Submitter : **Dr. Blake Johnson** **Date: 08/28/2007**

Organization : **ASA**

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

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. John Paul McGee **Date:** 08/28/2007

Organization : Evanston Northwestern Healthcare

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS 1385-P
Gentlemen:

The medicare payment schedule has consistently perpetuated a marked undervaluation of anesthesia services compared to other medical/surgical specialties. The RUC has recommended a change to increase anesthesia unit values to prevent the erosion of anesthesiologists leaving high penetration of medicare procedures because the compensation is inadequate to cover costs.

Thank you for your attention to this important issue.
'John Paul McGee II MD

CMS-1385-P-9645

Submitter : **Dr. Chris Flaim** **Date: 08/28/2007**

Organization : **ACA**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P - Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies; Revisions to Payment Policies for Ambulance Services for CY 2008;

For this to go thru and change is only putting undue financial hardship on already stressed medicare patients. It is also unneeded interference in doctors of chiropractic ability to treat

Submitter : Dr. Dominador Uy **Date:** 08/28/2007

Organization : CG1 Chiropractic Clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Sec attached

CMS-1385-P-9647

Submitter : Dr. Donald Walsh **Date: 08/28/2007**

Organization : Synergy Chiropractic and Wellness Solutions, LLC

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.

Sincerely,

CMS-1385-P-9648

Submitter : Dr. David Anderson **Date:** 08/28/2007

Organization : Dr. David Anderson

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P

Submitter : **Mr. Nick Refvem** **Date: 08/28/2007**

Organization : **University of Idaho**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Nick Refvem and I am an assistant athletic trainer at the University of Idaho. I have been a certified athletic trainer for over six years. I have been practicing primarily in the collegiate setting during this time, but I am considering other possible settings for future employment.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, state licensure, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients.

I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Thank you for your time and assistance in this matter.

Sincerely,

Nick Refvem MS, LAT, ATC

Submitter : Dr. Karen Zamzow **Date: 08/28/2007**

Organization : Dr. Karen Zamzow

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

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

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

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,
Karen Zamzow, DC

Technical Corrections

Technical Corrections

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

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

Sincerely,
Karen Zamzow, DC

Submitter : **Ms. Jennifer Schmunk** **Date: 08/28/2007**

Organization : **University of Oklahoma**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer for the University of Oklahoma. I am licensed by the state of Oklahoma to practice as an athletic trainer. I work as a graduate assistant athletic trainer for the men's and women's cross country and track and field teams. I attended Oregon State University where I earned my B.S. in Excercise and Sport Science with an option in athletic training.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Jennifer Schmunk, ATC, LAT

Submitter : Amy Owsley **Date:** 08/28/2007

Organization : Amy Owsley

Category : Individual

Issue Areas/Comments

Technical Corrections

Technical Corrections

CMS-1385-P 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,

Amy Owsley

CMS-1385-P-9653

Submitter : **Angela Miller** **Date: 08/28/2007**

Organization : **Alexandria Orthopaedics Associates**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Angela Miller. I am an certified athletic trainer at an orthopedic clinic in rural Minnesota. I currently provide physician extender services including casting, splinting and post operative management. I have a B.S. from South Dakota State University and M.A. from the University of Minnesota. I have been a certified athletic trainer for 8 years.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Angela Miller, ATC

Submitter : Dr. James Van Antwerp

Date: 08/28/2007

Organization : Dr. James Van Antwerp

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.

James Van Antwerp, M.D.

CMS-1385-P-9655

Submitter : Dr. Stanley Eckert **Date:** 08/28/2007

Organization : Dr. Stanley Eckert

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

Stanley R. Eckert, MD

Submitter : Dr. Marc Weller **Date:** 08/28/2007

Organization : Inland Valley Anesthesia Medical Group

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

Dear Ms. Norwalk:

I strongly support the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. There has been a tremendous disparity for the reimbursement of anesthesia care since the creation of the RBRVS, and this has had a major negative effect on the growth of the specialty. Anesthesia specialty groups such as the one I currently manage struggle to attract quality providers due to our significant proportion of elderly patients. The RUC has recommended that CMS increase the anesthesia conversion factor by $4.00 per anesthesia unit and this would certainly represent a significant step towards correcting the calculated 32% undervaluation of anesthesia services. Implementation of this increase will significantly enhance the ability of seniors to access quality anesthesia care.

Thank you for your attention in this matter.

Marc L. Weller M.D.
managing partner
Inland Valley Anesthesia Medical Group

CMS-1385-P-9657

Submitter : **Mr. Greg Banks** **Date: 08/28/2007**

Organization : **Rehabilitation Centers of Charleston**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Greg Banks and I am a certified atheltic trainier and strength and conditioning specialist in Charleston South Carolina. I have been in practive for 15 years in Charleston and have some concerns about the current bills and proposals.
I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Greg Banks, ATC, CSCS

CMS-1385-P-9658

Submitter : **Alan Crothers** **Date: 08/28/2007**

Organization : **Idaho Physical Therapy Licensure Board**

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

The Idaho Physical Therpy Licensure Board submits the attached comments on the proposed rules changing the definition of 'physical therpist' in Section 484, Title 42 of the Code of Federal Regulations.

CMS-1385-P-9658-Attach-1.DOC

9658

IDAHO PHYSICAL THERAPY LICENSURE BOARD
Bureau of Occupational Licenses
1109 Main Street, Suite 220
Boise, ID 83702-5642

August 28, 2007

Administrator

Center 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 Idaho Physical Therapy Licensure Board 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 a part of the 2008 proposed Revisions to the 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 "[p]assed the National Examination approved by the American Physical Therapy Association." We strongly suggest that CMS rely on state licensure and that the additional examination requirements contained in subsections (i)(B) and (ii)(B) of the definition of "physical therapist" be deleted from the final rule. At the very least, the Centers for Medicare and Medicaid Services ("CMS") should delay promulgation of the proposed rule until CMS has had an opportunity to understand the examination, credentialing and licensing processes currently in place.

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

CMS should not usurp the states' function of licensing physical therapists and other professionals. Health car 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 professional, 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 of licensing physical therapists would be inconsistent with not only the rights of the states, but also CMS' own standards.

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

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 therapist, patients, including Medicare and Medicaid beneficiaries and recipients, and others could face substantial confusion and interruption of service. As a state physical therapy licensure board, we would continue to have authority to select an exam of our choice for licensing purposes. However, under the proposed rule, a physical therapist would have to pass a second exam approved by the APTA to qualify for Medicare reimbursement. Thus, patients might be forced to change

physical therapists as they become Medicare or Medicaid eligible, and the current uniformity and continuity of standards across the country would be lost. Thus, the proposed rules undermine CMS" ambition for uniformity of standards.

CMS and the federal government should not empower an advocacy group, like the APTA, to establish an examination or any qualifications for professional to provide healthcare serviced to patients. The APTA's mission is to advocate and promote the profession of physical therapy. 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 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 Idaho Physical Therapy Licensure Board 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,

Alan B. Crothers, PT, SCS
Chair
Idaho State Physical Therapy Licensure Board

Submitter : **Dr. Wendy Flynn** **Date: 08/28/2007**

Organization : **Flynn Clinic, Inc.**

Category : **Health Care Professional or Association**

Issue Areas/Comments

TRHCA--Section 101(d): PAQI

TRHCA--Section 101(d): PAQI

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. Wendy L. Flynn

Submitter : Dr. Barbara Gasior

Date: 08/28/2007

Organization : American Society of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

I 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. Barbara Gasior

CMS-1385-P-9661

Submitter : Dr. Alex Rubin **Date:** 08/28/2007

Organization : Anesthesiologist

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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.

Alexander S. Rubin, M.D.
6611 Hunter Trail Way
Frederick, MD 21702

CMS-1385-P-9662

Submitter : Mr. Jason Amrich **Date:** 08/28/2007

Organization : Boulder Community Hospital

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

The potential for fraud and abuse exists whenever physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutlization of physical therapy services under the Medicare program, and enhance the quality of patient care. The in-office ancillary services exception has created a loophole that has resulted in the expansion of physician-owned arrangements that provide physical therapy services. Because of Medicare referral requirements, physicians have a captive referral base of physical therapy patients in their offices. Physician direct supervision is not needed 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.

