Submitter : Dr. Jeff Parker **Date:** 08/27/2007

Organization : Dr. Jeff Parker

Category : Chiropractor

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

This has the possibility of creating a financial hardship for seniors. More importantly it increases the risk for injury by discouraging appropriate diagnostic imaging. Please reject this revision.

CMS-1385-P-8321

Submitter : Dr. Sarah Williams **Date:** 08/27/2007

Organization : Proffesional Pathology Services

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Columbia, S.C. and I am part of a 15 member group. We operate both an independent laboratory as well as practice in a hospital setting.

I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.

Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.

Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.

Sincerely,
Sarah G. Williams, M.D.

Submitter : Dr. leslie walsh **Date:** 08/27/2007

Organization : Dr. leslie walsh

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

In regard to CMS-1385-P I fully support the proposed increase in the anesthesia reimbursement under the 2008 Physician Fee Schedule. Medicare payment for anesthesia services is currently approximately $16.00 per unit. This in many practice locations does not even cover the cost for providing the anesthesia service, and while providing some positive cash flow in other practice locations, it is so small that it is a strong incentive NOT to practice in an area with a large medicare population. This low payment rate is due to the undervaluation of anesthesiology services compared to other physicians. In an effort to correct this very frustrating situation, the RUC recommended that CMS increase the anesthesia conversion factor which is currently estimated to be 32 percent undervalued. This would result in an increase of almost $4.00 per anesthesia unit and serve to help rectify the long-standing undervaluation of anesthesia services. To ensure that medicare patients have access to expert anesthesiology care, it is very important that CMS implement an increase in the anesthesia conversion rate as recommended by the RUC.

Thank you for your consideration.

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

Organization : Paul Lopes

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a Physical Therapist employed in a Physician Owned Physical Therapy Clinic. Our patients consistently report high levels of satisfaction with the Rehabilitation Services they receive in our clinics by our Therapists. Our Therapist staff retention is very high based on the Therapists enjoying the close communication and interaction with the physicians, and are better able to coordinate patient care. There is better access to medical documentation, diagnostics, surgery reports and office visits, that directly enhance the Therapist s knowledge of the patient s medical history, which leads to a more well informed, and safer Therapy Plan of Care to be administered to the patient.

With regards to the areas you are seeking comment on:

1)I see no reason why Therapy services should be singled out to be excluded from the in-house ancillary services exception. Therapy services are integral in providing treatment to restore a patient s return to independent function. Therapy services provided under the supervision and direction of a Physical Therapist with better ability to consult with the Referring Physician, or another Physician in the group, lead to a better medical understanding of the patient s underlying pathology. This ultimately leads to better care, shorter lengths of stay and lower healthcare costs. Physicians and Therapists working in this type of environment work closely on designing Rehabilitation treatment protocols for many pathologies, with excellent levels of success. The physician s confidence level in Therapy is enhanced as they know the treating Therapists are familiar with the treatment protocols and can readily ask questions on specific patient cases when necessary, to make sure each patient receives the best possible individualized care. Therapists employed by physician groups are licensed professionals who should be able to direct, supervise and bill for Physical Therapy services, as is done in non-physician owned Therapy clinics. State licensing requirements are the same for all Physical Therapists, regardless of type of setting the Therapist practices in; therefore I do not see why there should be access or billing differences based on incident to and direct Therapy services when Licensed Physical Therapists are performing, guiding and directing care in both scenarios.

2)I believe any restrictive change in the definition of centralized building as defined in 411.351, only acts to restrict access to patients needing skilled therapy services based on geographical issues, which is not in the best interest of the patients care. Patients should have access to skilled, comprehensive, and non-fragmented care through various geographical Therapy sites. We should strive to improve, not restrict, access to competent Therapy sites for our Medicare beneficiaries, to encourage early Therapy intervention when it is most needed and can do the most good for our patients, which leads to shorter stays in Therapy and lowers healthcare costs.

