CMS-1385-P-10001

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

Organization : **Northwestern Memorial Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

Acting Administrator

Centers for Medicare and Medicaid Services

Attention: CMS-1385-P

P.O. Box 8018

Baltimore , MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

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

Organization : American Association Nurse Anesthetist

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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.
First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,Ruth Anne Bendel, CRNA, MSN

Submitter : Mr. Scott Peterson **Date:** 08/28/2007

Organization : Mr. Scott Peterson

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom it may concern:

As a practicing physical therapist of the the past 20 years and in private practice the past 5 years I have great interest in the proposed changes to the physician fee schedule and the change which would close the loop hole in the Stark Law for referal for profit physical therapy services.

I am hopeful that the proprosed changes in 1385-P will bring about positive change in not allowing under qualified individuals to practice in a rehabilitation capacity. I am aware there are those professions who feel they are qualified and by so doing are employed by physicians in their offices.

I strongly encourage the CMS to continue in a direction to persue these changes.

Sincerely,

Scott E. Peterson, PT, ATC

Northwest Orthopedic and Sports Physcial Therapy, LLC

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

Organization : **Dr. Bryan Borsum**

Category : **Physician**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Bryan D. Borsum
Chiropractic Physician

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

Organization : **Anesthesiologists of Columbia**

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.

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

Organization : **Prevea Health**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

The 1/1/2009 dead line requiring EMR medical facilities to submit prescriptions only via e-prescription clearinghouses or printed hard copy is too soon. Only 14% of ambulatory medical facilities have an EMR, and the ones that have an EMR have paid significant funds, and continue to work on implementation. It would cost an additional $50,000 to implement e-prescribing. We live in a rural area where a number of our patients use non-chain store pharmacies that will not have e-prescribing. E-prescribing would not be better customer service for our patients. We can not use one clearinghouse for retail pharmacies and mail-in centers. The clearinghouses are not ready to accommodate the volume in this time frame. Until clearinghouses and EMR vendors and ALL pharmacies can get up to speed it will have a negative effect on the service we provide our customers.

Mike Fischer
Director Information Services
Prevea Health Green Bay WI

CMS-1385-P-10007

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

Organization : **Consultant Anersthesiologist Inc**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Scc Attachmcnt

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

Organization : **Anesthesia Medical Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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.

Eric J. Radel, D.O.
Anesthesia Medical Consultants, P.C.
3333 Evergreen Dr. NE
Grand Rapids, MI
49525

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Regarding physician self-referral provisions: As a physical therapist working in private practice owned by a Physical Therapist, I feel that physician owned physical therapy practices are a detriment to the community and patients. If a physician owns his/her own physical therapy practice, the physician will have a tendency to refer his patients to his own practice in order to make a profit. This is not only unethical, it may be harmful to the patient. Often times the patient does exactly what his/her physician wants, not realizing they have a choiee in where to go for physical therpay. If a physician refers only to himself, the patient may not do research to find the best physical therapist in their area. In addition, physical therapists rely on physician referrals. If these referrals are not eoming in because the physician is referring to him/herself, the privately owned practice cannot survive. This eliminates the competition which is what forces providers to become better and more skilled. With a lack of competition, there is no reason to try to make one's practice better, because patients have not other options. As stated earlier, this is the problem with POPTS: it eliminates the competition that makes us all better.

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

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Dwayne Beam. I am currently the Head Athletic Trainer at Coastal Carolina University in Conway, SC. I have been a practicing Athletic Trainer for 12 years at the collegiate level. I received my undergraduate degree from Appalachian State University and my graduate degree from East Carolina University.

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,

Dwayne Beam, ATC

Submitter : **Abbey Thomas** **Date: 08/28/2007**

Organization : **Abbey Thomas**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am graduate student in Kinesiology (athletic training) with part time appointments educating students in my university's undergraduate athletic training program and at a local high school 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.

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Sincerely,

Abbey Thomas, MEd, ATC

Submitter : Dr. Jeremy Sibold
Organization : University of Vermont
Date: 08/28/2007
Category : Academic

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

Please accept this letter of opposition to 1385-P. I have been a certified athletic trainer for 11 years, and treated thousands of patients both in the clinical and collegiate arena.

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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Sincerely,

Dr. Jeremy Sibold Ed.D, ATC

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

Organization : **Atlantic Pathology Group**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir/Madam:
As an introduction, I am a practising double boarded certified pathologist and a member in good standing of both the College of American Pathology and the Florida Society of Pathology. For the last seventeen years, I have practice in Melbourne Florida, first as a Hospital-based pathologist in a large group and most recently (eight years ago) as an independent Pathologist providing services to our local physicians only in diagnostics anatomic pathology.
I also would like to thank you for this opportunity to submit my personal comments on the Physiscian Self-Referral Provisions of CMS-1385-P.
I want to congratulate CMS on taking on this very important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my local practice area that gives physician groups a share, either directly or indirectly, of the revenues generated by the pathology services ordered and performed from the local groups's patients. These arrangements, in my opinion, are an abuse of the Stark law prohibition against physician self-referral and I strongly support revisions to close the apparent loopholes that allow physicians to profit from pathology services. Specifically, I support the expansion of the anti-markup rule to purchase pathology interpretation and the exclusion of anatomic pathology from the in-ofice ancillary services exception to the Stark law. These revisions to the Medicare reassigment rule and physician self-referral provisions are necessary to curtail and eliminate financial self-interest in clinical decision-making. I strongly believe that physicians, other than Board-certified Pathologist, should not be able to profit for providing Pathology Services to any community.
These proposed changes, in my opinion, do not affect patient care or the quality of the work provided by the local Pathologist. In addition, these proposed changes do not impact the availability or delivery of pathology services in any of our communities. They are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.
Yours truly,
Jose Reilova, MD

CMS-1385-P-10014

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

Organization : **Bon Secours Hospital**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have worked off and on in these Labs.The Drs. are ordering what ever they want,because of financial gains.How can they be allowed to run a full Lab.with extensive menu and no body watching over them.We are trained Pathologists and are so regulated about our activities, and these Labs. are doing roaring business.the Practitioners are seeing the patients and ordering tests ,collecting money for their own financial gains.The practicing physicians sould be allowed only office type of tests to be done (eg, glucose ,urine dip stick ,may be a pregnancy test),and not the full menu of a pathologist run Labs.Thanks

Submitter : **Steven R. Sweat** **Date: 08/28/2007**

Organization : **Manatee County Rural Health**

Category : **Physician**

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 item under the technical corrections section dated July 12th which calls for the end of the current regulation that permits a beneficiary to be reimbursed by Medicare for an X-ray taken by a non-treating provider and used by a Doctor of Chiropractic to determine a subluxation should be eliminated. In fact,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 pathology and to aid in the determination of a diagnosis and treatment plan. 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,

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

Organization : **Wellness Concepts of Florida, L.L.C.**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Chiropractors sometimes depend on xray to reveal possible contraindictions to an adjustment. If the right to refer to a radiologist is abolished, treatment will be hindered and slowed, risk will increase, and overall health care cost will rise as the patient then visits their primary for a referral. Please abolish CMS 1385 P and continue to allow those suffering to receive quality care.