Submitter : Dr. John Keating **Date:** 08/28/2007

Organization : Anesthesia Medical Group of Santa 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
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 $15.96 per unit in our locality. 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 as we have in Santa Barbara.

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

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

Thank you for your consideration of this serious matter.

Sincerely,

John Keating, M.D.
Anesthesia Medical Group of Santa Barbara
514 West Pueblo, Second Floor
Santa Barbara, CA 93105

CMS-1385-P-9664

Submitter : Dr. Gregory Charlop **Date:** 08/28/2007

Organization : Kaiser

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:

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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.
Gregory Charlop MD

Submitter : Dr. Joel Slade **Date:** 08/28/2007

Organization : University of Tennessee, Memphis

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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.

CMS-1385-P-9666

Submitter : **Mr. Chris Heard** **Date: 08/28/2007**

Organization : **St. James Healthcare**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer, with my Masters of Science in Health and Human Performance from the University of Montana (1997). I am a highly educated and qualified individual in the field of physical medicine and rehabilitation services. In turn, I am the Supervisor of the Rehabilitation Department at St. James Healthcare in Butte, Montana. I supervise and direct our physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and sports medicine departments.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Chris J. Heard,MS,ATC
Supervisor Rehabilitation Services
St. James Healthcare
400 S. Clark
Butte, MT 59701
406-723-2549

Submitter : Dr. Ralph Posch

Date: 08/28/2007

Organization : Ralph J. Posch, MD, FACS, PA

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attachment

Submitter : **John Fowler** **Date: 08/28/2007**

Organization : **Univ of Wisconsin Hospital & Clinics Sports Med**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is John Fowler and I am employed by The University of Wisconsin Hospital and Clinics as a Licensed Athletic Trainer who functions in our sports medicine clinic as a physician extender providing care to our patients under the supervision of the attending physician. In our clinic, licensed athletic trainers function alongside the attending physicians so that we can provide timely, compassionate, high quality healthcare to our patients. I have been performing these duties for 11 years after receiving my Masters Degree from the University of Illinois @ Urbana-Champaign in Therapeutic Kinesiology.

I am writing today to voice my opposition to the therapy standards and requirements in regard to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditons of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

John Fowler, MS ATC

CMS-1385-P-9669

Submitter : Dr. Marsha Ness **Date:** 08/28/2007

Organization : Dr. Marsha Ness

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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.

CMS-1385-P-9670

Submitter : Dr. Wei Pan **Date:** 08/28/2007

Organization : Baylor College of Medicine

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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.

CMS-1385-P-9671

Submitter : Dr. paul johnston **Date:** 08/28/2007

Organization : Ambulatory Surgery Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I strongly support CMS1385-P provisions which increase reimbursement for services. Even with these changes we still are reimbursed less per hour than the plumber who serviced my home this past month! Thank you, Sincerely, Paul M Johnston MD

CMS-1385-P-9672

Submitter : Dr. Michael Perouansky **Date:** 08/28/2007

Organization : University of Wisconsin

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 t is remarkable that CMS has finally recognized the gross undervaluation of anesthesia services, and that the Agency is taking the overdue steps to address this complicated issue.

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Thank you for your consideration of this serious matter.

CMS-1385-P-9673

Submitter : Mr. Brett Smith **Date:** 08/28/2007

Organization : York Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

CAP Issues

CAP Issues

My name is Brett Smith and I am a Physical Therapist in York, NE. I am writing to you requesting that the therapy cap be repealed. I practice in a private practice clicic but also provide contract services to two rural hospitals. The cap seems to be an arbitrary restriction of trade for private practioners but more importantly it restricts care from our Medicare population and increases the costs of these services. The fees charged by these hospitals is significantly higher than charged in our private practice. It does nothing to control costs but has done just the opposite. Unfortunately, it has been my experience that these hopitals charge an exorbinate fee and there is no attempt to help control costs. The reimbursement should be equal to both the hospitals and the private clinics and let the public decide where the best care is provided at the most reasonable cost for them. The CMS should do a cost comparison between the outpatient PT departments in hospitals and private clinics. It has been my experience that the hospitals are charging significantly more per case than the outpatient private clinics and the outcomes are much better in the private setting. The way this cap was imposed doesn't control costs but it forces people to use the outpatient PT departments in hospials where the costs is higher. Granted there is an exemptions process in place however this increases costs/work for the private practioner and some people are not eligible for the exemptions but still require Physical Therapy. The CMS should incentivise the small businesses rather than throwing money into the endless pit of a hospital which traditionly have done a poor job of money management especially when there is no incentive to control costs. Hospitals have been rewarded because they throw money at lobbists. Please repeal this cap and allow fair and equal reimbursement to all providers irregardless of the practice setting. Let the public decide where they want there services!

Submitter : **Dr. Mark Mulder** **Date: 08/28/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Sincerely,

Mark G. Mulder, MD
North County Anesthesia Medical Associates
1100 Las Tablas Rd.
Templeton, CA 93465

Submitter : **Mr. Ronald Woessner** **Date: 08/28/2007**

Organization : **ZixCorp**

Category : **Device Industry**

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

ZixCorp respectfully submits it comments on the "Proposed Elimination of Exemption for Computer-Generated Facsimiles" from the National Council for Prescription Drug Programs (NCPDP) SCRIPT standards. Please see the attached document.

CMS-1385-P-9675-Attach-1.DOC

9675

August 28, 2007

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1385-P
P. O. Box 8010
Baltimore, MD 21244-8010

Re: "PROPOSED ELIMINATION OF EXEMPTION FOR COMPUTER-GENERATED FACSIMILES" 72 Fed. Reg. 38122-01 (proposed July 12, 2007).

Zix Corporation respectfully submits its comments on the CMS "Proposed Elimination of the Exemption for Computer-Generated Facsimiles" from the National Council for Prescription Drug Programs (NCPDP) SCRIPT standards.

INTRODUCTION:

Zix Corporation is the parent company of PocketScript, Inc. ("PocketScript"), the leading U.S. e-prescribing service. We have been in the electronic prescribing business since 2003, and since that time we have processed more than 12 million e-prescriptions and are currently processing e-prescriptions at a rate exceeding 140,000 per week. We are in the process of being certified by RelayHealth and are certified with RxHub, Express Scripts, Medco Health Services, and Caremark/Advance PCS and SureScripts for the purposes of accessing eligibility, formulary, and dispensed drug history information. We are also certified with SureScripts, Express Scripts, Medco Health Services and Caremark/Advance PCS to send prescriptions via electronic data interchange. PocketScript® is one of two vendors actively participating in the country's largest and most successful e-prescribing initiative - the eRx Collaborative in Massachusetts. Currently, we have prescribers using the PocketScript service to write electronic prescriptions in California, Connecticut, Illinois, Louisiana, New Jersey, New York, North Carolina, and Pennsylvania through payor-sponsored programs, in addition to prescribers in other states across the country. The PocketScript e-prescribing service processed 3.6 million e-prescriptions during the first six months of this year.

PocketScript's service enables prescribers to order prescriptions through a secure wireless mobile personal digital assistant or secure Web site and deliver them electronically to the patient's preferred pharmacy. Mobility enables PocketScript to provide clinical decision support at the point-of-care with real-time access to a drug reference guide as well as patient-level eligibility, formulary, and co-pay information to aid the prescriber in selecting the most cost-effective prescription based on the patient's benefits. The application also provides comprehensive drug-to-drug and drug-to-allergy interaction alerts, based on patient-specific dispensed drug history. Through business

relationships with various insurance companies and pharmacy benefit managers, as enabled through RxHub, SureScripts and RelayHealth, PocketScript delivers end-to-end connectivity within the healthcare system to reduce unnecessary costs, improve patient safety and convenience, and enhance practice efficiency. PocketScript is also a SureScripts GoldRx Certified Solution.

COMMENTS ON THE PROPOSED RULE CHANGE:

Zix Corporation fully supports the efforts that CMS is making towards removing barriers to the widespread adoption of e-prescribing. We agree with CMS that e-prescribing using electronic data interchange ("EDI") means will help achieve the important goals of improving patient safety and decreasing the administrative costs of fulfilling prescriptions. We fully support any reasonable regulatory effort to encourage the widespread adoption of e-prescribing.