3)

4)With regard to potential program or patient abuse I would like to share these points:

a)Physicians and Therapists have an ethical duty and professional responsibility to do what is best for their patients, and act accordingly.

b)Therapists in Physician owned facilities are held to the same documentation standards as non Physician owned Therapy sites. They are constantly re-evaluating patient progress toward goals and justify the need for continued skilled care, and expectation for improvement through the documentation.

c)Medicare payments are capped for Therapy. The exception process allows for additional Therapy visits only when substantiating supportive documentation in the record by the Therapist justifies ongoing care.

d)Insurance companies do not allow for payment of unnecessary services.

e)Licensed Physical Therapists in close communication with the Referring Physician provide a more comprehensive approach to the Physical Therapy care.

CMS-1385-P-8324

Submitter : **Dr. Laurie Lazott** **Date: 08/27/2007**

Organization : **Dr. Laurie Lazott**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Dr. Laurie Lazott

Submitter : **Mr. Peter Stathas** **Date: 08/27/2007**

Organization : **Mr. Peter Stathas**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

CMS-1385-P-8325-Attach-1.DOC

8325

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

FREEDOM

PHYSICAL THERAPY
SERVICES, S.C.

Dear Mr. Weems:

I am a physical therapist who has worked in private practice in Milwaukee, Wisconsin for the past 16 years. I own my own practice and am active within the physical therapy community. I would like to comment on the July 12th proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception.

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

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

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

Sincerely,

Peter Stathas, PT

Submitter : Dr. Dale Gonzales **Date:** 08/27/2007

Organization : Dr. Dale Gonzales

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

In regard to CMS-1385-P I fully support the proposed increase in the anesthesia reimbursement under the 2008 Physician Fee Schedule. Medicare payment for anesthesia services is currently approximately $16.00 per unit. This in many practice locations does not even cover the cost for providing the anesthesia service, and while providing some positive cash flow in other practice locations, it is so small that it is a strong incentive NOT to practice in an area with a large medicare population. This low payment rate is due to the undervaluation of anesthesiology services compared to other physicians. In an effort to correct this very frustrating situation, the RUC recommended that CMS increase the anesthesia conversion factor which is currently estimated to be 32 percent undervalued. This would result in an increase of almost $4.00 per anesthesia unit and serve to help rectify the long-standing undervaluation of anesthesia services. To ensure that medicare patients have access to expert anesthesiology care, it is very important that CMS implement an increase in the anesthesia conversion rate as recommended by the RUC.

Thank you for your consideration.

Submitter : **Dr. Brett Babat** **Date: 08/27/2007**

Organization : **Premier Orthopaedics**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Regarding physisican-owned in-office physical therapy.

I strongly urge CMS to continue to allow physician-owned PT and OT. My patients routinely comment on the prompt response to changes in the therapy regimen prescribed. As patients make progress, prompt, accurate communication between therapist and physician is necessary to adjust therapy restrictions and goals. Such communication is significantly facilitated when the physician and therapist are literally under the same roof. Furthermore, when patients are not making the expected progress, the therapist and physician clearly have better communication in physician-owned PT practices. My patients and I both know that I can better direct their PT regimen, as well as more quickly respond to their changing needs and/or problems, when they do their therapy in my office, rather than across town.

The APTA has been trying to mobilize their members to urge a change in the exception, but I do not think that the sheer number of letters they generate outweighs the clear benefit to patient care that the existing rule allows.

Submitter : **Mrs. Michelle Oswald-Gay** **Date: 08/27/2007**

Organization : **Oregon Imaging Centers**

Category : **Other Health Care Professional**

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 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.

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

Organization : **Jim Capps Therapy Services, Inc.**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Currently there is a proliferation of physician owned physical therapy services (POPTS) in just about all parts of the country. With managed care and physicians wanting to increase their profits, POPTS are becoming more common than not.

In our area (the Augusta/CSRA) almost all, if not all, of the orthopedists, neurosurgeons, and "pain clinic" physicians have POPTS situations. Unfortunately, the "owned" therapy services are not always provided by licenced physical therapists. There are instances where a massage therapist, athletic grainer, and/or a chiropractor is used to provide physical therapy services. In other instances, persons that I have known for twenty years (we are a small community) are required to travel to August (25-30 miles away) to receive therapy in a physician's office when therapy is available in their hometown.