CMS-1385-P-10018

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

Organization : **Lancaster Orthopedic Group**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Chris Evans and I am a Certified Athletic Trainer working in Lancaster PA at the Lancaster Orthopedic Group.

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,

XXXXXX, ATC (and/or other credentials)

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

Organization : **Dr. Brandon Cooper**

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

August 28, 2007

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. Brandon Cooper, DC

Submitter : **Mary Allen** **Date: 08/28/2007**

Organization : **Physiotherapy Associates**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

RE: 'In-office ancillary services' exception. As a practicing outpatient orthopedic PT, I have witnessed first-hand the reasoning behind a large group of physicians representing several specialties, including orthopedics, who starting their own PT clinic. I worked for an independent clinic in the same building as the physicians for 7 years. Our group had been in the facility since the early 90's and had an excellent, but independent, relationship with the physicians. A year ago they announced plans to proceed with opening their own physician-owned physical therapy service for the express reason of profiting from the clinic. The physicians stated over and over that they had been very happy with the quality of care we had provided for their patients over the years but saw this as a way to increase their revenue and help recruit new doctors to the practice. We have loss our lease and a major source of referrals, which affected not only the PT clinic, but also hand therapy, aquatic therapy and work conditioning clinics. Several other providers of physical therapy in the community are also affected by the doctor's decision. Note that there was no interest on the part of the physicians in taking over the aquatic therapy aspect of rehab even though it is the only warm water therapy pool in our community and is used by a large number of community members to self-manage chronic conditions such as arthritis, fibromyalgia, wheel-chair bound conditioning, etc. The physicians frequently referred patients to aquatic therapy prior to opening their own clinic but due to the high cost of managing such a program they were not interested in continuing that 'in-office ancillary service.' Our physical therapy clinic ran the pool at a loss because we saw the benefit for patients and for the community members who had a need for that service; with the loss of our lease those benefits for patients and the community may disappear.
Although the AMA promotes in-house PT services as a benefit for patients, locally the exception has been used to provide benefits for the doctors financially. Excellent PT care, 1:1 communication existed prior to the physicians opening their own service. PT services are located throughout the city, thus the downtown location of the doctor's clinic is not necessarily more convenient for patients. This is not a 'sour-grapes' letter. We could have applied for a position with the physicians, only one member of our large staff of PT's and PTA's opted to do that. The remainder of us did not believe a physician-owned service was in the best interest of patients and chose a more difficult path of building new relationships with other providers, having hours cut, expanding into a new specialty areas, doing whatever it took to survive the loss in referrals. Our state is a self-referral state, thus patients can self-refer to PT. As profession we pride ourselves in conducting thorough exams, making a physical therapy diagnosis, then establish a plan of care based on that diagnosis. We work individually with the patient to improve their function and quality of life. Direct physician supervision is not needed to administer physical therapy services. In the event of a physician referral, we maintain a channel of communication per that physician's preference. With all the modern means of communication, one does not have to be in direct contact for meaningful communication to happen. Research studies have demonstrated an increase in utilization of PT services when owned by physicians, some states have outlawed the practices and insurance companies have put up red flags and reduced payment levels to physician-owned services. I ask for your help in closing the loophole that has resulted in the expansion of physician-owned services so patients can receive the best care without influence by those profiting from the referral. This will also assist with the containment of health care costs.

Submitter : **Ms. Ashly Shannon** **Date: 08/28/2007**

Organization : **AthletiCo LTD**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Ashly Shannon and I work as an outreach athletic trainer to Lakes Community High School in Lake Villa, IL out of the AthletiCo Clinic in Grayslake, IL. I received my bachelor's degree in 2005 from Northern Michigan University in Athletic Training and my master's degree in 2007 from Central Michigan University in Exercise Science. I have been working as a Certified Athletic Trainer since 2006.

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,

Ashly M. Shannon, MA, ATC

CMS-1385-P-10022

Submitter : **Dan Wagner** **Date: 08/28/2007**

Organization : **Dakota Wesleyan University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

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,

Dan Wagner EdD, ATC
Athletic Training Education Program Director
Dakota Wesleyan University

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

Organization : **Ms. Jennifer LaFalce**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10023-Attach-1.DOC

#10023

Dear Sir or Madam:

My name is Jennifer LaFalce and I am a licensed and certified athletic trainer. I received my bachelor's degree in Athletic Training from Sargent College at Boston University and my master's degree in Kinesiology and Health Promotion with a concentration in Athletic Training from the University of Kentucky. I have worked in Division I, II, and III collegiate athletic settings, including the University of Kentucky, West Chester University of Pennsylvania, and, currently, Massachusetts Institute of Technology.

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 M LaFalce, MS, ATC

Assistant Athletic Trainer

Kasser Sports Medicine Center

Department of Athletics, Physical Education, and Recreation

Massachusetts Institute of Technology

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

Organization : **Diablo Valley College**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a physical therapist and athletic trainer and have been active as a practitioner and college instructor in both professions so I am well aware of the educational standards and qualifications of athletic trainers and physical therapists.

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,

Michael Chisar, MPT, SCS, ATC, CSCS

Submitter : **Mr. Justin Lewis** **Date: 08/28/2007**

Organization : **American Society of Anesthesiologists**

Category : **Other Health Care Professional**

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,

Justin R. Lewis, MS-IV
Indiana University School of Medicine
American Society of Anesthesiologists- Student Member

Submitter : Mr. Leon Gooden

Date: 08/28/2007

Organization : Mr. Leon Gooden

Category : Nurse Practitioner

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.
Leon Gooden CRNA

CMS-1385-P-10027

Submitter : **Michelle Landis** **Date: 08/28/2007**

Organization : **Indiana State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Michelle Landis an I am the Associate Athletic Trainer at Indiana State University. 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,

Michelle Landis MEd,LAT,ATC
Associate AThletic Trainer
Indiana State University

CMS-1385-P-10028

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

Organization : **Elon University**

Category : **Academic**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Greg Calone. I am employed as the Director of Athletic Training Education at Elon University in Elon, NC. I have degrees in Sports Health Care and Athletic Training. I am a Certified Athletic Trainer and a Certified Strength and Conditioning Specialist.