CMS has stated that if the computer-generated facsimile exemption is completely eliminated, it could have the unwanted effect of encouraging prescribers to simply revert to traditional prescribing means.[1] We agree.

We, therefore, recommend a narrow elimination of the computer-generated facsimile exemption. Computer-generated facsimiles should not be permitted where the prescriber/dispenser is using software that is capable of transmitting EDI prescriptions (*i.e.*, SCRIPT compliant transactions), but is not doing so, subject to the two caveats noted below.[2]

First, computer-generated facsimiles should be permitted during a network outage or when other technical errors occur. There are two technology outage scenarios that could affect the prescriber's ability to send a prescription by EDI. One scenario is where a "catastrophic" technological stoppage imposes a substantial downtime of the EDI prescription delivery system. The service level commitments of EDI vendors who deliver prescriptions to pharmacies customarily permit potential delivery system downtime (due to technical difficulties) of periods ranging from 4 to 15 hours per month. Should downtime of such durations occur, the alternative means of computer-generated facsimile should be permitted to enable a compromised (but usable) delivery service. For non-"catastrophic" technical difficulties, these vendors customarily support a complex coded error message system with error message interpretations that are partner-dependent and with timing (relative to prescription transmission attempt) that is indeterminate. Consequently, a difficult-to-interpret error message could be received at the point-of-care

[1] CMS has expressed concern about "the extent to which eliminating the exemption would cause entities using fax technology to revert to paper prescribing rather then updating their current software." *See* Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimiles, 72 Fed. Reg. 38122-01 (proposed July 12, 2007).

[2] Computer generated facsimiles should, of course, be permitted if applicable federal or state law would permit the sending of the script via facsimile, but not via EDI.

after the patient has left the provider's premises. In order for a point-of-care system to ensure delivery of a prescription with certainty and in an accurate form to the pharmacy under such circumstances, computer-generated facsimiles should be permitted.

Second, computer-generated facsimiles should be permitted to be sent to those independent pharmacies[3] and long-term-care facilities that are not technically enabled to receive EDI scripts.

CONCLUSION:

Zix Corporation applauds CMS's continuing efforts to remove barriers to the wide-spread adoption of e-prescribing. We hope that CMS finds these comments useful. If we may offer any additional assistance, please contact the undersigned at 214-370-2000.

Respectfully submitted,

ZIX CORPORATION

/s/ Ronald A. Woessner
Ronald A. Woessner
Senior Vice President and General Counsel

/s/ David J. Robertson
David J. Robertson
Vice President, Engineering

[3] As stated in the notice of proposed rulemaking, approximately "20 percent of independent pharmacies are capable of sending and receiving SCRIPT transactions. Independent pharmacies are less likely to perceive a return on investment for e-prescribing due to low numbers of practices seeking to move to e-prescribing using the SCRIPT transaction." *See* Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimiles, 72 Fed. Reg. 38122-01, at 38195 (proposed July 12, 2007).

Submitter : **Mrs. Christine Ahlf** **Date: 08/28/2007**

Organization : **Mt. Carmel High School - Poway Unified School Dist**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Christine Ahlf and I am athletic trainer in the state of California. I received my Bachelor's of science degree and became a certified athletic trainer in 2002. Since then I have advanced my knowledge in the field by receiving my Master's of Science degree and attending various continuing education courses and seminars. I am employed full time as an athletic trainer at a public high school in the San Diego area. Daily I respond to and care for athletic injuries that range in severity from minor to life threatening. My training and skills have prepared me to respond properly in all emergency situations and to seek outside medical support as the occassion arises. Care of immediate injuries is only one small facet of being an athletic trainer. I also care and rehabiliate the injured athletes, educate the athlete about care of their body, and seek out ways to prevent injuries from occuring. It is a ever-changing and exciting profession and I am proud to call myself an athletic trainer.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

XXXXXX, ATC (and/or other credentials)

Submitter : **Dr. Linda Mulder** **Date: 08/28/2007**

Organization : **Dr. Linda Mulder**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Linda Mulder, MD
1760 Arbor Rd.
Paso Robles, CA

Submitter : **Dr. Terry Tipton,D.C.** **Date: 08/28/2007**

Organization : **Tipton Chiropractic Center**

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,

Terry L. Tipton, D.C.
21021 Farmington Rd.
Farmington Hills, MI 48336
Ph. 248-477-4200

CMS-1385-P-9679

Submitter : Mr. Chuck Kimmel **Date:** 08/28/2007

Organization : Appalachian State University

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am an athletic trainer who works in student health services at Appalachian State University providing care to injured students. I have been a certified athletic trainer since 1978.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which I am certain you know is not the same as physical therapy. My education, clinical experiences, national certification, and state license ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. I believe it is irresponsible for CMS, who's responsibility it to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS appears to have come to these proposed changes without clinical or financial justification, I would strongly encourage CMS to consider the recommendations of those professionals that are taksed with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Chuck Kimmel, LAT, ATC

CMS-1385-P-9680

Submitter : Mr. ANDREI CERNEA **Date: 08/28/2007**

Organization : Mr. ANDREI CERNEA

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.

Andrei Cernea, MD

Submitter : **Dr. Carl D Bartholomew** **Date: 08/28/2007**

Organization : **Diocese of Florida Healthcare Services**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Poor areas like Madison County Florida and others cannot afford neccssary diagnostic xrays by the physician (chiropractor). Please do not take away the referral to radiologist or hospital ability, the cost to the patient is to high.

Submitter : Dr. J. Philip Saul **Date:** 08/28/2007

Organization : Medical University of South Carolina

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

We are writing regarding the proposed change to bundle CPT 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350.

As with the evaluation of adults, 93325 is billed for the vast majority of echocardiograms in children and patients with congenital heart disease. However, 93325 is a critical and time consuming part of a pediatric cardiac echocardiogram. Consequently, it is also critical that any bundling of this code with other codes include the RVU value of 93325 as additive. The surveys performed to set the work RVU s for the echo codes utilized specifically by pediatric cardiologists and affected by this proposed change were performed more than 10 years ago. As a result, particularly with respect to the 93325, the RVU s are more reflective of the technology component than the advances in care that have been developed as a result of the technology. A much needed new survey would provide evidence that the work and risk components of the procedures that involve Doppler Color Flow Mapping have evolved to the point where the relative value of the procedures have shifted to a significantly greater work component.

We strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other pediatric cardiology echocardiography codes <93303, 93304, 93315> until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Thank you for your consideration of this serious matter.

CMS-1385-P-9682-Attach-1.DOC

9682

The Children's Heart Program
Of South Carolina
165 Ashley Avenue
PO Box 250915
Charleston, SC 29425

(843) 792-3300
(800) 343-1983
FAX (843) 792-3284
FAX EKG (843) 792-8415
www.pediatrics.musc.edu/pedscard

CHARLESTON
J. Philip Saul, M.D.
Director

Andrew M. Atz, M.D.
Varsha Bandisode, M.D.
Andrew D. Blaufox, M.D.
Geoffrey Forbus, M.D.
Melissa Henshaw, M.D.
Jon Lucas, M.D.
Tim C. McQuinn, M.D.
Jeremy Ringewald, M.D.
Girish S. Shirali, M.D.
Frances Woodard, RN, MSN, CPNP

COLUMBIA
Sharon J. Kaminer, M.D.
C. Osborne Shuler, M.D.
Luther C. Williams, M.D.

FLORENCE
Charles A. Trant, M.D.

GREENVILLE
Benjamin S. Horne, M.D.
David G. Malpass, M.D.
John P. Matthews, M.D.
R. Austin Raunikar, M.D.

CARDIOTHORACIC SURGERY
Fred A. Crawford, Jr., M.D.
Scott M. Bradley, M.D.

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

August 27, 2007

Re. File Code: CMS-1385-P, CODING—ADDITIONAL CODES FROM 5-YEAR REVIEW

To CMS:

We are writing regarding the proposed change to bundle CPT 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350.

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We strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other pediatric cardiology echocardiography codes <93303, 93304, 93315 >until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Thank you for your consideration of this serious matter.