As far as quality of service is concerned, private practice physical therapists must continuously provide quality and affordable services in order to stay in business, whereas the physician has a captive client that has no choice in quality or price. Case in point: there are patients being treated with an electrical stimulation machine (which is nothing more than a high volume galvanic with suction sups to hold the pads in place) for practically every imaginable condition and Medicare reimburses me approximately $9.00 to administer. The above mentioned electrical stimulation has a price tag of $250.00 for a 30-minute session. This is one of the many similar inbalances between POPTS and private practice physical therapists.

It would be of the best interest of the patient, private practice physical therapists (and the physical therapy profession in general) and CMS to get rid of the "Stark Referral for Profit Loophole."

Sincerely,
Jim Capps III, P.T.

Submitter : **Ms. Debra Ness** **Date: 08/27/2007**

Organization : **National Partnership for Women & Families**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-8330-Attach-1.DOC

#8330

National Partnership
for Women & Families

August 27, 2007

The Honorable Michael O. Leavitt
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1385-P, Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies.

Dear Secretary Leavitt:

The National Partnership for Women & Families is a nonprofit, nonpartisan organization that uses public education and advocacy to promote quality health care for women and their families. Last year, CMS made significant cuts in Medicare reimbursement for technologies used to screen for osteoporosis and breast cancer. Specifically, those cuts, to be phased-in over four years, were as follows:

- dual-energy x-ray absorptiometry (DXA), the most accurate method for measuring bone density, by 68%
- computer aided detection (CAD) as an adjunct to mammography, by 48%; and
- screening mammography, already a financially marginal service, by more than 5%.

We share CMS's concern that federal spending on imaging services under the Medicare physician fee schedule has increased at an alarming rate. But breast imaging represented only .7% of all imaging services, and DXA utilization – far smaller - was too insignificant to be broken out of the total. Given the size of these reimbursement cuts – and the importance of these particular technologies to women's health – we ask CMS to carefully examine the impact of these reductions on women's access to important screening services before moving forward with the second year of cuts, scheduled to take effect in January 2008.

Sincerely,

Debra L. Ness
President

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

Organization : **Intermountain Healthcare**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physical therapy should be included in the in-office ancillary services exception. Without this exception, physicians will potentially have an incentive to refer patients who may not need physical therapy. There would also potentially exist an incentive to pressure the physical therapist to see the patient more times than necessary for the condition. The exception would remove any potential incentive to over-utilize services.

Submitter : Dr. Craig Denholm **Date:** 08/27/2007

Organization : Dr. Craig Denholm

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.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.

Submitter : **Ms. Mildred Hague** **Date: 08/27/2007**

Organization : **Ms. Mildred Hague**

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 : **Mr. Scott Foster** **Date: 08/27/2007**

Organization : **individual**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Scott Foster

Submitter : Dr. Ron Berju **Date:** 08/27/2007

Organization : Dr. Ron Berju

Category : Chiropractor

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

This is the most ridiculous thing I heard. To refuse a medicare and medicaid patient the right to go directly to the radiology group to have an x-ray with a perscription from a chiropractor. It is only going to cost medicare and medicaid more because they will have to pay the medical doctor for a visit so they could write the x-ray perscription. It will also cost the patient more because they will have to pay their copay. Wake up and do what's right for the patient instead of thinking your lowering your budget when your really going to pay more.

Submitter : **Dr. Paul Rhodes** **Date: 08/27/2007**

Organization : **Rhodes to Health Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

August 27, 2007

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

Re: TECHNICAL CORRECTIONS

I am writing in strong opposition to the July 12th proposed rule that would eliminate the option for a Chiropractor to refer to a radiologist for x-rays. The current regulation permits myself to refer to a radiologist for these x-rays and should be retained.

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,

Paul G. Rhodes, D.C.

Submitter : **Dr. Naiel Salameh** **Date: 08/27/2007**

Organization : **Michigan Ass. of Chiropractors**

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,
Naiel Salameh D.C.