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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Sincerely,

Greg Calone, MS, LAT, ATC, CSCS
Director of Athletic Training Education
Elon University

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

Organization : **Chaminade College Preparatory**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Eric Dick and I work in the secondary school setting as an athletic trainer providing care for athletic injuries to over 200 high school athletes (both male and female). I have been working in this setting for the past 13 years and in the clinical setting (physical therapy office) for the 3 years before the high school setting. I received my bachelors degree from CSU Northridge in 1991 and my masters degree in 2004 from GCU.

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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Sincerely,

Eric Dick, M.Ed. ATC

Submitter : **Ms. Kimberly Moncel** **Date: 08/28/2007**

Organization : **SMDC Health Care System**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

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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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,

Kimberly R. Moncel MS, ATC/R

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

Organization : Commonwealth Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

From James W. Stone, M.D.--I support the proposed $4.00 increase (per unit)in the conversion factor for anesthesiologists. This is a much needed correction in undervalued services to our nation's seniors. Full letter to Leslie Norwalk, Esq. could not be uploaded to this website.

CMS-1385-P-10032

Submitter : Mr. Nathan Newman **Date:** 08/28/2007

Organization : Loras College

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I would first like to let you know a little bit about my background. I am a graduate from the University of Iowa with a Bachelor of Science degree in Exercise Science, with an emphasis in Athletic Training. While at the University of Iowa, I spent numerous hours as an intern in their sports medicine program. During this time I was able to learn and practice physical medicine. Upon my graduation, I sat for and passed the National Athletic Training Board of Certification Exam. This test allowed me to prove my knowledge and skills in the field of athletic training.

Once I was certified in athletic training, I furthered my education by recieving a Master of Science degree in Kinesiology from Western Illinois University (WIU). While at Western Illinois University, I was employed as a graduated assistant athletic trainer. This opporunity allowed me to further develop and expand my skills and knowledge in athletic training.

I am currently employed at Loras College in Dubuque, Iowa. This job requires me to work very closely with the athletes on campus and provide them with quality health care for any injuries they suffer while competing in athletics.

I feel this is a job that I am very qualified for. I have spent almost 5 years in undergraduate and graduate school preparing for this job. I have provided physical medicine and rehabiliation care for a wide variety of injuries under the supervision of our Medical Director. The results of this care has been satisfactory to the athletes I treat, their families, and Loras College.

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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Sincerely,

Nathan Newman, MS, ATC

Submitter : David Henze **Date:** 08/28/2007

Organization : University of Alabama System

Category : Other Practitioner

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
I have been a Certified Athletic Trainer for the last 25 years. I have been employed in many settings including a professional sports team, NCAA division 1 university, junior college, and a rural high school. This vast body of experiences I believe makes me qualified to speak on the following topic.
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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Sincerely,
David P. Henze MS ATC/L
Assistant Athletic Director - Finance
University of Alabama at Birmingham
205E Bell Bldg
1220 University Blvd
Birmingham, AL 35294-1160
205.934.3040
205.996.5830 (fax)
slammer@uab.edu

CMS-1385-P-10034

Submitter : **Ms. Janice Simmons** **Date: 08/28/2007**

Organization : **Fork Union Military Academy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

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,
Janice Simmons, ATC (and/or other credentials)

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

Organization : **Dr. James Rossignol**

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 : Ms. Susan Stevenson

Organization : Northern Illinois University

Date: 08/28/2007

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

August 28, 2007

Dear Sir or Madam:

My name is Susan Stevenson and I am a Certified Athletic Trainer in Illinois. I work at Northern Illinois University as the Academic Coordinator of Clinical 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,

Susan Stevenson MS, ATC/L, CSCS

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

Organization : **SMDC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Please approve the proposed unit value conversion factor increase for anesthesia providers.
Yours Truly,
Paul R. Anderson MD

CMS-1385-P-10038

Submitter : **Mrs. Shelly Mullenix** **Date: 08/28/2007**

Organization : **Louisiana State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Shelly Mullenix and I am a Certified Athletic Trainer at Louisiana State University. I am an alumni from Florida State University with an undergraduate degree in Health Education and a Master's degree in Athletic Administration. I currently serve as Senior Associate Athletic Trainer and Clinical Education Coordinator/instructor for our CAATE accredited Athletic Training Curriculum at LSU. I have been a Certified Athletic Trainer for over 15 years and have worked directly with over 2000 student-athletes during this time. I assist our student athletes in managing both their mental health and the physical well-being during a very critical time in their young lives.

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 some of my student athletes.

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.

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Sincerely,

Shelly Mullenix, M.S., ATC
Senior Associate Athletic Trainer
Louisiana State University

CMS-1385-P-10043

Submitter : **Mrs. Erin Rossignol** **Date: 08/28/2007**

Organization : **Mrs. Erin Rossignol**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Bethany A.W Galimore

Organization : Winther Family Chiropractic Center

Date: 08/28/2007

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Bethany A.W. Galimore, D.C.

CMS-1385-P-10045

Submitter : Mrs. Sara Myers **Date:** 08/28/2007

Organization : Methodist Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Sara Myers and I work for Methodist Sports Medicine in Indianapolis, Indiana. I am an outreach/clinical certified athletic trainer and I recieved my Master's in Kinesiology from Indiana University.

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,

Sara Myers, M.S., ATC, CSCS, NSCA-CPT

CMS-1385-P-10046

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

Organization : **Dr. Lawrence Opisso**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Referencing file code CMS-1385-P
I strongly oppose this proposal. X-rays are often needed promptly
in order to properly evaluate and treat the patient. Medicare patients represent a high risk group for secondary pathologies, which are often necessary to rule out for the efficacy of Chiropractic care.
Referral back to the PCP for x-ray referral causes a delay in treatment, and is an added hardship to the patient.

CMS-1385-P-10047

Submitter : **Kate Swett** **Date: 08/28/2007**

Organization : **West Palm Beach VA Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

RE: Docket #1385-P Therapy Standards and Requirements, Physician Self-Referral Provisions

BRIEF INTRO ABOUT SELF: My name is Kate Swett and I currently am employed at the West Palm Beach VA Medical Center in West Palm Beach, Florida. I work as a Registered Kinesiotherapist where I see a variety of inpatients and outpatients all with multiple medical problems and rehab needs. I attended the University Of Southern Mississippi where I received a Bachlor of Science with an emphasis in Kinesiotherapy.