Sincerely yours,

For The Children's Heart Program of South Carolina
J. Philip Saul, MD
Director, Charleston

Osborne Shuler, MD
Director, Columbia

Benjamin Horne, MD
Director, Greenville

CMS-1385-P-9683

Submitter : **Mr. Bryce Davis** **Date: 08/28/2007**

Organization : **ATI Physical Therapy**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Bryce Davis, I am a Certified Athletic Trainer that has been working in the clinic settin for 9 years. I have my Masters Degree in Health Sciences as well as a supporting specialization in rehabilitation methodology. I am very concerned with the current legislation change, and would like to submit my thoughts.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Bryce Davis, MS, ATC, CSCS, CHES

Submitter : **Dr. Channing Bolick** **Date: 08/28/2007**

Organization : **The Bolick Clinic**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

In reference to file code CMS-1385-P Technical Corrections" Please abolish 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. X-rays, when needed, are integral to the overall chiropractic treatment plan of Medicare patients, and unfortunately in the end, it is the beneficiary who will be negatively affected by this proposed change in coverage. The current X-ray Medicare protocol has served patients well, and there is no clinical reason for this proposed change. If doctors of chiropractic are unable to refer patients directly to a radiologist, patients may be required to make additional and unnecessary visits to their primary care providers, significantly driving up the costs of patient care.

You should instead reimburse chiropractors for x-rays taken in their clinic.

Submitter : **Mr. Patrick Callahan** **Date: 08/28/2007**

Organization : **Mercy Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Patrick Callahan and, I am a certified Athletic Trainer and a certified strength and conditioning specialist. I have worked in Physical Therapy for the past 15 years at Mercy Hospital located in Valley City, ND.

I am writing to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

I am concerned with these proposed changes to the hospital Conditions of Participation have not recieved the proper and usual vetting, and I am also more concerned that these proposed rules will create additional lack of access to the quality of health care that patients recieve from my care.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience over the past 15 years and national certification exam ensure that my patients will recieve quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and theses proposed regulations will circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry and Athletic Trainers with their knowledge can fill that void very successfully. I believe it is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas , to further restrict their ability to recieve those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients recieve the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would like to see the CMS consider the recommendations of those professionals that are overseeing the day-to-day health care needs of their patients. I respectfully wish that you would withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Patrick S. Callahan, ATC,CSCS

Submitter : **Mr. Eric Schwartz** **Date: 08/28/2007**

Organization : **Allentown High School**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My Name Eric A. Schwartz and I am the head athletic trainer at Allentown High School, Upper Freehold Regional School District, which is in Alletown, NJ. I am a certificed athletic trainer with a BS in athletic training from East Stroudsburg Universtiy and Masters in Health Education from the College of New Jersey.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Eric A. Schwartz, M.ED, ATC

Submitter : **Dr.** **Date: 08/28/2007**

Organization : **Dr.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Michael Cernea** **Date: 08/28/2007**

Organization : **Mr. Michael Cernea**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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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.

Sincereley,

Professor Michael Cernea

Submitter : **Dr. Tamara Valovich McLeod** **Date: 08/28/2007**

Organization : **A.T. Still University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a board certified athletic trainer and strength and conditioning specialist working as an Associate Professor in an accredited post-professional athletic training education program. In addition, my research agenda focuses on pediatric sports medicine issues, specifically focusing on sport-related concussion and prevention of lower extremity injuries in athletes. I am actively involved in collaborative research efforts with many athletic trainers at the high school level.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Tamara C. Valovich McLeod, PhD, ATC
Associate Professor, Athletic Training
A.T. Still University
Mesa, AZ

Submitter : **Mr. Andrew Hull** **Date: 08/28/2007**

Organization : **Student**

Category : **Health Care Professional or Association**

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,

Andrew Hull

Submitter : **Mrs. Ruth Cernea** **Date: 08/28/2007**

Organization : **Mrs. Ruth Cernea**

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.

Sincerely,

Ruth Cernea

Submitter : **Ms. Kathryn Webster** **Date: 08/28/2007**

Organization : **University of Toledo**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Kathryn Webster. I am currently an instructor at the University of Toleo in Toledo, OH. I have been a Board Certified Athletic Trainer for ten years and am State licensed in both Illinois and Ohio.

I am writing today to commnicate my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not been given the proper and usual validation, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. I have worked under the supervision of various phyiscians who have expressed full confidence in my abilities, referring numerous patients to my care.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Physicians have continually depended on the services and expertise of certified athletic trainers as have the patients they refer.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Kathryn Webster, MS/ATC

Submitter : **Dr. Osborne Shuler** **Date: 08/28/2007**

Organization : **University of South Carolina**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

We are writing regarding the proposed change to bundle CPT 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350.

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We strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other pediatric cardiology echocardiography codes <93303, 93304, 93315> until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Thank you for your consideration of this serious matter.

CMS-1385-P-9693-Attach-1.DOC

#96 93

The Children's Heart Program
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Charleston, SC 29425

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(800) 343-1983
FAX (843) 792-3284
FAX EKG (843) 792-8415
www.pediatrics.musc.edu/pedscard

CHARLESTON
J. Philip Saul, M.D.
Director

Andrew M. Atz, M.D.
Varsha Bandisode, M.D.
Andrew D. Blaufox, M.D.
Geoffrey Forbus, M.D.
Melissa Henshaw, M.D.
Jon Lucas, M.D.
Tim C. McQuinn, M.D.
Jeremy Ringewald, M.D.
Girish S. Shirali, M.D.
Frances Woodard, RN, MSN, CPNP

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Luther C. Williams, M.D.

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GREENVILLE
Benjamin S. Horne, M.D.
David G. Malpass, M.D.
John P. Matthews, M.D.
R. Austin Raunikar, M.D.

CARDIOTHORACIC SURGERY
Fred A. Crawford, Jr., M.D.
Scott M. Bradley, M.D.

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

August 27, 2007

Re. File Code: CMS-1385-P, CODING—ADDITIONAL CODES FROM 5-YEAR REVIEW

To CMS:

We are writing regarding the proposed change to bundle CPT 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350.

As with the evaluation of adults, 93325 is billed for the vast majority of echocardiograms in children and patients with congenital heart disease. However, 93325 is a critical and time consuming part of a pediatric cardiac echocardiogram. Consequently, it is also critical that any bundling of this code with other codes include the RVU value of 93325 as additive. The surveys performed to set the work RVU's for the echo codes utilized specifically by pediatric cardiologists and affected by this proposed change were performed more than 10 years ago. As a result, particularly with respect to the 93325, the RVU's are more reflective of the technology component than the advances in care that have been developed as a result of the technology. A much needed new survey would provide evidence that the work and risk components of the procedures that involve Doppler Color Flow Mapping have evolved to the point where the relative value of the procedures have shifted to a significantly greater work component.

We strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other pediatric cardiology echocardiography codes <93303, 93304, 93315 >until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Thank you for your consideration of this serious matter.

Sincerely yours,

For The Children's Heart Program of South Carolina
J. Philip Saul, MD
Director, Charleston

Osborne Shuler, MD
Director, Columbia

Benjamin Horne, MD
Director, Greenville

Anderson Beafort Charleston Columbia Florence Greenville Greenwood Lancaster Myrtle Beach Orangeburg Pawley's Island Sumter
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CMS-1385-P-9694

Submitter : Dr. Jason Su **Date:** 08/28/2007

Organization : University of Utah School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS:

I am writing regarding the proposed change to eliminate CPT 93325 (Doppler Color Flow Mapping) and bundle this code into other echocardiography CPT codes. As a cardiac specialist caring for patients with congenital heart disease, this is of particular concern to me for a number of reasons.

I do not believe the appropriate process has been followed with respect to this proposed change. After significant interaction and research between the Relative Value Scale Update Committee (RUC) and the appropriate specialty societies (ACC and ASE), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that other echo codes be bundled as well with the 93325. Because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

Importantly, there is no proposed change to the RVUs of the codes with which 93325 will be bundled. The proposal would simply eliminate reimbursement for CPT 93325, yet the amount of work performed and time spent by the physician for this service will remain the same.

