Submitter : **Mr. Steven Hart** **Date: 08/29/2007**

Organization : **Cleveland Clinic Foundation**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Steven Hart. I am the Regional Head Athletic Trainer at the Cleveland Clinic in Cleveland, Ohio. I have a BS in Sports Medicine and a MA in Sport Administration. I have worked in the outpatient orthopaedic rehabilitation setting for nearly fourteen 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,

Steven K. Hart, MA, ATC

Submitter : **Miss. Jamie Puckett** **Date: 08/29/2007**

Organization : **North Georgia College and State Univeristy**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jamie Puckett. I am a Certified Athletic Trainer at North Georgia College and State University where I work as an Assistant Athletic Trainer and Professor for the 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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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,

Jamie M. Puckett, MEd., ATC

Submitter : Mr. Matthew Howe **Date:** 08/29/2007

Organization : Emporia State University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Matthew Howe and I am a Certified Athletic Trainer. I work at Emporia State University as an Assistant to the Athletic Training Education Program Director. It is my responsibility to advise current and prospective students on their future as an athletic trainer. Not only do I advise but I also instruct the students in various classes and have first hand experience in knowing what skills our students must leave here with after graduation. After spending a summer reviewing and re-organinzing our competencies, it is impossible to imagine that our students do not have what it takes to perform their jobs to the upper-most level.

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

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

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

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

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

Sincerely,

XXXXXX, ATC (and/or other credentials)

Submitter : **Sherman McMurray** **Date: 08/29/2007**

Organization : **Sherman McMurray**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Eric Neller **Date:** 08/29/2007

Organization : OUHSC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Increasing medicare reimbursement for anesthesia providers is very important in order to maintain quality anesthesia care.

Submitter : Ms. Robert Burke **Date:** 08/29/2007

Organization : VA Boston Healthcare System

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

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

My name is Robert Burke and I am a registered Kinesiotherapist who has been employed by the DVA for 24 years. I have been a staff therapist in the Physical Medicine and Rehab Service at both the Boston VA Medical center (5 years)
and the West Roxbury VA Medical Center (19 years).
As a staff Kinesiotherapist I have been providing specialized quality care and service in the form of therapeutic exercise and education to our veterans including rehab treatment in the areas of; spinal cord injury, amputee, cardiac rehab, orthopedics, neurology, general medical and mental health. I have provided clinical treatment to both acute inpatients and outpatients.

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 Amerieans, 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,
Robert J. Burke RKT/BS/M.Ed.
Staff Kinesiotherapist/ Physical Medicine and Rehab Service
VA Boston Healthcare System
West Roxbury Division
West Roxbury, Ma.

Submitter : **Mr. Andrew Carter** **Date: 08/29/2007**

Organization : **North Carolina State University**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Andrew Carter. I am a certified athletic trainer at North Carolina State University. I have been in the athletic training profession for 5 years. I have a bachelor s degree in athletic training and a master s degree in exercise science. I have two nationally recognized certifications, which are Athletic Trainer Certified (ATC) and Certified Strength and Conditioning Specialists (CSCS). I also hold a state license to allow me to practice athletic training in my state. As an athletic trainer I have a continuing education unit requirement to uphold to keep my certifications valid.

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,

Andy Carter ATC/LAT, CSCS

CMS-1385-P-10692

Submitter : Dr. Scott Stieber **Date:** 08/29/2007

Organization : Lancaster General Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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.

Scott F. Stieber, M.D.
Anesthesia Associates of Lancaster, LTD

Submitter : Mrs. Jessica Setzer **Date:** 08/29/2007

Organization : Occupational Health Group

Category : Other Health Care Provider

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Jessica Setzer. I am a Certified Athletic Trainer, licensed to practice in the state of Alabama. I attained my Athletic Training Certification in 2002. I have a Master s of Science in Kinesiology from Indiana University. I have a Bachelor s of Science in Biology with an Exercise Physiology emphasis from the University of Alabama in Huntsville. I am currently the Wellness Coordinator for Occupational Health Group. We offer on-site screenings, evaluations, and educational classes. I am also a PRN Certified Athletic Trainer for Huntsville Hospital Therapy Services. We offer medical care to area high school, middle school, college, and semi-pro athletic teams.

