effects.[4]

A careful assessment of the balance between individual breast cancer risk, chemoprotective effects, concomitant morbidities, and acute/chronic toxicities will help to define whether and which women should indeed receive this form of chemoprophylaxis, as well as the optimal schedule or agent to be used. Previous studies of chemically induced breast cancer in rats have shown that the cyclooxygenase (COX)-2-blocker celecoxib seemed more effective than ibuprofen in reducing incidence, multiplicity, and volume of anthracene-induced breast tumors in rats.[5] It remains to be seen whether these findings apply also to human breast malignancies. COX-2 inhibitors show a high selectivity for this enzyme and a lower gastrointestinal toxicity when compared with conventional NSAIDs such as aspirin or ibuprofen, They are, however, not completely devoid of toxicity, as inhibition of the COX-2 enzyme may delay wound healing, negatively affect ovulation, and induce a prothrombotic diathesis.[4,6,7]

Submitter : **Mr. Steven Duke** **Date: 08/27/2007**

Organization : **Mr. Steven Duke**

Category : **Other Technician**

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.

CMS-1385-P-8150

Submitter : **Mr. Joshua Kermisch** **Date: 08/27/2007**

Organization : **Oregon Imaging Centers**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

The Physician Work RVU-CPT 77080 (DXA)
The Direct Practice Expense RVU for 77080 (DXA)
Indirect Practice Expense for DXA and VFA
Deficit Reduction Act

Dear Mr. Weems:

I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.

As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:

a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;

b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:

? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;

? the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.

c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and

d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,

Josh Kermisch

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

Organization : **Mr. Robert Miles**

Category : **Drug Industry**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

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

Organization : **Dr. David Mullin**

Category : **Chiropractor**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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

Re: TECHNICAL CORRECTIONS

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

Sincerely,

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

Organization : **Mrs. Ginger Miles**

Category : **Nurse**

Issue Areas/Comments

GENERAL

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

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

Thank you for your consideration of this serious matter.

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

Organization : **Mr. Jake 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)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

CMS-1385-P-8155

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Paul Santoro** **Date: 08/27/2007**

Organization : **Mr. Paul Santoro**

Category : **Other Health Care Provider**

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

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

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

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,

Paul W. Santoro MS, CRNA

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

Organization : **Dr. David Brand**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : University of Florida College of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#8158

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.

CMS-1385-P-8159

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

Organization : **Mr. James Kirk**

Category : **Attorney/Law Firm**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

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

Organization :

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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.

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

Organization : **University of Florida College of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Cordially,

Richard J. Rogers, MD, PhD
Assistant Professor
Department of Anesthesiology
University of Florida College of Medicine

CMS-1385-P-8162

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

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

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

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

The Physician Work RVU-CPT 77080 (DXA)
The Direct Practice Expense RVU for 77080 (DXA)
Indirect Practice Expense for DXA and VFA
Deficit Reduction Act
Dear Mr. Weems:
I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.
As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:
a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;
b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:
? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;
? the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.
c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and
d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image. The Physician Work RVU-CPT 77080 (DXA)
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Submitter : **Dr. Robert Burger** **Date: 08/27/2007**

Organization : **Adjustments for Life**

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.

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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,
Dr. Robert A. Burger DC

Submitter : **Dr. William Saucier** **Date: 08/27/2007**

Organization : **Dr. William Saucier**

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.

CMS-1385-P-8166

Submitter : Dr. Cary Teodori **Date:** 08/27/2007

Organization : Michigan Association of Chiropractors

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Re: TECHNICAL CORRECTIONS

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Sincerely,

Submitter : **Dr. Beatrice Edwards** **Date: 08/27/2007**

Organization : **Northwestern University**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Kerry Weems, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-1385-P Proposed Revisions to payment policies under the physician fee schedule and other Part B payment policies for CY 2008

Comments:

The Physician Work RVU-CPT 77080 (DXA)
The Direct Practice Expense RVU for 77080 (DXA)
Indirect Practice Expense for DXA and VFA
Deficit Reduction Act

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c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and

d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.
e. DXA is one of the few medical procedures or tests demonstrated to be cost effective or cost savings. The US Surgeon General Report on Bone Health and Osteoporosis in 2004 highlighted the severity and magnitude of osteoporosis as a public health problem. The CMS proposal to decrease reimbursement for this DXA test will result in more women suffering fractures (pain and suffering), hospitalizations, nursing home admissions, and death from osteoporosis