I am writing today to voice my opposition to the proposed therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and other facilities proposed in Federal Register issue #1385-P. As a Kinesiotherapist, I would be excluded from providing physical medicine and rehabilitation services under these rules.

I am concerned that these proposed rules will create additional lack of access to quality health care for my patients. This is particularly important because my colleagues and I work with many wounded Veterans, an increasing number of whom are expected to receive services in the private market. These Medicare rules will have a detrimental effect on all commercial-pay patients because Medicare dictates much of health care business practices.

I believe these proposed changes to the Hospital Conditions of Participation have not received the proper and usual vetting. CMS has offered no reports as to why these changes are necessary. There have not been any reports that address the serious economic impact on Kinesiotherapists, projected increases in Medicare costs or patient quality, safety or access. What is driving these significant changes? Who is demanding these?

As a Kinesiotherapist, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, and Registered status insure that my patients receive quality health care. Hospital and other facility medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards and accepted practicThe lack of access and workforce shortage to fill therapy positions is widely known throughout the health care industry. It is irresponsible for CMS to further restrict PMR services and specialized professionals.

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. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to reconsider these proposed rules. Leave medical judgments and staffing decisions to the professionals. 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,
Kate Swett, RKT

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

Organization : **Dr. Mark Ferraro**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

To whom it may concern:

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Mark T. Ferraro, D.C.

Submitter : **Ms. Summer Bloom** **Date: 08/28/2007**

Organization : **Milken Community High School**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Summer Bloom and I am the Coordinator of Sports Science and Medicine at Milken Community High School, in Los Angeles.

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,
Summer Bloom, ATC, EMT-B

Submitter :

Date: 08/28/2007

Organization :

Category : Health Care Professional or Association

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-10051

Submitter : **Mr. Todd John** **Date: 08/28/2007**

Organization : **Southwest Baptist University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

BRIEF INTRO ABOUT SELF ie. Where you work, what you do, education, certification, etc.

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,

Todd John, MA ATC/L (and/or other credentials)

CMS-1385-P-10052

Submitter :

Date: 08/28/2007

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached word file.

Thank you.

CMS-1385-P-10052-Attach-1.DOC

10052

Dear Sir or Madam:

My name is Christine Lo Bue-Estes and I am a Certified Athletic Trainer and additionally possess graduate degrees above my Bachelors degree. I am a clinician, educator, and provider of excellent care to patients in multiple settings.

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,

Christine Lo Bue-Estes, ATC, MS, PhDc

CMS-1385-P-10053

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

Organization : **Mr. Michael Engle**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

RE: Docket #1385-P Therapy Standards and Requirements, Physician Self-Referral Provisions

I am a registered Kinesiotherapist (RKT) and have been working in the field for more than 12 years. I have spent my entire career working for the Department of Veterans Affairs (VA) providing care to America's Veterans.

I am writing today to voice my opposition to the proposed therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and other facilities proposed in Federal Register issue #1385-P. As a Kinesiotherapist, I would be excluded from providing physical medicine and rehabilitation services under these rules.

I am concerned that these proposed rules will create additional lack of access to quality health care for my patients. This is particularly important because my colleagues and I work with many wounded Veterans, an increasing number of whom are expected to receive services in the private market. These Medicare rules will have a detrimental effect on all commercial-pay patients because Medicare dictates much of health care business practices.

I believe these proposed changes to the Hospital Conditions of Participation have not received the proper and usual vetting. CMS has offered no reports as to why these changes are necessary. There have not been any reports that address the serious economic impact on Kinesiotherapists, projected increases in Medicare costs or patient quality, safety or access. What is driving these significant changes? Who is demanding these?

As a Kinesiotherapist, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, and Registered status insure that my patients receive quality health care. Hospital and other facility medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards and accepted practices.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the health care industry. It is irresponsible for CMS to further restrict PMR services and specialized professionals.

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. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to reconsider these proposed rules. Leave medical judgments and staffing decisions to the professionals. 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,
Michael R Engle, RKT

CMS-1385-P-10054

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I just wanted to voice my concerns over the loopholes in the Stark Law and MD self referral practices. In my area, EVERY orthopedist has their own PT office and openly says how they have to do things to get around the Stark Law.Why? So that they can self refer and make a lot of $. This leads to fraud and abuse in that patients who do not require skilled care get sent for PT regardless so that the MD can make more money. This makes it seem that PT is being over-utilized. It is also a problem for the Physical Therapy profession in that if the MD's are only sending patients to their own offices we will continue to be put out of our own businesses. As for patients, the MD is also advising them to go to their offices because"we have a close relationship with our PT's and are kept more informed." This makes patients think they have to go to these offices as they are unaware they actually have a choice. The bottom line is that the MD has their own profession and can own their own businesses, why should they own ours as well? Self-referral leads to over-utilization and potential for abuse. Please take this seriously and close the loophole for good as they have found ways around it time and again which include having a PT own the office on paper in exchange for an exorbitant rent or having a family member as the owner. Please help us keep our profession an honest and proud one. Thank you for your time and work on this issue.

CMS-1385-P-10055

Submitter : Mr. Robert Wang **Date:** 08/28/2007

Organization : University of California, Santa Barbara

Category : State Government

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I currently work at the University of California, Santa Barbara as an Certified Athletic Trainer. As Certified Athletic Trainer I am alarmed about the standards proposed in 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,

Robert Wang, ATC

CMS-1385-P-10056

Submitter : Mr. Anthony Recinella

Date: 08/28/2007

Organization : Vanderbilt Orthopaedic Institute

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-10056-Attach-1.DOC

#10056

August 28, 2007

Dear Sir or Madam:

My name is Anthony Recinella and I work at the Vanderbilt Orthopaedic Institute in Nashville, TN where I along with 18 other Certified Athletic Trainers work with outpatient therapy. We are all individuals with Master's Degrees, NATA certification and state licensure. Our rehabilitation model is one of the most efficient in the country and provides the patient the best care available as Athletic Trainers are utilized as a team member with our physical therapists. The extensive training and education that we as athletic trainers have in the area of orthopaedics is a perfect fit in outpatient therapy and far surpasses that of a PTA or PT tech.