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,
Jessica Setzer, MS, ATC/L, CAOHC

Submitter : Dr. Anthony DiNardo **Date:** 08/29/2007

Organization : Dr. Anthony DiNardo

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Re: CMS -1385-p. There is, clearly, no clinical reason for this proposal. There are adequate review mechanisms and clear published guidelines covering the determination of need for x-ray evaluation of a patient. It is a doctor's responsibility to diagnose a patient before rendering or recommending treatment or other courses of action.This is a patient safety issue. This will simply add a significant roadblock to patients trying to access a doctor of chiropractic for their health care needs. Is that the ultimate purpose of this proposal?

Submitter : **Mr. Mark Rosen** **Date: 08/29/2007**

Organization : **Mr. Mark Rosen**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 27, 2007

Mr. Kerry Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1385-P
P. O. Box 8018
Baltimore, Maryland 21244-8018

SUBJECT MEDICARE PROGRAM: Proposed Revisions to Payment Policies Under the Physician Fee Schedule and Other Part Payment Policies for CY 2008: Proposed Rule

PHYSICIAN SELF-REFERRAL ISSUES

Dear Mr. Weems:

The purpose of this letter is to provide input and personal experiences relative to the issues surrounding physicians self-referral and the in-office ancillary services exception. I hope the following comments will further highlight the abusive nature of physician-owned physical therapy services, and demonstrate the support needed for physical therapy services removal from permitted services under the in-office ancillary exception.

As a background, I have been in private practice as a licensed physical therapist in Philadelphia, Pennsylvania for the past 33 years. I am a member of the American Physical Therapy Association and have been an independent practitioner during this time period. Over these many years, I have developed relationships with a variety of medical providers, who have trusted in me the rehabilitative care of many of their patients. Obviously, in a free enterprise system, patients had the opportunity to seek services in a variety of settings, including: private practices, hospitals and rehabilitation centers. With the present loop hole, physicians presently influence their patients to stay at their own facility to benefit themselves economically, often at the cost of potential outcomes.

After listening to a large majority of my referring physicians complaints about reimbursement issues causing difficulty in economic survival of their practice, many have said they have no alternative but to include physical therapy services within their practice as an opportunity to enhance their income. As you can imagine, this has caused an ongoing hardship for practitioners like me and others in similar circumstances. We have dedicated our professional lives and built reputations to enhance the well-being of people in our demographic regions. Indeed, it is more than ironic that we find ourselves in direct
August 27, 2007

competition with the aforementioned referring physicians who previously entrusted our care - now keeping those patients within their own practices for economic gain. There is certainly a conflict of interests and professionalism with this situation.

My own personal experience has identified many offices with inadequate staffing and treatment options that could not compare to those provided in most independent private practitioner facilities. Most physician-owned facilities target new graduate physical therapists that are willing to work for just slightly above normal entry level payment; thereby allowing the physicians to reap large profits for services they, themselves, do not personally provide. Obviously, there is incentivisation to continue treating these patients as long as possible, with the referring physician reaping the economic benefits. Physicians have often felt insulated with these arrangements, as the physical therapists are responsible for the patients care, as well as signing the charts&yet often aides and assistants provide the majority of services.

I certainly hope that CMS will take the appropriate steps to close this loop hole, which in my opinion will not just improve the quality of care for Medicare and Medicaid patient populations, but also will reduce spending with the elimination of self-referral.

Sincerely,

Mark J. Rosen, P.T.
MJR/cr

Submitter : Dr. Lee Staebler **Date:** 08/29/2007

Organization : Lee Staebler, P.T., P.C.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

My name is Lee Staebler. I am a physical therapist in Mattituck, New York. I have a D.P.T. degree and have been in private practice in Mattituck for over five years and have been practicing as a licensed physical therapist for over 19 years. I have provided quality service to hundreds of area patients and have earned the respect of many area doctors.