Submitter : **Ms. Sharon Merrick** **Date: 08/27/2007**

Organization : **Ms. Sharon Merrick**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-8338-Attach-1.PDF

8338

August 27, 2007

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

Re: CMS-1385-P
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.

Sharon K. Merrick

Submitter : Dr. Joseph Darr **Date:** 08/27/2007

Organization : Chiropractic Plus

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Re: Technical Corrections

To Whom It May Concern:
I propose no change concerning medicare reimbursement for X-rays. X-rays are a necessity to all chiropractors in order to perform a proper diagnosis.
Sincerely,
Dr. Joseph A. Darr, D.C., D.N.B.C.E.

Submitter : **Dr. Raymond Omerza** **Date: 08/27/2007**

Organization : **Traverse Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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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. Smokey Stover **Date:** 08/27/2007

Organization : MultiCare

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

We believe that e-prescribing is the safest and most secure method for communicating prescriptions to pharmacies. We support the push to make electronic prescriptions the standard for the country. However, we believe that eliminating the ability to fax prescriptions by January 2009 is too soon and that a date of January 2010 would cause undue hardship on many healthcare providers who are still planning for and implementing the new technology.
We have a strong interest in pursuing standard electronic prescription writing, but planning and implementing an electronic prescription solution takes months of time and assumes that a customer is using the appropriate software versions to take advantage of the technology. Upgrading to those versions can often take as much or more time than the implementation of those new features.
While January 2010 would still be a challenge, it s a challenge that could be met. January 2009 would be too soon. This would mean that we, who currently very successfully fax prescriptions to pharmacies today, would have to revert to paper prescriptions after the proposed rule takes effect. This would be a very unfortunate consequence of a premature date: computer-generated faxes are in almost all cases safer, more secure, and more convenient than printed prescription.

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

Organization : Nancy Inglis

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-8342-Attach-1.PDF

#8342

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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Thank you for your consideration of this serious matter.

Nancy Ingalls

Submitter : **Mrs. Gretchen McElveen** **Date: 08/27/2007**

Organization : **Orthopedic Specialists of Alabama**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom It May Concern:

I am a Physical Therapist working for a company that provides rehabilitation services within a physician s practice. My past work experience was in an outpatient rehab clinic within a hospital. Comparing my current clinical model to my previous clinical experience, I find that my current situation is more patient-centered and cost efficient.

Being in the same facility as the physicians allows me to have frequent contact with them regarding plans of care, treatment plans, protocols, contraindications, restrictions, etc. It enables me to revise plans of care in a timely manner if a patient s condition changes. I am able to consult the physician immediately if problems arise during a patient s course of physical therapy. It also allows for better clinical protocol development with the physician s involvement. This enhanced therapist-physician communication yields enhanced quality and outcomes. The accessibility to physicians, patient care coordinators, and medical and financial records enables me to provide more comprehensive care to my patients. I am able to provide care with cost-containment as a priority.

The patient satisfaction survey scores from the facility in which I work are very high. They like the convenience of not having to go to a separate facility for their therapy. They express that they are cared for in a positive, supportive, and knowledgeable environment. They disclose that they are receiving high quality of care for their healthcare dollars.

This in-house PT/OT model is cost-effective as immediate treatment of the patients results in 30-40% less visits for the same clinical outcomes, resulting in a 30-40% reduction in costs. With this model there is enhanced physician clinical control, which prevents the over-utilization often found in freestanding private practices.

As a rehab provider, I ask for your continued support of the in-house PT/OT model. The partnership between physicians and therapists provides a positive environment in which I am able to provide quality care in a cost efficient manner. This model benefits both the patients and healthcare system at large.