Color Doppler is typically performed in conjunction with 2D echo to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow velocities. The performance of echo in patients with congenital anomalies is unique in that it is frequently necessary to use color Doppler (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 code for the pediatric population stating that color Doppler is "& even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." There are many other complex anatomic and physiologic issues that we as cardiac specialists face on a daily basis when performing echos on patients with complex heart disease. Color Doppler imaging is a critically important part of many of these studies, requiring additional time and expertise from both the sonographer and the cardiologist interpreting the study. Bundling 93325 with other echo codes does not take into account this additional time, effort, and expertise. I am concerned that this change would adversely impact access to care for cardiology patients with congenital cardiac malformations. Programs caring for this select patient population do so not only for those with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for congenital cardiac services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to our patients will not be sufficient to continue to do so should the proposed bundling of 93325 with other echo codes be implemented.

I strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other cardiology echo codes until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Submitter : **Stephanie Bridges** **Date: 08/28/2007**

Organization : **Practitioner**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Stephanie Bridges and I am a Certified Athletic Trainer (ATC). I work for a Hospital based Out-Patient Physical Therapy Clinic in rural Kentucky. I am contracted through my employer by Mid-Continent University to provide Athletic Training services for their institution. I have worked as an ATC for the past ten years and have provided Athletic Training services to numerous schools in rural Kentucky.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,

Stephanie Bridges MA, ATC

CMS-1385-P-9695-Attach-1.TXT

#96.95

Dear Sir or Madam:

My name is Stephanie Bridges and I am a Certified Athletic Trainer (ATC). I work for a Hospital based Out-Patient Physical Therapy Clinic in rural Kentucky. I am contracted through my employer by Mid-Continent University to provide Athletic Training services for their institution. I have worked as an ATC for the past ten years and have provided Athletic Training services to numerous schools in rural Kentucky.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Stephanie Bridges MA, ATC

Submitter : **Beth Hoffman** **Date: 08/28/2007**

Organization : **Beth Hoffman**

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,

Beth M. Hoffman, D.C.

Submitter : **Mr. Luke Howard** **Date: 08/28/2007**

Organization : **Marshfield Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Licensed Athletic trainer in the State of Wisconsin and a Certified Athletic Trainer through the National Athletic Trainer's Association, working at Marshfield Clinic Sports Medicine. I provide clinical outreach sports medicine services to secondary schools, both public and private. My services help those that are in need of proper health care services that their families cannot afford due to their low income status.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Luke D. Howard, M.S., L.A.T., A.T.,C.
Marshfield Clinic
Sports Medicine
2116 Craig Road
Eau Claire, WI 54703
715-858-4928..office
howard.luke@marshfieldclinic.org

Submitter : **Dr. David Holtzclaw** **Date: 08/28/2007**

Organization : **California Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

David Holtzclaw

Submitter : **Dr. Benjamin Horne** **Date: 08/28/2007**

Organization : **Greenville Hospital Systems**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

We are writing regarding the proposed change to bundle CPT 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350.

As with the evaluation of adults, 93325 is billed for the vast majority of echocardiograms in children and patients with congenital heart disease. However, 93325 is a critical and time consuming part of a pediatric cardiac echocardiogram. Consequently, it is also critical that any bundling of this code with other codes include the RVU value of 93325 as additive. The surveys performed to set the work RVU s for the echo codes utilized specifically by pediatric cardiologists and affected by this proposed change were performed more than 10 years ago. As a result, particularly with respect to the 93325, the RVU s are more reflective of the technology component than the advances in care that have been developed as a result of the technology. A much needed new survey would provide evidence that the work and risk components of the procedures that involve Doppler Color Flow Mapping have evolved to the point where the relative value of the procedures have shifted to a significantly greater work component.

We strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other pediatric cardiology echocardiography codes <93303, 93304, 93315> until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Thank you for your consideration of this serious matter.

CMS-1385-P-9699-Attach-1.DOC

#9699

The Children's Heart Program Of South Carolina
165 Ashley Avenue
PO Box 250915
Charleston, SC 29425

(843) 792-3300
(800) 343-1983
FAX (843) 792-3284
FAX EKG (843) 792-8415
www.pediatrics.musc.edu/pedscard

CHARLESTON
J. Philip Saul, M.D.
Director

Andrew M. Atz, M.D.
Varsha Bandisode, M.D.
Andrew D. Blaufox, M.D.
Geoffrey Forbus, M.D.
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John P. Matthews, M.D.
R. Austin Raunikar, M.D.

CARDIOTHORACIC SURGERY
Fred A. Crawford, Jr., M.D.
Scott M. Bradley, M.D.

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

August 27, 2007

Re. File Code: CMS-1385-P, CODING— ADDITIONAL CODES FROM 5-YEAR REVIEW

To CMS:

We are writing regarding the proposed change to bundle CPT 93325 into CPT codes 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350.

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We strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other pediatric cardiology echocardiography codes <93303, 93304, 93315 >until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Thank you for your consideration of this serious matter.

Sincerely yours,

For The Children's Heart Program of South Carolina
J. Philip Saul, MD
Director, Charleston

Osborne Shuler, MD
Director, Columbia

Benjamin Horne, MD
Director, Greenville

Anderson Beafort Charleston Columbia Florence Greenville Greenwood Lancaster Myrtle Beach Orangeburg Pawley's Island Sumter
"An equal opportunity employer, promoting workplace diversity".
http://www.musckids.com

Submitter : Dr. Erik Roach **Date:** 08/28/2007

Organization : Citrus Injury and Wellness

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

You must abolish this reccommendation.

Submitter : **Dr. Michael Mathesie** **Date: 08/28/2007**

Organization : **Dr. Michael Mathesie**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Estimates have stated that chiropractic services cost the Medicare system less that 1/6 of 1% of the healthcare dollar spent. The thought of not allowing a patient to be reimbursed for a procedure that this type of physician normally orders regularly in his office for non-medicare patients is a mockery. The thought that Medicare still thinks that chiropractors are not able to determine the proper treatment methods by not reimbursing for physical therapy and x-rays for a patient is insulting. The thought that chiropractors save Medicare millions of dollars each year in healthcare expenses and someone has thought of another way to cost the system more money by limiting the ability to receive chiropractic sevices to the aged is just a travesty. When will the system realize that when chiropractic discrimination ends and equality occurs the cost of neuromusculoskeletal care will be reduced dramatically in the Medicare system.

Submitter : Mr. Mike Long, M.Ed, ATC **Date:** 08/28/2007

Organization : Trover Health System Sports Medicine

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Mike Long, M.Ed., ATC, CSCS
Senior Athletic Trainer
Trover Health System
Sports Medicine & Rehab.
500 Clinic Drive
Hopkinsville, Ky
42240

Submitter : **Dr. Susan Verscheure** **Date: 08/28/2007**

Organization : **University of Oregon**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Physician Self-Referral Provisions

Physician Self-Referral Provisions

This is the specific arca that my letter is referring to.

CMS-1385-P-9704-Attach-1.DOC

9704

UNIVERSITY OF OREGON
College of Arts and Sciences

Dear Sir or Madam:

My name is Susan Verscheure PhD, ATC and I work at the University of Oregon in the Department of Human Physiology. I am the program director for an accredited Post-Professional Athletic Training Master's Program. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day to day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

SVerscheure.

Susan Verscheure PhD., ATC
Post-Professional Graduate Athletic Training Program Director
541.346.1487
susankv@uoregon.edu

CMS-1385-P-9705

Submitter : **Mr. Keoki Kamau** **Date: 08/28/2007**

Organization : **Grossmont High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is George Kamau, I'm a certified athletic trainer at our local high school and I humbly submit a letter asking for your support.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for our student athletes and other family members of these students.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that the student athletes receive quality health care. State law and hospital medical professionals such as the team doctor that I work with have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards when additional care is needed at a clinic or hospital setting.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring members of our community to receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

George P. Kamau,III ATC, COSS

CMS-1385-P-9706

Submitter : **Mr. Caesar Ocampo** **Date: 08/28/2007**

Organization : **Eugene 4j School District**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Caesar Ocampo, I am a Certified Athletic Trainer working in a High School setting. Although I am now employed by the school district in Eugene I was once employed by Albany General Hospital.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Caesar Ocampo,MS ATC

Submitter : **Dr. Elizabeth Perry** **Date: 08/28/2007**

Organization : **Florida Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my 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.