I am writing today to comment on the March 26 interim final rule on Physicians Referrals to Health Care Entities with Which They Have Financial Relationships (Phase II). The wording as it stands leads to concerns that the final rule will condone and most likely even promote physician-owned physical therapy facilities which, in my opinion, is a distinct conflict of interest and will open the door to more fraud and abuse that will take a toll on the already burdened Medicare system. Congress acted to protect physical therapy services, but there needs to be further work to prevent major loopholes which will actually hurt the profession.

Addressing and correcting the loophole factor in the subsequent Phase III regulations before the final policy is adopted is essential not only for physical therapists, but for the Medicare system. The potential for fraud and abuse is exponential when physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest. The situation is further compounded by Medicare s requirement of a physician referral for physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to over-utilize those services for financial reasons. Also, in physicians offices, services may be provided by non-physical therapists and billed under the physician s provider number as physical therapy services. There is no way to be sure with in-office ancillary services that the patient is receiving proper physical therapy from a qualified provider or is being treated by an aide.
Thank you for your consideration in this matter. It is an important item which impacts many people: physical therapists as well as beneficiaries.

Lee Staebler, P.T., D.P.T.

Submitter : **Date: 08/29/2007**

Organization : **Trinity Universtiy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dcar Sir or Madam:

My namc is Marc Powcll and I currcntly serve as the Head Athletic Trainer at Trinity University.

I am writing today to voicc my opposition to thc therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilitics proposcd in 1385-P.

Whilc 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 thesc proposed rulcs will create additional lack of access to quality health care for my patients.

As an athlctic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My cducation, clinical cxpericnce, 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,

Marc Powell LAT, ATC
Head Athletic Trainer
Trinity University
San Antonio, TX 78212

Submitter : **Dr. Thomas Cutter** **Date: 08/29/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I would like to express my enthusiastic support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS 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 unable to practice in areas with disproportionately high Medicare populations.

In an effort to rectify this unsustainable 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 ,

Thomas W, Cutter, MD

Submitter : **Ms. Amanda Tiffany** **Date: 08/29/2007**

Organization : **Lakeland Central School District**

Category : **Other Health Care Professional**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Dear Sir or Madam:

My name is Amanda Tiffany, and I have been a certified athletic trainer for 16 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.

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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,

Amanda Tiffany, ATC, LAT

Submitter : **Dr. Miguel Cruz Correa** **Date: 08/29/2007**

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. David Tonry** **Date: 08/29/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

? 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,

Name & Credential
David C. Tonry, CRNA
820 West College Ave
Jacksonville, IL 62650

Submitter : **Mr. Jamie Peterson** **Date: 08/29/2007**

Organization : **Cadillac Area Public Schools**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

See attachment.

CMS-1385-P-10702-Attach-1.DOC

10702

Dear Sir or Madam:

My name is Jamie Peterson, and I have been a Certified Athletic Trainer at Cadillac High School for the past ten years. My job is to provide quality health care to the numerous athletes as well as the faculty and staff at both the high school and junior high school levels. I graduated from Central Michigan University in 1998 with a bachelor's degree in sports medicine, and I also hold a teaching certification from Ferris 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,

Jamie Peterson, ATC

Submitter : Mr. Joseph Sharpe **Date:** 08/29/2007

Organization : Charlotte Bobcats

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Athletic trainers are a valuable health care provider that should not be restriced by law to provide care.

Submitter : **Dr. Guillermo Garcia** **Date: 08/29/2007**

Organization : **Miami Beach Anesthesiology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Guillermo Garcia, MD

Submitter : **Mr. Richard Boergers** **Date: 08/29/2007**

Organization : **Stony Brook University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Richard Boergers and I'm a certified athletic trainer. I currently am a professor of athletic training at Stony Brook University. I am a BOC certified athletic trainer, who graduated from a CAAHEP accredited athletic training program and I also have a masters degree in human performance (biomechanics and exercise physiology). As an athletic training educator, I can attest that our students complete rigorous standards prior to graduation and are extrememly well suited to care for injuries and illnesses of physically active people.