Sincerely,

Beatrice J Edwards MD, FACP
Bone Health and Osteoporosis Center
Feinberg School of Medicine
Northwestern University
675 North Saint Clair, suite 14-100
Chicago, IL 60611

Submitter : **Mrs. Doris Burnett** **Date: 08/27/2007**

Organization : **Willie J. Sessions, M.D.**

Category : **Other Health Care Professional**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

As an Office Manager for a Cardiologist who provides echocardiography services to Medicare patients and other patients in North Carolina, I am writing to object to CMS's proposal to "bundle" Medicare payment for colow flow Doppler (CPT Code 93325) into all echocardiography "base" services. It is my contention that even though the Color flow Doppler is critical to decision making in patients with suspicion of heart valve disease and selection of patients for valve surgery (and is very important in accurately diagnosing many other cardiac conditions), it is not "intrinsic" to the performance of all echocardiography procedures.

CMS's proposal to "bundle" color flow Doppler totally disregards the expenses incurred by our practice and the physician time involved in performance and interpretation of these studies. Even though the color flow Doppler can be performed at the same time as the imaging component of echocardiographic studies, performing the color flow Doppler increases the sonographer time, equipment time and physician time involved. These increases are not included in the relative value units for any other echocardiography "base" procedure. Therefore, this proposal would totally eliminate payment for a very important and useful procedure that is not reimbursed under any other CPT code.

Already the reimbursement for this procedure has been drastically cut and to totally eliminate reimbursement would adversely affect our ability to provide the best quality care for our patients.

Therefore, I implore you to refrain from finalizing the proposed "bundling" of color flow Doppler into other echocardiography procedures.

Sincerely,

Doris G Burnett

Submitter : Dr. John Talmadge **Date:** 08/27/2007

Organization : Campbell County Chiropractic Center

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Dear Sirs:

It has come to my attention that CMS published a proposed rule in the Federal Register that would eliminate patient reimbursement for x-rays taken by a radiologist or other non-treating physician and then used by a doctor of chiropractic.

If this rule is adopted or takes effect it would severely hamper senior citizen's health care resources, effecting them both physically and financially. This would force senior citizens seeking chiropractic care to visit their family physician and request that he recommend or take x-rays, thereby incurring an extra cost before going to the chiropractor.

Additionally, it is not unusual for a medical doctor to take x-rays, and not having the benefit of a chiropractic analysis of those x-rays, send the patient on for an MRI or other costly diagnostics that would have otherwise been avoided had the chiropractor ordered the x-rays to begin with.

Since many of our patients have already been the medical route, it has been shown that patients will inevitably seek chiropractic care when other approaches have failed so the cost of chiropractic care is not averted while the overall cost the patient entails is greatly exagerated over what it should have been.

I urge you to reconsider this proposed rule and continue to allow senior citizens this avenue of diagnostics when seeking chiropractic care.

John Talmadge, DC
Lynchburg, VA

Submitter : **Ms. Barbara Marone** **Date: 08/27/2007**

Organization : **Alliance of Specialty Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-8170-Attach-1.PDF

8170

200,000 Physicians Strong

Gordon Wheeler, Chair
gwheeler@acep.org
202.726.0610

Lucia DiVenere, Vice Chair
ldivenere@acog.org
202.863.2510

August 20, 2007

Herb B. Kuhn, Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-1385-P

RE: Medicare Program; PROPOSED Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2008

Dear Mr. Kuhn:

On behalf of the undersigned members of the Alliance of Specialty Medicine, a coalition of 11 medical societies representing more than 200,000 specialty physicians in the United States, we appreciate the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with our comments on the proposed rule for physician payment for 2008 that was published in the Federal Register on July 12, 2007.

The Alliance was founded in 2001 to serve as a strong voice for specialty medicine. Its mission is to improve access to quality medical care for all Americans through the unified voice of specialty physicians promoting sound federal policy. A fee schedule that adequately and fairly accounts for the costs of furnishing medical services to Medicare beneficiaries indisputably affects access to and the quality of care for our nation's elderly citizens, and thus, is of paramount concern to us.