Elizabeth Perry, MD

Submitter : **Dr. Eric Larsen** **Date: 08/28/2007**

Organization : **Scott & White Hospital Dept. of Aneshesiology**

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. Lori Greenwood** **Date: 08/28/2007**

Organization : **Baylor University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Sce Attachcment

CMS-1385-P-9709-Attach-1.DOC

9709

BAYLOR

BAYLOR UNIVERSITY

Dear Sir or Madam:

I have been a Certified Athletic Trainer for 22 years. I am currently employed as an Associate Professor in Athletic Training at Baylor University and I am the director of both the undergraduate and graduate athletic training education programs. So I speak as both an allied health professional and as an educator of future athletic trainers.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. As an athletic training educator, I know that the students that are graduating from accredited athletic training programs and becoming nationally certified and state licensed, are also qualified to perform physical medicine and rehabilitation in that this is a large content area of their curriculum.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Lori Greenwood, PhD, ATC, LAT
Associate Professor
Director, Athletic Training Education
SCHOOL OF EDUCATION • DEPARTMENT OF HEALTH, HUMAN PERFORMANCE & RECREATION
One Bear Place # 97313 • WACO, TEXAS 76798-7313
254-710-3505

Submitter : **Mr. Steven Stepp** **Date: 08/28/2007**

Organization : **Sports Rehabilitation**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

To Whom it May Concern,
My name is Steven Stepp. I am a Board Certified and State Licensed Athletic Trainer in the state of Georgia. I care for and rehabilitate patients everyday in an outpatient orthopaedic rehabilitation setting.
I am writing today to voice my opposition to the therapy and standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

Although I am concerned that these proposed changes to the hospital Conditions of Participation have not recieved the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As a Certified Athletic Trainer, I am qualified to perform physical medicine and rehabilitation services, which is not the same as physical therapy. My education and 23 years of clinical experience as well as credentialing with a national exam ensure that my patients recieve quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for the CMS, which is supposed to be concerned with the health of Americans to further restrict their ability to recieve those services. The flexible current standards in staffing in hospitals and other rehabilitation facilities are pertinentin ensuring patients recieve the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. Please WITHDRAW the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Steve L. Stepp MS, ATC, LAT

CMS-1385-P-9711

Submitter : Dr. Dean Andropoulos **Date:** 08/28/2007

Organization : Baylor 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)

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.

As Chief of Anesthesiology at a teaching hospital of a major medical school, I also strongly support this change as it will help us support our education and training system.

Thank you for your consideration of this serious matter.

Sincerely,

Dean B. Andropoulos, M.D., M.H.C.M.
Chief of Anesthesiology
Director, Pediatric Cardiovascular Anesthesiology
Texas Children's Hospital
Professor, Anesthesiology and Pediatrics
Baylor College of Medicine

Submitter : **Dr. Richard Williams** **Date: 08/28/2007**

Organization : **University of Utah**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS:

I am writing regarding the proposed change to eliminate CPT 93325 (Doppler Color Flow Mapping) and bundle this code into other echocardiography CPT codes. As a cardiac specialist caring for patients with congenital heart disease, this is of particular concern to me for a number of reasons.

I do not believe the appropriate process has been followed with respect to this proposed change. After significant interaction and research between the Relative Value Scale Update Committee (RUC) and the appropriate specialty societies (ACC and ASE), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that other echo codes be bundled as well with the 93325. Because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

Importantly, there is no proposed change to the RVUs of the codes with which 93325 will be bundled. The proposal would simply eliminate reimbursement for CPT 93325, yet the amount of work performed and time spent by the physician for this service will remain the same.

Color Doppler is typically performed in conjunction with 2D echo to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow velocities. The performance of echo in patients with congenital anomalies is unique in that it is frequently necessary to use color Doppler (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 code for the pediatric population stating that color Doppler is "& even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." There are many other complex anatomic and physiologic issues that we as cardiac specialists face on a daily basis when performing echos on patients with complex heart disease. Color Doppler imaging is a critically important part of many of these studies, requiring additional time and expertise from both the sonographer and the cardiologist interpreting the study. Bundling 93325 with other echo codes does not take into account this additional time, effort, and expertise. I am concerned that this change would adversely impact access to care for cardiology patients with congenital cardiac malformations. Programs caring for this select patient population do so not only for those with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for congenital cardiac services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to our patients will not be sufficient to continue to do so should the proposed bundling of 93325 with other echo codes be implemented.

I strongly urge CMS to withdraw the proposed change with respect to bundling 93325 with other cardiology echo codes until such time as an appropriate review of all related issues can be performed, working within the prescribed process and timeframe, in order to achieve the most appropriate solution.

Sincerely,

Richard V. Williams, MD
Associate Professor of Pediatrics
University of Utah

CMS-1385-P-9713

Submitter : Dr. Gary Noseworthy

Date: 08/28/2007

Organization : Noseworthy Chiropractic

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

I hope common sense prevails in this issue. To deny or make it more difficult to order X-rays for the elderly by Chiropractors is putting the patients health at risk. Why not deny Cardiologist access to stress tests and just have them prescribe medication without valuable information. Idiotic!!!!!

Submitter : **Mrs. Janice Watkeys** **Date: 08/28/2007**

Organization : **Accelerated Rehab**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer in good standing with the NATA. I have been working in the area of clinical rehab for 23 years and currently work for Accelerated Rehab. However, my future employment is in jeopardy because of 1385-P.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Janice Watkeys, ATC, CMT

CMS-1385-P-9715

Submitter : Dr. Kelly Lumpkin

Date: 08/28/2007

Organization : Lee University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Program Director for an Athletic Training Education Program. I am a certified Athletic Trainer licensed in the state of Tennessee. I am not only a college professor but I enjoy working with the youth in my community. I serve as a choir director assistant. I volunteer as a soccer, softball, and basketball coach for my community of Cleveland, TN. I also volunteer athletic training services two the two local middle school programs.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kelly Lumpkin, PhD, ATC

Submitter : **Dr. Rebecca Doubler** **Date: 08/28/2007**

Organization : **Dr. Rebecca Doubler**

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.

Rebecca C. Doubler, M.D.

Submitter : **Mr. Paul Walnum** **Date: 08/28/2007**

Organization : **Mr. Paul Walnum**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a licensed athletic trainer within my state and nationally certified by the Board of Certification of the National Athletic Trainers Association.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create an additional lack of access to quality health care for many patients who currently receive rehabilitative services from me and many other athletic trainers across this country.
As an athletic trainer, recognized by the AMA as an allied health professional, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It seems irresponsible for CMS, which is supposed to be concerned with the health of Americans; especially those in rural areas, to further restrict their ability to receive those services. The current standards which offer flexibility of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available. Since CMS appears to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,

Paul K. Walnum, LAT, ATC, CSCS
Indianapolis, IN

Submitter : Dr. Robert Cross

Date: 08/28/2007

Organization : Oregon Health & Science University

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-9718-Attach-1.DOC

9718

Jeffrey R. Kirsch, M.D.
Professor and Chair
Department of Anesthesiology and Peri-Operative Medicine
Oregon Health & Science University, School of Medicine
3181 SW Sam Jackson Park Road, UHS-2
Portland, Oregon 97239
503.494-4908 ~ Fax: 503.494-4588
E-Mail: kirschje@ohsu.edu

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:

Thank you for the opportunity to comment on the proposal to adjust the anesthesia payments under the 2008 Physician Fee Schedule to a more appropriate level. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to rectify this complicated issue.

As you know, anesthesia is the only specialty that is outside of the RBRVS system. When the decision was made to allow anesthesia to continue to use a separate unit system that included base, time, and modifier units, the payment rate initially established per unit by CMS was inappropriately calculated, creating a huge payment disparity for anesthesia care compared to other physician services paid according to the RBRVS methodology. While other specialties are paid about 70% of their average commercial payments by Medicare, anesthesia continues to receive about 32% of their average commercial payments. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services averages just $16.19 per unit nationally, and this rate is even lower in the Portland area at $15.47. The latest ASA survey shows the average commercial payment at $51.04 per unit. The Medicare payment 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.

As an academic institution we face additional challenges with the Medicare payment system. We serve a higher portion of the Medicare population and are greatly impacted by the teaching rule and the concurrence penalty. This results in even lower payments and a greater burden of teaching and providing tertiary care.