Sincerely,
Gretchen McElveen, Physical Therapist
Orthopedic Specialists of Alabama
1022 1st Street North
1022 Tower Suite 220
Alabaster, AL 35007
205-621-3955

Submitter : **Dr. Clayton Cheney** **Date: 08/27/2007**

Organization : **Dr. Clayton Cheney**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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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. Jenny Slykhuis** **Date: 08/27/2007**

Organization : **Precision Chiropractic Clinic, PC**

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,

Jenny L. Slykhuis, DC

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

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physicians should not supply physical therapy services in their office for many reasons. To name a few, abuse of patient/physician relationship, poor patient care that is rooted in monetary gains rather than patient outcomes, fraudulent financial reasons whereby physicians have financial incentives to refer patients to their own offices, etc. These are just some reasons how physician owned physical therapy (POPT) practices are thriving at the expensive of true quality patient care with successful outcomes. They say that money is the root of all evil, and in this case, physicians found a loophole in creating their own physical therapy offices to make more money, bottom line. They try to hide the benefits they receive (increased patients, increased money, etc.) under the guise that is convenient for the patient to be seen in the same office. Having your physician recommend PT in his office abuses the patient/physician relationship and creates guilt in the client. How can one, especially an elderly client, say "no" to the almighty physician? It is not going to happen, and this is the exact scenario that creates abuse in the system. Please do not allow POPT practices to continue. Place the care back in the hands of those who have healing hands and caring hearts, physical therapists, and physical therapist assistants in out-patient clinics, rehabs, hospitals, nursing homes, etc. Make the physicians find some other way to continue their climb into upper class America, but not at the expensive of our patients whom we love.

Submitter : **Dr. Tushar Ramani** **Date: 08/27/2007**

Organization : **Anesthetix**

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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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. Sarah Merritt **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

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Thank you for your consideration of this serious matter.

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

Organization :

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 : Dr. cecil stehr **Date:** 08/27/2007

Organization : Texas Chiropractic Association

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

7-28-07
Dear Sirs, I oppose the revision of payment policies that will not pay for x-rays ordered by a Chiropractor and completed by an independent radiology lab for the purpose of treating a medicare patient. This revision will add to the cost of the medicare patient seeking treatment specifically for a musculo-skeletal condition and may result in more serious conditions being overlooked and/or the patient deciding to choose no treatment at all. This fails to provide adequate medical treatment and diagnostic studies required by the medicare recipient to adequately treat their musculo skeletal conditon. It also affects their ability to choose the treatmet of their choice in a free country supposely operated for our best interest. Please see that the revision as written does not become law. Respectfully Submitted, Cecil Stehr, D.C.

Submitter : **Dr. Wynda Chung** **Date: 08/27/2007**

Organization : **American Society of Anesthesiologist**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Organization : **ASA**

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 : **Dr. Samuel Cherry** **Date: 08/27/2007**

Organization : **Dr. Samuel Cherry**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

Re: CMS-1385-P

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Submitter : **Dr. Charles Myers** **Date: 08/27/2007**

Organization : **Dr. Charles Myers**

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.

Charles L. Myers, M.D.
Lafayette, LA

Submitter : **Dr. Marcos Melo** **Date: 08/27/2007**

Organization : **Massachusetts General Hospital**

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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Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Sincerely,

Marcos F. Vidal Melo, MD

Submitter : **Dr. Shu-Ming Wang** **Date: 08/27/2007**

Organization : **Yale School of medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Baltimore, MD 21244-8018

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Sudha Rajagopalan** **Date: 08/27/2007**

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Dr. Sudha Rajagopalan

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

Organization : **Dr. David Waisel**

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 : **Dr. Tim VadeBoncouer** **Date: 08/27/2007**

Organization : **Univ of Illinois @ Chicago Dept. of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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.

Submitter : **Dr. Elvin Cruz-Zeno** **Date: 08/27/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Elvin J. Cruz-Zeno, MD, MS
Board Certified Anesthesiologist

Submitter : **Dr. Nader helmi** **Date: 08/27/2007**

Organization : **Cleveland Clinic Foundation**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Organization : **Dr. John Quinn**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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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. Michael Gatley** **Date: 08/27/2007**

Organization : **Dr. Michael Gatley**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Michael W. Gatley, M.D.

CMS-1385-P-8365

Submitter : **Dr. Morgan McCarroll** **Date: 08/27/2007**

Organization : **Associated Anesthesiologists of Reno**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Sincerely,
Morgan McCarroll

Submitter : **Dr. Seth Roussel** **Date: 08/27/2007**

Organization : **Dr. Seth Roussel**

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.