Impact

After seven years of reimbursement cuts, freezes, or updates that were less than the rate of inflation, physicians are now faced with the largest payment reduction ever (- 9.9%). The nation's physicians are not impervious to continuing growth in costs of staff, liability premiums, equipment, and other expenses of running their medical practices. In response to shrinking practice revenues, physicians may not completely drop out of the Medicare program, but they will in many cases be forced to explore other means to limit their exposure to continuing losses, which in turn may unfortunately have an adverse effect on beneficiary access.

Each year, we work with the Administration and Congress to urge rescinding of the SGR and replacing it with a formula that recognizes reasonable inflationary costs, similar to all of the other Medicare payment systems. This proposal has been repeatedly recommended by the Medicare Payment Advisory Commission (MedPAC) and other policy experts as well.

TRHCA – Section 101(d)

While the largest challenge is on Congress to act, CMS has done nothing to ameliorate the growing cost of the SGR fix and has repeatedly refused to take drugs out of the SGR pool while also under estimating the costs of new Medicare benefits. This year, CMS proposes to take the $1.35 billion that Congress set aside in the TRHCA legislation of 2006 and use it for the physicians' quality reporting initiative which will benefit a limited number of participating physicians, rather than as a down payment for a longer term payment fix that would be of direct benefit to all participating physicians.

The Alliance strongly supports use of the $1.35 billion available in the Physician Assistance and Quality Improvement Fund to buy down the deleterious effects of the 9.9 percent payment cut. We believe the proposal to apply these funds to the PQRI is counter to the intent of Congress and MedPAC's recommendation. CMS should and can overcome the "legal and operational" problems associated with applying the funds to the negative update, as the dire situation posed by the harmful cuts surely prevails over the potential obstacles. Use of these funds to ameliorate the severe reduction to the fee schedule will have a more positive impact on all physicians than a reporting program whose value has not yet been demonstrated.

Budget Neutrality Adjustment

We were disappointed by CMS' decision to make the budget neutrality adjustment to the physician work values for 2007, particularly after the large majority of physician specialties asked CMS to make this adjustment to the conversion factor. From 1998 to 2006, CMS achieved budget neutrality requirements by adjusting the Medicare conversion factor, so clearly CMS supported this policy. Further, as CMS has never satisfactorily explained the rationale for the 2007 decision, the Alliance again urges the Agency to make any budget neutrality adjustment for 2008 to the conversion factor, rather than impose a nearly 12 percent reduction to the work values.

Publishing Relative Value Units (RVUs) for Non-covered Services

We reiterate our request that CMS publish services for CPT codes that remain non-covered by Medicare. Since many other payers look to CPT codes, we strongly support CMS publishing relative values for all services, regardless of Medicare's coverage policies. It is our understanding that CMS can include a table in the final rule for New and Revised CPT codes.

TRHCA –Section 101(b) Physician Quality Reporting Initiative (PQRI)

The Alliance members have been engaged in significant efforts to develop performance measures, and are working closely with external stakeholders to develop measures that will help us provide even better care for our patients. However, we are concerned that the process for developing the 2008 PQRI is advancing while the 2007 PQRI just began July 1. This timeframe leaves scant opportunity to evaluate the most basic elements of the 2007 PQRI program, such as impact on patient care, physician participation rates, and implementation costs before moving forward. While we understand that CMS is required by TRHCA to implement the 2008 program, we urge the agency to use its discretion to closely evaluate the 2007 program before moving ahead, and support provisions included in S. 1519/ H.R. 2749, the Voluntary Medicare Quality Reporting Act. Specifically, we urge CMS to work with medical specialties to identify gaps in care for which quality measures are genuinely needed and to ensure that any Medicare quality program for physicians remains voluntary. Further, we believe that any incentives linked to such a quality program should be paid with new funds.

In addition, we believe that the requirement that measures for the 2008 program be developed "through the use of a consensus-based process" is too broad. For any reporting system to improve quality, the measures must be

meaningful to clinical care and relevant to practicing physicians. Therefore, direct physician involvement in the development, testing and implementation of quality measures is the only way to ensure measures are appropriate and clinically relevant. While we appreciate that the proposed rule recognizes the American Medical Association's Physician Consortium for Performance Improvement (the Consortium) as a source for the development of quality measures eligible for inclusion in PQRI 2008, we urge CMS to go further and consider the Consortium as the only entity appropriate for the development of physician-level quality measures. The Consortium process is consensus-based and physician-led. This characteristic will ensure physician buy-in on measures which is essential for an effective quality reporting program. Further, tasking the Consortium as the only group for developing physician measures significantly reduces the risk of duplicative or contradictory measures and ensures measure harmonization.