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, national certification, and licensure 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 a disservice 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,

Anthony J Recinella, MA, ATC/L, HFI

Assistant Manager Patient Access
Vanderbilt Orthopaedic Institute

CMS-1385-P-10057

Submitter : **Mr. Danny Sterling** **Date: 08/28/2007**

Organization : **Longwood University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a certifed athletic trainer, I have been working in college atheltics for over 12 years. I am currently the assistant athletic director at Longwood University.

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,

Danny Sterling, MS ATC

CMS-1385-P-10058

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

Organization : **Indiana University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am the Undergraduate Athletic Training Education Program Director at Indiana University in Bloomington, Indiana and I am also an Athletic Trainer. Our Curriculum is set up so that students must apply to get into the program so the number of students we have is fairly small for a major on a big campus but is mighty in terms of the competition to get in. We start out with approxmiately 100 students on campus wanting to major in athletic training and end up taking the top 20 each year. I tell you this because athletic training students are at the top of the class in a very competitive major. Once they complete their undergraduate degree they must then pass a national Board of Certification Exam and depending on the state in which they are employed they must become credentialed in that state. The point is that athletic trainers are highly educated (80%+ have a Master's Degree), have passed a rigorous national exam and state reguirements. We must also maintain CEUs at the state and national level.

I am writing today ob behalf of my students who will become athletic trainers and all of those other idividuals who are concerned that we are not taken seriously as Health Care Professionals. Anyone who states that we are not qualified to provide rehabilitation and physical medicine services is not being honest with you and the reality is we arevey qualified and in many ways very uniques in the services we provide. I am voicing 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,

Katie Grove PhD, LAT, ATC
Clinical Associate Professor
Indiana University
Bloomington, IN 47408

CMS-1385-P-10059

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

Organization : **United States Military Academy**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

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 a wide range of patients.

As a certified athletic trainer, professionals like myself are qualified to perform physical medicine and rehabilitation services, which you know are not the same as physical therapy. Our education, clinical experience, and national certification exam ensure that our patients receive quality health care. State laws and hospital medical professionals have deemed us 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. Certified athletic trainers play a critical role as first line providers in many healthcare settings. Access to althletic training services is often better and less expensive than other services and can facilitate proper and efficient referal to additoinal 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,

Kenneth L. Cameron, PhD, ATC
Director of Orthopaedic and Sports Medicine Research
KACH

CMS-1385-P-10060

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

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

i think it should be mandatory that you REMOVE physical therapy from the "in office ancillary services" exception to the federal physician self-referral laws. physical therapy should not be allowed to be practiced in a physicain office, billed for by the physician, and carried out by anyone other than a physical therapist. all PT's have either a masters or doctorate degree. thier expertise is in musculoskeletal medicine. i own 5 private PT offices and i see, on a DAILY basis, a complete lack of understanding, concernig the proper treatment of nonoperative musculoskeletal injuries. so if a physican is allowed to perform and bill for a servive which he/she knows nothing about, then the patient is getting poor care. also the patient is, in my clinical experience , not being told that the physician owns the in house therapy and is not given the choice to go anywhere else. i see this all the time. this sets up a situation of abuse where the MD is referring for a servive which he profits from, yet has no way to control the quality because he knows nothing of the profession. there are so many unethical issues with this scenereo and i am not good at writing my views down, i would prefer someone contact me to discuss this matter. i am a PT with 15 years experience, and 10 years as a business owner and political activist. call me at the office at 850 650 4186. thanks, bob seton PT

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

Organization : **Dr. Linda Abbott**

Category : **Physician**

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Linda C. Abbott

CMS-1385-P-10062

Submitter : Ms. Anna Hartman **Date:** 08/28/2007

Organization : Athletes Performance

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Anna Hartman; I am a certified athletic trainer (ATC), certified by the NATABOC, the only national certification for the athletic training field. I received my BS degree in exercise and movement science from University of Oregon. While at University of Oregon I helped to provide healthcare to the football, track and field, and softball teams as well as a local high school. My summers were spent in Peoria, AZ volunteering with the Seattle Mariners medical staff working with players in the Arizona league, instructional league, and rehabilitation assignments. I continued my education at Arizona School of Health Sciences in Meza, AZ and completed my MS in sports health care in 2004. While at ASHS, my master s thesis investigated the acute effectiveness for the horizontal adduction and prone internal rotation stretches on increasing posterior shoulder mobility in professional baseball players. After finishing my Master s degree, I worked for the United States Olympic Committee at the Olympic Training Center in San Diego, CA. providing health care to both Olympic and Paralympics athletes. I currently work at Athletes Performance in Tempe, AZ where I provide health care to elite athletes as the assistant athletic trainer. I am a licensed ATC in the state of Arizona and a NSCA certified strength and conditioning specialist (CSCS).

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,

Anna J. Hartman, MS, ATC, CSCS

Submitter : **Dr. Michael O'Donnell** **Date: 08/28/2007**

Organization : **Dr. Michael O'Donnell**

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.

Michael O'Donnell MD

CMS-1385-P-10064

Submitter : **Mr. Matt Nelson** **Date: 08/28/2007**

Organization : **Advanced Kinetics**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I OBJECT to this rule for reasons of patient safety and access to healthcare. As an "outpatient PMR therapist" this rule will impede my ability to provide effective patient care. More research on this topic needs to be completed and presented before an objective decision can be determined.

CMS-1385-P-10065

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

Organization : **Carr Chiropractic Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

My name is Eric Kannegieter and I am a Certified Athletic Trainer working in South Dakota. I ask you to reconsider this bill currently in legislation.

Submitter : **Mr. George Young** **Date: 08/28/2007**

Organization : **Presbyterian Hospital of Denton**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is George Young. I am a certified and licensed athletic trainer with 34 years of experience. I have spent the last 13 years working in the hospital setting.

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.

When I came to work for the hospital in 1994, I thought I would find other health care professionals that possessed the knowledge and skills that I possessed as an athletic trainer. Now that I am starting my 14th year at the hospital, I realize that I possess a unique set of skills and knowledge. This has manifested itself in the fact that I have been selected for the hospital's "Circle of Excellence" all six years that the program has existed and also chosen a "Star Performer" 3 of those six years.

As a baby boomer who is quickly approaching retirement age, it also concerns me that the provisions if implemented would drive the cost of health care up and not necessarily make it better. The regulations take decisions out of the hands of the people who best know the situation in the hospital and give it to a government agency.

As an athletic trainer, I know I am biased in my thinking about who I would want to take care of my rehab needs but believe me I would always appreciate the care given by athletic trainers whether I am young school age athlete or a senior citizen who has had knee replacement.

Please reject any changes to the current regulations regarding staffing.