Sincerely,
Dr. Seth Roussel
Georgetown University Hospital

CMS-1385-P-8367

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

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

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

Organization : **David Barbara**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Thank you for your consideration of this serious matter.

Submitter : Dr. Adam Dorin **Date:** 08/27/2007

Organization : Anesthesia Services Medical Group

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Thank you for giving serious consideration to creating a fair 'equity' for the anesthesia services Medicare payment factor. In order to continue to provide safe, reliable and continued services to all patients, this is an excellent step in the right direction!

Submitter : **Dr. Heather Nath** **Date: 08/27/2007**

Organization : **Dr. Heather Nath**

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.

Heather Nath, MD

Submitter : **Dr. Zhiyi Zuo** **Date: 08/27/2007**

Organization : **University of Virginia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Submitter : **Dr. Randy Hewitt** **Date: 08/27/2007**

Organization : **Portland Chiropractic Group**

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 elimination of 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. 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.

We 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,

Randy L. Hewitt, DC Elise G. Hewitt, DC

CMS-1385-P-8373

Submitter : **Dr. Brian Jones** **Date: 08/27/2007**

Organization : **CASE**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

CMS-1385-P-8374

Submitter : Dr. Kumar Belani **Date:** 08/27/2007

Organization : University of Minnesota

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please approve the 32% increase in anesthesia work value. I work in an academic program and have been doing so for over 25 years. This has allowed me to teach and train anesthesia providers that help many patients needing surgical and pain care. This increase is much over due to keep up with so many other increases in costs of daily living and personal care. Thank you very much.

Submitter : **Dr. H. Chester Boston** **Date: 08/27/2007**

Organization : **University Orthopaedic Clinic, P.C.**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached letter with comments about CMS-1385-P.

CMS-1385-P-8375-Attach-1.DOC.

8375

University Orthopaedic Clinic & Spine Center

H. CHESTER BOSTON, JR., M.D. ★● △ ❑
Spinal Disorders
Surgery of the Spine ▲

JOHN P. BUCKLEY, M.D. ★● ○ ❑
Arthroscopic &
Orthopaedic Surgery
Surgery of the Hand &
Upper Extremity ▲

STEPHEN T. IKARD, M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Total Joint Replacement ▲

DONALD S. SCOTT, M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Work Related Injuries

L. SCOTT ATKINS, JR., M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Knee & Shoulder Surgery

JAMES T. BARNETT, JR., M.D. ■
Physical Medicine &
Rehabilitation

WILLIAM C. STANDIFER, JR., M.D. ● ❑
Arthroscopic &
Orthopaedic Surgery
Sports Medicine ▲

FREDERICK S. GRAHAM, M.D. ■
Physical Medicine &
Rehabilitation
Interventional Spine Procedures ▲

BRIAN S. CLAYTOR, M.D.
Spinal Disorders
Surgery of the Spine ▲

DONNA S. WOOD
Chief Executive Officer

OFFICES
305 Bryant Drive, East
P.O. Box 2447
Tuscaloosa, AL 35403

400 Bryant Drive, East
Tuscaloosa, Alabama 35401

Northport Medical Plaza
2702 Hospital Dr., Suite 101
Northport, Alabama 35476

Phone: (205) 345-0192
(800) 218-4UOC (4862)
Tuscaloosa Fax: (205) 345-7341
Northport Fax: (205) 333-9935

www.univorthoclinic.com
Email: uoc@dbtech.net

OTHER LOCATIONS
Bibb Medical Associates
Centreville, Alabama

Fayette Medical Associates
Fayette, Alabama

August 27, 2007

Via Electronic Submittal to CMS
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018.

RE: CMS 1385-P
In Office Ancillary Services Exemption

Dear Sir or Madam:

Thank you for the opportunity to comment regarding whether changes are necessary pertaining to the Physician self-referral rules.