As CMS seeks to make refinements in the program, the Alliance asks that measures used for PQRI be coordinated with measures in use by other CMS programs, e.g., the Hospital Compare program and the Surgical Care Improvement Project (SCIP). For example, in the case of SCIP, measure VTE-1 (also referred to as the National Quality Forum Consensus Standard for Prevention and Care of Venous Thromboembolism) and the CMS PQRI Voluntary Reporting Measure #23, Perioperative Care: Venous Thromboembolism (VTE Prophylaxis) are incongruent. PQRI rewards individual physicians for the use of certain treatments for all common inpatient surgical procedures, while SCIP rewards hospitals for a narrower set of treatments for a limited set of procedures.

In the case of the Hospital Compare program, measure AMI-6, Beta Blocker at Arrival for Acute Myocardial Infarction (AMI), rewards hospitals for administration of beta blocker within 24 hours after hospital arrival, while the PQRI Measure #29: "Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)" rewards individual physicians for documenting receipt of beta blocker within 24 hours before or after hospital arrival.

CMS should review all of its quality initiatives and work with measure developers in a transparent and inclusive process to ensure that performance measures throughout the different programs, though operating separately, are compatible and are not in conflict in order to avoid confusion and unduly burdensome reporting.

The Alliance asks CMS to clarify how the reporting requirements indicated in the 2008 PQRI program apply across the seven categories of proposed measures—including clinical, process and structural measures and how successful reporting may be achieved. The Alliance urges CMS to take a very flexible approach in its consideration of the use of electronic means of reporting measures. Such consideration should include registry, electronic health record and other means of electronic reporting, and we urge that CMS ultimately adopt quality reporting mechanisms that allow all providers to effectively report.

Physician Self-referral Provisions - Alternative Criteria for Satisfying Certain Exceptions

The Alliance commends CMS on its attempt to bring rationality to the strict enforcement of inadvertent form violations of the self-referral regulations. However, the Alliance also believes that CMS should amend the proposal so as not to be so unilateral in its enforcement. The proposed rule states that whether the criteria have been met will be determined "at the sole discretion" of CMS and that decisions will not be "subject to further administrative or judicial review." Surely, CMS can preserve its authority while simultaneously ensuring that those who are subjected to this rule and exception are able to access the benefits of it.

The Alliance of Specialty Medicine appreciates the opportunity to comment on these important issues affecting Medicare beneficiaries and the physician community. Please contact Barbara Marone, Director Federal Affairs, ACEP, at bmarone@acep.org (202) 728-0610, or Anne Marie Bicha, Director of Regulatory Affairs, AGA, abicha@gastro2.org (240) 482-3223 if you have any questions regarding our comments and recommendations.

American Academy of Dermatology Association
American Association of Orthopaedic Surgeons
American Association of Neurological Surgeons
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American Gastroenterological Association
American Society of Cataract & Refractive Surgery
American Urological Association
Congress of Neurological Surgeons
National Association of Spine Specialists

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

Organization :

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

I strongly support an increase in the Anesthesia Conversion Factor for Medicare reimbursement for Anesthesia services. Medicare reimbursement has lagged significantly behind that of other 3rd party payors since the inception of the RBRVS methodology. This discourages anesthesia practitioners from practicing in areas with a high medicare population and negatively impacts on the care of the elderly. Also, why does this docket (CMS-1385-P) refer to 'Ambulance' services rather than 'Anesthesia' services? Perhaps this oversight is an extension of the oversight our profession experienced over a decade ago when the RBRVS was implemented.

Submitter : **Mrs. Patricia Wilson** **Date: 08/27/2007**

Organization : **Mrs. Patricia Wilson**

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. Roy Minks** **Date: 08/27/2007**

Organization : **Horn Lake Chiropractic Centre, Inc.**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services
Demonstration

Chiropractic Services Demonstration

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Dr. R. Alan Minks

Submitter : Mr. Ben Massey **Date:** 08/27/2007

Organization : NC Board of Physical Therapy Examiners

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

08-27-07

Administrator
CMS
Dept HHS
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 North Carolina Board of Physical Therapy Examiners (NCBPTE) 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, 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 policing body, have been able to protect the public by ensuring that only qualified therapists are licensed care for our citizens.