If this situation is not rectified it could decimate academic anesthesia practices when combined with the pending SGR cuts. While we recognize that CMS must implement the SGR, this will compound the issues with our already low paid specialty and make it more difficult to recruit and retain qualified physicians to train the next generation of physicians.

I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

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

Thank you for your consideration of this serious matter.

Sincerely,

Robert Cross, MD

cc. The Honorable Darlene Hooley, Darlene@mail.house.gov
The Honorable David Wu, david.wu@mail.house.gov
The Honorable Greg Walden, greg.walden@mail.house.gov
The Honorable Earl Blumenauer, earl@mail.house.gov
The Honorable Peter DeFazio, peter.defazio@mail.house.gov
The Honorable Earl Blumenaur, write.earl@mail.house.gov

CMS-1385-P-9719

Submitter : **Dr. Joseph Day** **Date: 08/28/2007**

Organization : **Southeastern Indiana Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my 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.

CMS-1385-P-9720

Submitter : **Dr. Brian Mack** **Date: 08/28/2007**

Organization : **Dr. Brian Mack**

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 less than $16 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 our community, Medicare accounts for nearly half of our work, yet only 7% if our revenue.

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

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

Thank you for your consideration of this serious matter.

Respectfully Yours,
Brian Richard Mack, MD
Santa Barbara, CA

CMS-1385-P-9721

Submitter : **Mrs. Kristen Schellhase** **Date: 08/28/2007**

Organization : **University of Central Florida**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a certified athletic trainer working at the University of Central Florida. I have been a health care provider for 12 years and am quite proud of my profession. I am also the program director for the Athletic Training Major at UCF. I ensure that the students graduating from my program possess the knowledge necessary to be amazing health care professionals.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Kristen C. Schellhase, MEd, ATC, LAT, CSCS

Submitter : srinivasan adayapalam **Date: 08/28/2007**

Organization : srinivasan adayapalam

Category : Physician Assistant

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.

CMS-1385-P-9723

Submitter : **Mr. Mark Coberley** **Date: 08/28/2007**

Organization : **Iowa State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

To Whom it May Concern:

My name is Mark Coberley and I am the Director of Athletic Training Services at Iowa State University. I am a Licensed Athletic Trainer by the State of Iowa and a nationally certified athletic trainer through the Board of Certification for Athletic Trainers. I am a college teacher as well as a practicing athletic trainer. I have a Master's degree in Athletic Training, and provide comprehensive health care services to athletes (of all ages and skill levels) in my community and in the State of Iowa.

I am writing today to oppose the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to these hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of accesss to quality health care for people in my area. The recent ruling of CMS on therapy "incident to" has already negatively affected the access to athletic training services provided by physician's offices in outreach to local schools and organizations, and this ruling will further restrict access to quality health care delivered to people in the hospital outreach setting.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workfoce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The recent CMS ruling on "incident to" services and this proposed change will have a profound effect on the ability of people in smaller communities to access services provided by the licensed athletic trainer. The flexible current standards of staffing in hospitals and other rehabiliation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hopitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Feel free to contact me anytime for information on athletic training services or qualifications of the athletic trainer. coberley@iastate.edu or (515) 294-4441.

CMS-1385-P-9724

Submitter : **Dr. marbelia gonzalez** **Date: 08/28/2007**

Organization : **hartford anesthesia associates**

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

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.

Marbelia Gonzalez

CMS-1385-P-9725

Submitter : Dr. Sara Skrlin

Date: 08/28/2007

Organization : Oregon Health & Science University

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-9725-Attach-1.DOC

9725

Jeffrey R. Kirsch, M.D.
Professor and Chair
Department of Anesthesiology and Peri-Operative Medicine
Oregon Health & Science University, School of Medicine
3181 SW Sam Jackson Park Road, UHS-2
Portland, Oregon 97239
503.494-4908 ~ Fax: 503.494-4588
E-Mail: kirschje@ohsu.edu

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:

Thank you for the opportunity to comment on the proposal to adjust the anesthesia payments under the 2008 Physician Fee Schedule to a more appropriate level. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to rectify this complicated issue.

As you know, anesthesia is the only specialty that is outside of the RBRVS system. When the decision was made to allow anesthesia to continue to use a separate unit system that included base, time, and modifier units, the payment rate initially established per unit by CMS was inappropriately calculated, creating a huge payment disparity for anesthesia care compared to other physician services paid according to the RBRVS methodology. While other specialties are paid about 70% of their average commercial payments by Medicare, anesthesia continues to receive about 32% of their average commercial payments. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services averages just $16.19 per unit nationally, and this rate is even lower in the Portland area at $15.47. The latest ASA survey shows the average commercial payment at $51.04 per unit. The Medicare payment 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.

As an academic institution we face additional challenges with the Medicare payment system. We serve a higher portion of the Medicare population and are greatly impacted by the teaching rule and the concurrence penalty. This results in even lower payments and a greater burden of teaching and providing tertiary care.

If this situation is not rectified it could decimate academic anesthesia practices when combined with the pending SGR cuts. While we recognize that CMS must implement the SGR, this will compound the issues with our already low paid specialty and make it more difficult to recruit and retain qualified physicians to train the next generation of physicians.

I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

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

Thank you for your consideration of this serious matter.

Sincerely,

Sara Skrlin, MD

cc. The Honorable Darlene Hooley, Darlene@mail.house.gov
The Honorable David Wu, david.wu@mail.house.gov
The Honorable Greg Walden, greg.walden@mail.house.gov
The Honorable Earl Blumenauer, earl@mail.house.gov
The Honorable Peter DeFazio, peter.defazio@mail.house.gov
The Honorable Earl Blumenaur, write.earl@mail.house.gov

CMS-1385-P-9726

Submitter : Mr. Thomas Picarella **Date:** 08/28/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

August 28th, 2007

Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

1. 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.

2. 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.

3. 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. Thank you for your concern and attention to this very important issue.

Sincerely,

Thomas Picarella, MSN, CRNA
4016 Ito Court
Cameron Park, CA, 95682

CMS-1385-P-9727

Submitter : **Dr. Assumpta Yau** **Date: 08/28/2007**

Organization : **Anesthesia Consultants of New Jersey**

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.

Assumpta Yau MD

CMS-1385-P-9728

Submitter : **Miss. Sarah Manville** **Date: 08/28/2007**

Organization : **North Carolina State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Sarah Manville and I am a certified athletic trainer working as a graduate assistant with the women's soccer team at North Carolina State University. I graduated from Florida Southern College with a Bachelor of Science in Athletic Training and am pursing my Master's degree in Adult Education.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Sarah Manville, ATC

CMS-1385-P-9729

Submitter : Dr. Robert Cline **Date:** 08/28/2007

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
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.

As you no doubt have heard, wben 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 is less than when I started private practice 22 years ago, and does not cover the cost of caring for our nation s seniors. This 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.

CMS-1385-P-9730

Submitter : Mrs. Amy Pearson **Date:** 08/28/2007

Organization : Heartland Rehabilitation Services

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

August 28, 2007

Dear Sir or Madam:
My name is Amy Pearson. I am a certified Athletic Trainer who works in an outpatient physical therapy clinic with outreach to secondary schools in my area. I received both a Bachelor s and Master s degree in Athletic Training from the University of Florida and currently reside and work in the Jacksonville, FL area. I am nationally certified and state licensed as an Athletic Trainer.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Amy S Pearson, MS, ATC, LAT

Submitter : **Julianne Whittington** **Date: 08/28/2007**

Organization : **American Association of Nurse Anesthetists**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. 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.

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,

Julianne Whittington, CRNA
5000 Rushland Drive
Winston-Salem, NC 27104

CMS-1385-P-9732

Submitter : **Mr. Doug Wiesner** **Date: 08/28/2007**

Organization : **Sports Rehabilitation**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Doug Wiesner and I am a Certified Athletic Trainer that has been working in an out-patient physical therapy clinic for the past 25 years. I graduated from the University of Missouri-Columbia and am certified nationally via the National Athletic Trainers Association and licensed in both the states of Missouri and Kansas as an Athletic Trainer. I have worked hand-in-hand for these 25 years with PT's and PTA's and other ATC's to establish a cutting edge physical therapy program for all our patients. Because of my 25 years of experience many of the PT's and PTA's come to me and utilize my experience for care of their patient all the while I find myself being able to do less for my patients because of your rulings.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Doug Wiesner, ATC

CMS-1385-P-9733

Submitter : **Dr. Brian Kradel** **Date: 08/28/2007**

Organization : **Anesthesia Unlimited, Inc.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please support the increase in Anesthesia payments for medicare recipients.
Our specialty has been undervalued since 1994 resulting in serious decreases in the training ability of our academic centers and expansion of our community practices.