CMS-1385-P-10067

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

Organization : **Ms. Jennifer Lancaster**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am writing as a concerned Certified Athletic Trainer. I currently work at the university level as an athletic trainer and educator. I am also currently working towards a PhD 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,

Jennifer Lancaster,MS, ATC, LAT

CMS-1385-P-10068

Submitter : **Mrs. Leanne Edwards** **Date: 08/28/2007**

Organization : **NovaCare**

Category : **Other Health Care Provider**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Leanne Edwards. I work for NovaCare as a contract with North Penn HIgh School in Lansdale, Pa as a Certified Athletic Trainer. I graduated with honors from Slippery Rock University majoring in Athletic Training. I passed my certification exam and moved on to graduate school at Tennessee Technological Unversity. I have used my education to propell myself into the athletic training profession. I work daily with all athletes at North Penn High School in the immediate care, assessment, treatment, and rehabiliation of injuries. As certified athletic trainers, we all use our knowledge to not only help atheltes, but serve as a referral source for treatment of injuries.

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,

Leanne Edwards, MA, ATC

Submitter : **Mr. Tony Sutton** **Date: 08/28/2007**

Organization : **University of Notre Dame**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

As an athletic trainer and parent I am concerned the changes proposed in 1385-P. The reality of these changes will result in many of my colleagues no longer being able to practice athletic training in clinical settings. Many physically active patients depend on the services provided by certified athletic trainers (ATC's). Athletic trainers in Indiana as well as most states are licensed health care providers who provide preventative, emergency care, treatment, and rehabilitative services.

My current position is as an athletic trainer at a collegiate setting. Thus these changes do not affect my ability to care for Notre Dame Football. However, the athletic trainer who serves my daughter's high school is employed by a hospital. Thus these changes will cause many schools to no longer receive on site medical services. The repercussions of these changes will affect the health care of many who depend on athletic trainers.

CMS-1385-P-10070

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

Organization : **Dr. Fred Rudin**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

It is time to make all chiropractic services reimbursable to the extent that services are provided within the scope of practice of the chiropractor's state. This would allow for an accurate diagnosis, spinal analysis, and appropriate referral when necessary. It is time to protect our consumers and eliminate restrictions that can delay proper treatment. Allow for referral for appropriate testing. Why not ask your chiropractic consultants about how they feel about your system!! They will surely tell you that their patients should be reimbursed for diagnostic services and therapeutic services that they provide and charge for. These become the burden of the patient while they are reimbursed elsewhere. Why?

Submitter : **Laura Taylor** **Date: 08/28/2007**

Organization : **Citizens Volunteer Fire Company EMS Division**

Category : **Other Health Care Provider**

Issue Areas/Comments

Ambulance Services

Ambulance Services

see attachment

CMS-1385-P-10071-Attach-1.DOC

#1007-1

CITIZENS VOLUNTEER FIRE COMPANY
EMERGENCY MEDICAL SERVICES DIVISION

P.O. BOX 31
FAWN GROVE, PA 17321

August 28, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, Maryland 21244-8018

Re: CMS-1385-P; Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions.

Dear Ms. Norwalk:

Our organization provides emergency and non-emergency ambulance services to the communities that we serve. The proposed rule would have a direct impact on our operation and the high quality health care we provide to Medicare beneficiaries. We therefore greatly appreciate this opportunity to submit comments on the proposed rule.

BENEFICIARY SIGNATURE

Our organization commends CMS for recognizing that providers and suppliers of emergency ambulance transportation face significant hardships in seeking to comply with the beneficiary signature requirements. Ambulance services are atypical among Medicare covered services to the extent that, for a large percentage of encounters, the beneficiary is not in a condition to sign a claims authorization during the entire time the supplier is treating and/or transporting the beneficiary. Many beneficiaries are in physical distress, unconscious, or of diminished mental capacity due to age or illness. The very reason they need ambulance transportation often contraindicates the appropriateness of attempting to obtain a signature from the beneficiary.

We believe strongly, however, that the relief being proposed by CMS would have the unintended effect of increasing the administrative and compliance burden on ambulance services and on the hospitals. Accordingly, we urge CMS to abandon this approach and instead eliminate entirely the beneficiary signature requirement for ambulance services.

Current Requirement

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

Summary of New Exception Contained in Proposed Rule

While the intent of the proposed exception is to give ambulance providers explicit relief from the beneficiary signature requirements where certain conditions are met, we note that the proposed exception does not grant ambulance providers any greater flexibility than that currently offered by existing regulations. Specifically, 42 C.F.R. §424.36(b)(5) currently permits an ambulance provider to submit a claim signed by its own representative, when the beneficiary is physically or mentally incapable of signing and no other authorized person is available or willing to sign on the beneficiary's behalf. If "provider" in this context was intended to mean a facility or entity that bills a Part A Intermediary, the language should be changed to also include "ambulance supplier". The proposed exception essentially mirrors the existing requirements that the beneficiary is unable to sign and that no authorized person was available or willing to sign on their behalf, while adding additional documentation requirements. Therefore, we believe that the new exception for emergency ambulance services set forth in proposed 42 C.F.R. §424.36(b)(6) should be amended to include only subsection (i), i.e. that no authorized person is available or willing to sign on the beneficiary's behalf.

It is important for CMS to realize that the first two requirements in the proposed sub-division (ii) are always met, as the ambulance crew will always complete a trip report that lists the condition of the beneficiary, the time and date of the transport and the destination where the beneficiary was transported. For this reason, we do not object to the requirements that an ambulance provider obtain (1) a contemporaneous statement by the ambulance employee or (2) documentation of the date, time and destination of the transport. Nor do we object to the requirement that these items be maintained for 4 years from the date of service. However, we do not see any reason to include these in the Regulation, as they are already required and standard practice.

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

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

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

Institute of Medicine Report on Hospital Emergency Department Overcrowding

The Institute of Medicine Committee on the Future of Emergency Care recently released a report citing hospital emergency department overcrowding as one of the biggest issues in emergency health care. According to that report, demand on hospital emergency departments (EDs) increased by 26% between 1993 and 2003. During that same period, the number of EDs fell by 425. Combined with a similar decrease in the number of inpatient hospital beds, this has resulted in serious overcrowding of our nation's ED. A further consequence has been a marked increase in the number of ambulance diversions, with 50% of all hospitals— and nearly 70% of urban hospitals— reporting that they diverted ambulances carrying emergency patients to a more distant hospital at some point during 2003.