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 licensing PTs 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 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.

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.

The NCBPTE 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.

Sincerely,

Paula B. Schrum, PT, MBA, Chair
NCBPTE

Submitter : **Mr. Seth Coulter** **Date: 08/27/2007**

Organization : **Arkansas State Board of Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-8175-Attach-1.DOC

#8175

Arkansas State Board of Physical Therapy

August 24, 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 Arkansas State Board of Physical Therapy 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.

9 Shackleford Plaza • Suite 3 • Little Rock, AR 72211
(501) 228-7100 • Fax (501) 228-0294
E-Mail: arptb@sbcglobal.net • Website: www.arptb.org

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 policing body, have been able to protect the public by ensuring that only qualified therapists are licensed 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 classically 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 licensing PTs 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 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.

CMSand 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 Arkansas State Board of Physical Therapy 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,

Seth Coulter, Chair

Arkansas State Board of Physical Therapy

Submitter : Dr. joe bryan **Date:** 08/27/2007

Organization : Texas Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS,
I would like to respectfully comment on the proposed increase in the Medicare conversion factor for Anesthesiology.Our national organization , ASA ,has developed a model indicating a 32% undervalue for work in the current reimbursement formulation for anesthesiologist services.Our surgical colleages receive a higher percentage of their private insurance rates for their services from Medicare.Another reason I feel the proposed increase is justified is that in areas with a high Medicare population increased Medicare reimbursement guarantees enough anesthesiologists to provide adequate and timely coverage in the operating room for all patients.This is especially important in areas where we dealwith large numbers of uninsured patients and Mexican nationals.Thank you for your consideration.Joe Bryan M.D.

Submitter : **Dr. Mark Iannini** **Date: 08/27/2007**

Organization : **Southern Arizona Rheumatology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Mr. Weems:

I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.

As a provider of DXA and/or VFA services, I request CMS to recvaluate the following:

a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;

b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:

? the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;

? the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.

c. The inputs used to derive Indirect Practiee Expense for DXA and VFA should be made available to the general public, and

d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,

Mark Iannini,MD, MPH
630 N Alvernon Suite 371
Tucson, AZ 85711
p.520.319.3956
f.520.319.3913

Submitter : **Dr. Janet Brierley** **Date: 08/27/2007**

Organization : **University of New Mexico**

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. Jeffrey Ferguson **Date:** 08/27/2007

Organization : Urological Associates

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

In our community, my partners and I are continually striving to provide state-of-the-art medical and surgical care to our patients. We have been the driving force behind the acquisition and implimentation of new techniques and technologies that have resulted in markedly improved care and superior outcomes. The hospitals in our community often do not have the funds, the expertise or the desire to purchase new and oftentimes expensive equipment, and that has put the burden on us. We have made significant capital outlays in order to bring extracorporeal shock wave lithtripsy, transurethral microwave thermotherapy, laser lithotripsy and laser photovaporization of the prostate to our community. Current billing rules have allowed us to recoup our investments over time. If the proposed changes go into effect they will essentially end the process of advancing care in our community through technology acquisition, and in fact in most communities in the US outside of the academic centers. The financial and legal risks would be too great for any physician or group to undertake, and ultimately patients would suffer. I strongly urge you to consider the ultimate consequences of the proposed changes and to reject them in the interest of patient care.

Submitter : **Dr. Frederic Ramsey** **Date: 08/27/2007**

Organization : **Dr. Frederic Ramsey**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

The Anesthesia Conversion Factor for Medicare reimbursement should be increasd to reflect the true value and cost of Anesthesia services, including the education of practitioners in our specialty. Since the inception of the RBRVS, reimbursement for Anesthesia services has been far less than other medical specialties, and the discrepancy should be corrected immediately. Perhaps there should be consideration for a retroactive increase, or the new conversion factor should take into considcration the undervaluation of Anethesia Services during the past 13 years.

Submitter : **Mrs. Susan Spoors** **Date: 08/27/2007**

Organization : **Anesthesia Medical Consultants**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

TO Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Meeicare and Medicaid Services
Attn: CMS - 1385-P
PO Box 80818
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 issue.