I am an orthopaedic surgeon practicing in a group with eight other physicians. We added physical therapy services within our group practice several years ago in compliance with the In Office Ancillary Services Exemption under the "Stark" regulations. Physical therapy is only provided to our own patients as part of a comprehensive treatment program with continuous physician oversight for better, more cost effective care. Patients are given a choice regarding where they want to have their services provided. Many patients prefer the convenience of having their physical therapy in the same location as their orthopaedic surgeon.

We have an exceptional group of 6 registered physical therapists who have chosen to practice in this environment because of superior patient outcomes due to close communication with the physicians and access to all patient medical records. Many times patients are able to begin physical therapy on the same day they are seen by the physician when physical therapy is prescribed.

The views expressed by a national letter-writing campaign promoted by the Alabama Physical Therapy Association are not representative of the opinions of the majority of physical therapists. They represent the opinion of a group of private practice physical therapists who want to eliminate competition from physician-employed physical therapists for the sole purpose of financial gain. Eliminating physician-owned physical therapy services would result in less competition and reduced access to care for patients with an increase in treatment delays. Removing physicians from the process will not reduce any potential conflicts of interest since physical therapists already formulate the Plan of Care and determine the number of visits and modalities to be performed.

For convenience of patients and better access to treatment, please preserve the centralized building provision that currently exists. With the advent of electronic health records, services can be provided in another location just as it would be within the same building where physician services are provided.

Your request for comments is very much appreciated.

Sincerely,

H. Chester Boston, Jr., M.D.

Submitter : Dr. ANTONIETTA SCULIMBRENE **Date:** 08/27/2007

Organization : Cumberland Healthcare

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.

Antonietta Sculimbrene MD MHA

Submitter : **Dr. Moises Lustgarten** **Date: 08/27/2007**

Organization : **Dr. Moises Lustgarten**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.
Moises Lustgarten, MD

Submitter : Dr. LINDA CAMERON **Date:** 08/27/2007

Organization : ANNE ARUNDEL MEDICAL CENTER

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

Organization : **Kenneth Bachenberg**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Submitter : **Dr. Jeffrey Amado** **Date: 08/27/2007**

Organization : **Dr. Jeffrey Amado**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Submitter : **Dr. sashi arabolu** **Date: 08/27/2007**

Organization : **Rush University Medical Center**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

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Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Submitter : **Dr. Ronald Pearl** **Date: 08/27/2007**

Organization : **Dr. Ronald Pearl**

Category : **Physician**

Issue Areas/Comments

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

Organization : **Commonwealth Anesthesia PSC**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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P.O. Box 8018
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Christopher M. Scheib,, MD

Submitter : **Dr. Judith Hutchinson** **Date: 08/27/2007**

Organization : **Dr. Judith Hutchinson**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Judith T. Hutchinson, M.D.

Submitter : **Dr. Rodney Trytko** **Date: 08/27/2007**

Organization : **Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
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P.O. Box 8018
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Submitter : **Dr. gregory towne** **Date: 08/27/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Gregory Towne MD

Submitter : **Dr. Salvatore Zisa Jr.** **Date: 08/27/2007**

Organization : **UMDNJ Robert Wood Johnson**

Category : **Physician**

Issue Areas/Comments

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

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

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Sarah R. James, MD

Submitter : **Dr. Keith Housman** **Date: 08/27/2007**

Organization : **Anesthesiology Consultants, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Sincerely yours,
Keith A. Housman, M.D.

Submitter : **Dr. Chad Itzkovich** **Date: 08/27/2007**

Organization : **Morris Anesthesia Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Re: CMS-1385-P

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-Dr Chad Itzkovich

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

Organization : **Metro Anesthesia Consultants**

Category : **Physician**

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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Sincerely,

Kyle Butkiewicz, M.D.

Submitter : **Dr. Benjamin Aquino** **Date: 08/27/2007**

Organization : **Dr. Benjamin Aquino**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Sincerely,
Ben Aquino, M.D.

Submitter : **Dr. Kenneth Song** **Date: 08/27/2007**

Organization : **Dr. Kenneth Song**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Sincerely,

Kenneth Song, M.D.
Anesthesiologist

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

Organization :

Category : **Physician**

Issue Areas/Comments

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