The report recommended that hospitals find ways to improve efficiency in order to reduce ED overcrowding. However, the requirement that ambulance providers or suppliers obtain a statement from a representative of the receiving hospital at the time of transport would only compound the existing problem, by adding an additional paperwork burden. To meet this requirement, ambulance crews would be forced to tie up already overtaxed ED staff with requests for this statement. The Institute of Medicine report makes clear that this time would be more efficiently spent moving patients through the patient care continuum.

Purpose of Beneficiary Signature

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

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

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

Signature Already on File

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

Electronic Claims

It is also important to note that, as a result of section 3 of the Administrative Simplification Compliance Act and the implementing regulations at 42 C.F.R. §424.32, with very limited exceptions (e.g. providers or suppliers with less than 10 claims per month), ambulance suppliers must submit claims electronically. Thus, the beneficiary

does not even sign a claim form. When submitting claims electronically, the choices for beneficiary signature are "Y" or "N". An "N" response could result in a denial, from some Carriers. That would require appeals to show that, while the signature has not been obtained, an alternative is accepted. As a result, many Carriers allow a "Y", even though the signature was not actually obtained, if one of the exceptions is met.

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

Program Integrity

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

Conclusion

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

- Amend 42 C.F.R. §424.36 and/or Pub. 100-02, Chapter 10, Section 20.1.1 and Pub. 100-04, Chapter 1, Section 50.1.6 to state that "good cause for ambulance services is demonstrated where paragraph (b) has been met and the ambulance provider or supplier has documented that the beneficiary could not sign and no one could sign for them OR the signature is on file at the facility to or from which the beneficiary is transported".
- Amend 42 C.F.R. §424.36 to add an exception stating that ambulance providers and suppliers do not need to obtain the signature of the beneficiary as long as it is on file at the hospital or nursing home to or from where the beneficiary was transported. In the case of a dual eligible patient (Medicare and Medicaid), the exception should apply in connection to a signature being on file with the State Medicaid Office.
- Amend 42 C.F.R. §424.36(b) (5) to add "or ambulance provider or supplier" after "provider".

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

AMBULANCE SERVICES – AMBULANCE INFLATION FACTOR

Our organization has no objection to revising 42 C.F.R §414.620 to eliminate the requirement that annual updates to the Ambulance Inflation Factor be published in the

Federal Register, and to thereafter provide for the release of the Ambulance Inflation Factor via CMS instruction and the CMS website.

Thank you for your consideration of these comments.

Sincerely,

Laura K.Taylor
EMS Chief, CVFC

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

Organization : **Dr. Gary Smith**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

See Attachment

CMS-1385-P-10072-Attach-1.DOC

#10072

Gary R. Smith, DC

5660 Clinton Street • Elma, NY 14059
(716) 686-0868 Voice
(716) 686-0869 Fax

Tuesday, August 28, 2007

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

Re: "TECHNICAL CORRECTIONS"

To Whom It May Concern:

I am contacting you with regard to the proposed rule dated July 12th that contains 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 to strongly oppose to this proposal. While subluxation does not always need to be detected by an X-ray, in some cases the patient clinically will require an X-ray for further evaluation of their condition. Clearly these patients are elderly and often have significant degenerative changes in their spine and in some cases underlying conditions which are direct contraindications to chiropractic care. X-rays are often a precursor needed to establish a diagnosis and in some cases will aid in identifying other pathology or "red flags," which may in fact help determine the need for further diagnostic testing, i.e. MRI or a referral to the appropriate specialist.

During the last 12 years in practice, I have had numerous patients who presented with what initially seemed like musculoskeletal complaints, which only after x-raying them showed medical problems (i.e. abdominal aortic aneurysm) which required immediate medical referral and subsequent surgery on an urgent basis.

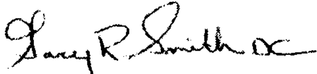
By limiting a Doctor of Chiropractic from referring for an X-ray study, the costs for patient care will go up significantly due to the necessity of a referral to another provider (orthopedist or rheumatologist, etc.) for duplicative evaluation prior to referral to the

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,



Gary R. Smith, D.C., D.I.B.E.

Diplomate, International Board of Electrodiagnosis
Board Certified in Electrodiagnosis

Certified, Electrodiagnosis
National University of Health Sciences

Assistant Professor
D'Youville College
Integrative Holistic Health Studies Department

Submitter : **Mr. Nathaniel Kelley, ATC** **Date: 08/28/2007**

Organization : **West High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Nathaniel Kelley and I am a Certified Athletic Trainer. I work with Denver Public Schools helping to prevent, assess, manage and rehabilitate injuries that student athletes at West High School may sustain. I have a bachelors degree in sports medicine and am certified by the National Athletic Trainers Assoc. Board of Certification 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,
Nathaniel R. Kelley, ATC

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

Organization : **ALL CARE CHIROPRACTIC**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dr. Sue McElrath

Submitter : **Ms. Dorienne Pearson** **Date: 08/28/2007**

Organization : **Symmetry Physical Therapy**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Dorienne Pearson, LATC. I have been a Certified Athletic Trainer for 12 years now. I was the Assistant Athletie Trainer for Iona College for 2 years. Then began working for a Physical Therapy Clinic for 7 years. I recently left that job to work with DME. I now again work in a private Physical Therapy clinic. I work full time in the Physical Therapy clinic where I split the hours between the clinic and being an Athletic Trainer for a local college. I have a B.S. in Psychology. I am also a Certified Personal Trainer through NCSF.

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,

Dorienne A. Pearson, LATC, CPT

CMS-1385-P-10076

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

Organization : Dr. Maria Meesit

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

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

In this day and age, where prices are skyrocketing in many aspects of life and things become more and more complicated, it is time to make sensible decisions and simplify issues wherever possible. Complications and expenses need to be reduced for everyone. The proposed changes defy that.

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,

Maria Meesit, D.C.

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

Organization : Worcester Polytechnic Institute

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Michael DeSavage and I have been a certified athletic trainer for 15 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,

Michael DeSavage, LATC, MEd.

CMS-1385-P-10078

Submitter : **Miss. Denise Yoder** **Date: 08/28/2007**

Organization : **Augustana College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

As a certified athletic trainer in the midwest at a small college, I believe the passing of this will have significant impact in my profession.

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,

Denise Yoder, ATC L

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

Organization : University of Virginia

Category : Academic

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

To Whom It May Concern:

I am an associate professor of kinesiology and physical medicine & rehabilitation at the University of Virginia in Charlottesville, VA. My clinical credentials are as an athletic trainer (ATC). 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. I am concerned that these proposed rules will create an additional lack of access to quality health care for patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services. This should be clearly evident by my joint faculty appointment in the Department of Physical Medicine & Rehabilitation at the University of Virginia, one of the leading academic medical centers in the country. However, this proposed legislation would limit the ability of myself or my athletic training colleagues from being reimbursed for such services.