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 anesthisa conversion factor increase as recommended by the RUC.

Thank you for your consideration in this matter.

Sincerely,
Susan Spoors CPC
Anesthesia Medical Consultants.

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

Organization : **Dr. James Cheatham**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Jon Nottingham** **Date: 08/27/2007**

Organization : **Gateway Anesthesia Associates, PLLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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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.

Jon P. Nottingham, MD
Gilbert, AZ 85234

Submitter : **Mr. Paul Adler** **Date: 08/27/2007**

Organization : **Memphis Heart Clinic**

Category : **Other Technician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

We do not always includc color flow doppler in our exams. We only bill for what is required.

Submitter : **Ms. Lisa Creswick** **Date: 08/27/2007**

Organization : **Anesthesia Medical Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Ms. Norwalk:

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Thank you for your consideration of this serious matter.

Sincerely,

Lisa Creswick, CPC

Submitter : **Mrs. Sharon Cheatham** **Date: 08/27/2007**

Organization : **Mrs. Sharon Cheatham**

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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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. Lisa Van Mullen** **Date: 08/27/2007**

Organization : **Anesthesia Medical Consultants PC**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Lisa Van Mullen
Medical Biller

Submitter : Dr. Thomas Rooney **Date:** 08/27/2007

Organization : Comments as individual anesthesiologist

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Dear Sirs:

I hope that CMS will adopt the increase in the anesthesia conversion factor which was submitted by Medicare's Relative Value Update Committee, based on well-developed econometric data by the American Society of Anesthesiologists (ASA). I have not attached the ASA letter regarding this necessary update to my electronic communication to you, but I agree with it in its entirety.

I am an academic anesthesiologist at a smaller residency program (University of Toledo Medical Center, formerly Medical College of Ohio, in Toledo, Ohio). We have trained most of the Anesthesiologists in NW Ohio (also true of other specialties). Please help us to survive the current difficulties academic anesthesia is experiencing. My University does not have huge endowments and resources like a Yale, Mayo or Cleveland Clinic does. We are dependent on fair payment for our services. As a teaching hospital, we are more dependent on CMS policies since we have a smaller portion of privately insured patients than the private hospitals in the area. I hope the issue of making the anesthesia conversion factor fairer with relation to other medical specialties is addressed with dispassionate, reasoned analysis and the damage of the last decade may begin to be repaired.

Sincerely,

Thomas A. Rooney, M.D.
Diplomat of the American Board of Anesthesia
thomas.rooney@utoledo.edu

Submitter : **Mr. Benjamin Regalado** **Date: 08/27/2007**

Organization : **Anesthesia Company LLC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

On behalf of the 36 physicians of Anesthesia Company in Annapolis, Maryland, I am writing to express our strong support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. We appreciate that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

As you have no doubt been made aware, the introduction of the RBRVS system created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, the average Medicare payment for anesthesia services is $16.19 per unit, below the $19.30 per unit rate of 1990. In our market we are paid $16.41, an amount that does not cover the cost of caring for our fast growing population of seniors (they are are fast growing patient group).

This will accelerate the issues we already see in Maryland, where an unsustainable system in which physicians of all specialties are electing to leave 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. We commend the Agency for accepting this recommendation in its proposed rule, support full implementation of the RUC s recommendation, and ask 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.

Again, on behalf of the 36 physicians of our practice, thank you for your consideration of this serious matter.

Benjamin Regalado
Practice Administrator

Anesthesia Company, LLC
700 Melvin Avenue, Suite 7A
Annapolis, MD 21401

Submitter : **Dr. Scott Kercheville** **Date: 08/27/2007**

Organization : **UTHSCSA**

Category : **Physician**

Issue Areas/Comments

Background

Background

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.

Scott E. Kercheville, MD

CMS-1385-P-8191

Submitter : Mr. Turner Blackburn **Date:** 08/27/2007

Organization : American Physical Therapy Association

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I would like CMS to remove physical therapy from the *in-office ancillary services* exception to the federal physician self-referral laws. This was the original intention of the law and should be inacted. Physical therapy services should be delivered by a physical therapist who has no financial ties to the referring physician. Their is a greater chance of inappropriate referrals when patients are referred to physician owned services.