Submitter : **Mr. Garry Gillis** **Date: 08/28/2007**

Organization : **Mr. Garry Gillis**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
My name is Garry Gillis. I am a licensed athletic trainer in Florida working for an outpatient rehabilitation company.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Garry Gillis, M.Ed., ATC, LAT

Submitter : **Mr. Kevin Barnes** **Date: 08/28/2007**

Organization : **Crystal Lake Orthopeadic Surgery & Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified/Licensed Athletic Trainer working as a Physician Extender in an Orthopeadic Sports Medicine Clinic as well as an Athletic Trainer for a local high school. Along with obtaining a national certification and state licensure, I have an NPI number with the National Plan & Provider Enumeration System. I work closely with four Orthopeadic Physicians three days a week, and provide care for approximately 400 high school student athletes six days a week.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an Athletic Trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Kevin F. Barnes, MA, LAT/ATC, CSCS

Submitter : Mr. Richard Jean **Date:** 08/28/2007

Organization : Christie Clinic

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,

My name is Richard Jean and I am a certified and licensed athletic trainer in Champaign, IL. I have been practicing for the past 19+ years treating thousand of patients. I am writing to voice my oppostion to the therapy standards and requirements concerning staffing in hosptials and facilities proposed in 1385-P
As an athletic trainer, am I more then qualified to perform physical medicine and rehab service, which is not the same as physical therapy. My educational background, experience and clinical background ensure that my patients recieve quality health care. The propsal 1385-P attempts to circumvent those standards I have attained.
It is irresponsible for the CMS to restrict patients access and the abilities to recieve services.
I would request that the CME withdraw the proposed changes related to hospitals, clinics, Medicar Part A or B hospital or rehab facilities.

Sincerly,

Richard Jean ATC, LAT, MS
Administrative Coordinator
Christie Clinic PT/Sports Medicine

Submitter : Dr. Christopher Kielich **Date:** 08/28/2007

Organization : Dr. Christopher Kielich

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
Christopher Kielich, MD

Submitter : **Mrs. Robin Hathaway** **Date: 08/28/2007**

Organization : **The Rose Center for Rehabilitation**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writting to strongly support The Stark Law in its original intent. That is to stop self referral for profit. Close the loop hole that is being abused. Patient's deserve to have the best care available and have the right to go to any physcial therapy clinic that will serve them best. Physicans will often refer their patient's to one clinic because of that clinics specialty, as it should be. The problem is when a physician has a direct financial gain to refer to their own clinic there is great potential for abuse.
There is already evidence of increased MRI, X-rays and other diagnostic tests being ordered since the onset of physician owned centers that provide these services. Physician owned Physical Therapy Clinics are no different. Eliminate the temptation for increasing profit versus improving patient care, close the loop hole in Stark's Law.
Thank you,
Robin Hathaway

Submitter : **Dr. Christopher Schmidt** **Date: 08/28/2007**

Organization : **Azusa Pacific University**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Christopher Schmidt and I am an assistant professor and program director of athletic training education at Azusa Pacific University in Azusa, CA. In my position, I prepare undergraduate students to become Certified Athletic Trainers (ATC). I have been an ATC for 13 years and possess a bachelor's degree in Physical Education and Recreation, a master's degree in Exercise and Sport Science and a PhD in Human Performance and Recreation. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Christopher R. Schmidt, PhD, ATC

Submitter : **Ms. Robin Lensch** **Date: 08/28/2007**

Organization : **Miami Valley Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I have been practicing as an Athletic Trainer in the state of Ohio for over 12 years. For most of this time I have been employed by a large hospital sports medicine center and contracted out to a local high school. I believe that there are many skills that I provide to my athletes at the high school that could benefit our patients at the sports medicine center but at this time there is little opportunity to do so. There are many physically active individuals that are missing out on the quality services of Certified Athletic Trainers.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Robin T. Lensch LAT, ATC, CSCS

CMS-1385-P-9742

Submitter : **Dr. David williamson** **Date: 08/28/2007**

Organization : **gulf shore anesthesia associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my 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.

David Williamson, MD

CMS-1385-P-9743

Submitter : Mrs. Rebecca Petersen, ATC **Date:** 08/28/2007

Organization : Long Island University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

August 28, 2007

Dear Sir or Madam:

My name is Rebecca A. Petersen, MS, ATC?. I have been a licensed certified athletic trainer in New York for the past 9 years and have worked at clinics, colleges, universities, and professional sports teams evaluating, treating and rehabilitating many different athletes and patients. I am currently the Clinical Coordinator, Assistant Professor for our CAATE (www.caatc.net) accredited Athletic Training Education Program at Long Island University in Brooklyn, NY. I oversee a rigorous clinical component of our accredited program. My students complete over 1,000 clinical hours in various work settings, and three years of the coursework before being able to sit for a national certification exam administered by the Board of Certification for Athletic Training (www.bocatc.org). Upon graduating with a combined BS/MS degree, students will have the opportunity to work in a variety of settings (secondary schools, universities, clinics, hospitals, professional sports teams, Department of Defense, etc). It would be very discouraging if newly certified athletic trainers would have employment opportunities taken away from them.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Rebecca A. Petersen, MS, ATC
Clinical Coordinator, Assistant Professor
Athletic Training Education Program
Division of Sports Sciences
Long Island University, Brooklyn Campus
Brooklyn, NY

CMS-1385-P-9744

Submitter : **Shelby Bernard** **Date: 08/28/2007**

Organization : **Fox Valley Orthopaedic Institute**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer employed through a clinic and then outreached to an area high school. I provide preventative measures, education, basic medical care and first-aid, and rehabilitation services to the approximately 1,000 athletes that participate in sports throughout the year. I have completed two B.S. degrees (one in athletic training, one in public health), complete 75 hours of continuing education every 3 years, passed a national certification exam, and met the standards in order to be licensed by the state of Illinois to practice athletic training.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Shelby Bernard, ATC, CSCS

CMS-1385-P-9745

Submitter : Ms. Joyce Koehl

Date: 08/28/2007

Organization : Middletown Regional Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Joyce Koehl and I am a certified athletic trainer. I am currently employed by Middletown Regional Hospital in Ohio and through the hospital I work at Carlisle High School preventing, treating and rehabilitating athletic injuries. I spent 4 years getting my bachelors degree in Athletic Training and 1 year getting my masters degree.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Joyce A Koehl, MS, ATC

CMS-1385-P-9746

Submitter : Dr. Steve Patton

Date: 08/28/2007

Organization : aac

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

it is about time you increased points in some field. Anesthcsia is a good start. Maybe surgery next

CMS-1385-P-9747

Submitter : **Mr. Gary Herman** **Date: 08/28/2007**

Organization : **University of Tennessee Lady Vol Athletic Training**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Gary Herman and I am an graduate assistant athletic trainer at the University of Tennessee. I have received my bachelor's degree at Missouri State University in Sports Medicine and Athletic Training and am currently working on my masters in Sports Psychology.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Gary Herman, ATC

CMS-1385-P-9748

Submitter : **Mr. Charles Limbach** **Date: 08/28/2007**

Organization : **Kearney High School**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Charles Limbach. I am a teacher/Athletic Trainer, Certified at Kearney High School in Kearney, Nebraska where I have been employed in that role for 21 years. Along with teaching in the Physical Education Department, I am responsible for the health care to over 450 student-athletes that participate in our 17 interscholastic sports programs. Practice and game coverage, evaluation of injuries, treatment and rehab services, are just some of the tasks I perform on a daily basis.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients. In rural Nebraska, these changes could abolish most if not all small high school coverage by outreach athletic trainers.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Charles Limbach, MA, ATC