CMS seems to have come to these proposed changes without clinical or financial justification. I respectfully request that CMS withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Jay Hertel, PhD, ATC, FACSM
Associate Professor of Kinesiology and Physical Medicine & Rehabilitation
University of Virginia
jhertel@virgina.edu

CMS-1385-P-10080

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

Organization : **Dr. Ronald Michelli**

Category : **Chiropractor**

Issue Areas/Comments

Technical Corrections

Technical Corrections

The proposed rule dated July 12th contained an item under the technical corrections section calling for the eurrent 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 determine diagnosis and treatment options, especially in older populaions. X-rays may also be required to help determine the need for further diagnostic testing, i.e. MRI or for a referral to the appropriate specialist.

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

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

Submitter : **Ms. Margaret Roberts-Brown** **Date: 08/28/2007**

Organization : **Cleveland Clinic Foundation**

Category : **Other Health Care Professional**

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.

Margaret Roberts-Brown, MBA
Administrator, Cardiothoracic Anesthesiology
Cleveland Clinic

Submitter : **Mr. Matt Webber** **Date: 08/28/2007**

Organization : **Page High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Matt Webber. I am a licensed and nationally certified athletic trainer who has worked in Arizona high schools for the past 25 years. I have served as the Chair of the Arizona Board of Athletic Training and helped write the regulations governing the practice of athletic training in Arizona.

I am writing today to state my strong opposition to the therapy standards and requirements regarding the staffing provisions for rehabilitation proposed in 1385-P.

I do not believe that these regulations have been properly researched or presented. I am particullarly concerned that groups are using CMS to increase their market share without CMS seriously studying the issue. Tax dollars should not be used to allow certain groups advance their political and economic agenda. The regulations as proposed are vague and can be applied capriciously.

I live in a rural area and these proposed rules will reduce the access to quality health care for those I serve. I do not believe it was the intent of Congress to reduce rural health care.

As an athletic trainer I perform physical medicine and rehabilitation services under my state license. My state has adopted statutes and regulations to ensure that those under my care receive quality services. Arizona state law says I am qualified to perform these services but now CMS wishes to restrict that practice with no justification provided.

If it is the intent of CMS to squelch the medical marketplace it is doing a good job. If not, serious research needs to be done before excluding providers and decisions need to be made based off of evidence, not the opinions of a few CMS staffers.

Thank you for your time and consideration.

Sincerely,

Matt Webber, L/AT, ATC
Page High School
P.O. Box 1927
Page, AZ 86040

CMS-1385-P-10083

Submitter : Brian Haden **Date:** 08/28/2007

Organization : Brian Haden

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

In the Dallas, Tx area many Orthopedic as well as Family Practice Physicians have opened or purhcased their own Physical Therapy practices. It has been my experience that the patients are not given a choice of locations other than their physicians office to receive their treatment. They then frequently have to wait weeks to get in due to overshceduling. Once their treatment begins, they complain of a lack of individual treatment as there are too many patients for the staff to attend to. I feel you should remove Physical Therapy from the in-office ancillary services exception to the federal physician self-referral laws.

CMS-1385-P-10084

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

Organization : **University of Louisiana at Lafayette**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Dr. Toby Dore' I am a Professor and the Porgram Director of Athletic Training Education at the Unviersity of Louisiana at Lafayette.

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,

Toby L. Dore',PhD,ATC

CMS-1385-P-10085

Submitter : **Ms. Christie Elton** **Date: 08/28/2007**

Organization : **Total Fitness Concepts, Inc.**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

RE: Docket #1385-P Therapy Standards and Requirements, Physician Self-Referral Provisions

I currently work for Total Fitness Concepts, Inc. as an exercise physiologist. I perform graded exercise testing in a corportate fitness setting. I graduated from the University of Toledo with a BS Exercise Science with a concentration in Kinesiotherapy. I am currently registered as a Kinesiotherapist.

I am writing today to voice my opposition to the proposed therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and other facilities proposed in Federal Register issue #1385-P. As a Kinesiotherapist, I would be excluded from providing physical medicine and rehabilitation services under these rules.

I am concerned that these proposed rules will create additional lack of access to quality health care for my patients. This is particularly important because my colleagues and I work with many wounded Veterans, an increasing number of whom are expected to receive services in the private market. These Medicare rules will have a detrimental effect on all commercial-pay patients because Medicare dictates much of health care business practices.

I believe these proposed changes to the Hospital Conditions of Participation have not received the proper and usual vetting. CMS has offered no reports as to why these changes are necessary. There have not been any reports that address the serious economic impact on Kinesiotherapists, projected increases in Medicare costs or patient quality, safety or access. What is driving these significant changes? Who is demanding these?

As a Kinesiotherapist, I am qualified to perform physical medicine and rehabilitation services. My education, clinical experience, and Registered status insure that my patients receive quality health care. Hospital and other facility medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards and accepted practices.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the health care industry. It is irresponsible for CMS to further restrict PMR services and specialized professionals.

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. Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to reconsider these proposed rules. Leave medical judgments and staffing decisions to the professionals. 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,

Christie Elton, RKT

CMS-1385-P-10086

Submitter : Justin Sharpe **Date:** 08/28/2007

Organization : Chicago Cubs

Category : Other

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Justin Sharpe. I am the minor league athletic training coordinator for the Chicago Cubs. I am a certified athletic trainer and hold a master's degree 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,

Justin Sharpe, M.S., ATC

CMS-1385-P-10087

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

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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-10088

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

Organization : Virginia Commonwealth University

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am currently a faculty member at Virginia Commonwealth University in Richmond, Virginia. I am also an athletic trainer, and prepare students for the athletic training profession through our Master of Science 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 patients.
As athletic trainers, we are qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. Our education, clinical experience, and national certification exam ensure that patients treated by athletic trainers receive quality health care. State law and hospital medical professionals have deemed us 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,
Brent L. Arnold, PhD, ATC

CMS-1385-P-10089

Submitter : Mrs. Mary Michelli **Date:** 08/28/2007

Organization : Mrs. Mary Michelli

Category : Individual

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

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

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

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

Organization : Ms.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Penny P. Tussing. I am a physical therapist, RRT and an ATC. I am a Director at Theramatrix Southfield in Michigan.

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,
Penny P. Tussing, MSPT,ATC,RRT