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,

Richard J. Boergers, MS, ATC

Submitter : **Mrs. Rebecca Anhold** **Date: 08/29/2007**

Organization : **Fort Defiance High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My Name is Becky Anhold. I am a Licensed, Certified Athletic Trainer at Fort Defiance High School in Fort Defiance, VA.

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,

Rebecca C. Anhold, VATL, ATC, EMT-Enhanced, EMT-Instructor

Submitter : **Dr. Jan Smith** **Date: 08/29/2007**

Organization : **University of Pittsburgh School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Jan D Smith MD
Clinical Professor
University of Pittsburgh School of Medicine

Submitter : Dr. Jonah Wassermann **Date:** 08/29/2007

Organization : Dr. Jonah Wassermann

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

With regards to Docket: CMS-1385P I am strongly opposed to this proposed change. It will have a negative impact on medicare patients access to quality chiropractic care. It will also cause patients to make unnecessary visitys to their medical doctors in order to obtain x-rays. This will greatly increase healthcare costs.

Submitter : Mr. Patrick Filipovitz **Date:** 08/29/2007

Organization : Mr. Patrick Filipovitz

Category : Device Industry

Issue Areas/Comments

Background

Background

I am writing this letter in support of your recently proposed Medicare regulations. I am currently employed with a privately owned and operated laser rental company that does not offer ownership to physicians. I am currently in a leadership role as a Regional Manager. I have worked for the last five years exposing and providing training for physicians on new technology and new surgical techniques that will enhance their practices and deliver a higher quality of care to the patients.

As the market for the use of lasers in medicine has grown, there have been businesses established that offer ownership to the end user, in our case the physician, creating what we believe to be an anti-competitive business environment. We welcome friendly competition in our business when decisions that are being made by the customer are based on availability of technology, service levels and marketing efforts. We have experienced that when a business model compensates the end user for increased usage of a service without personally incurring cost for the service, several unhealthy behaviors may happen as a result. The results are unhealthy for our business but more importantly for the patient and the healthcare system. The behaviors that may occur that are of most concern are listed below:

" Over-utilization of services driving increased insurance claims.
" Steerage of business from one location to another or threatening to do so based on increased compensation for the end user. This eliminates the hospital s ability to choose their business partners based on quality of technology, service and competitive pricing.
" Utilization of antiquated or lesser technology to contain cost and keep profitability of the company delivering the services as high as possible. The patient will not be receiving the best possible procedure.

I understand the physician s desire to maximize their earning potential but it should not continue in the form of the physician owned LLC delivering technology services on a per case basis. If additional revenue opportunities are needed to drive the behavior of the physicians to do what is right for the patients and healthcare, it should be done in the format of direct reimbursement for professional services.

Submitter : **Mrs. Tami mcdonald** **Date: 08/29/2007**

Organization : **aana**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Administrator:

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

This increase in Medicare payment is important for several reasons.

? 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,

_____

Name & Credential
Tami McDonald, CRNA
357 s. CHERRY ST.
PITTSFIELD, IL 62363

Submitter : **Dr. Beth Ann Traylor** **Date: 08/29/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Beth Ann Traylor M.D.

Submitter : Mr. Dennis Dyer **Date:** 08/29/2007

Organization : University of Michigan, MedSport

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Patrick Dyer. I received an Undergraduate Degree in Sports Medicine, am a Certified Athletic Trainer and most recently completed my MBA. I have been employed by the University of Michigan Hospital as an Athletic Trainer for 13 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,

D. Patrick Dyer, ATC MBA

Submitter : **Mr. Thomas Iannetta, ATC, CSCS** **Date: 08/29/2007**

Organization : **Cleveland Clinic**

Category : **Other Practitioner**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Thomas Iannetta,ATC,CSCS. I have nearly 20 years of experience as a Certified and Licensed Athletic Trainer as well as a Certified Strength and Conditioning Specialist in the State of Ohio. I am employed by the Cleveland Clinic (one of the top hospital systems in the United States as documented by US News and World Report). 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.

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Sincerely,

Thomas A. Iannetta,ATC,CSCS

Submitter : **Miss. Mary Bennett** **Date: 08/29/2007**

Organization : **Meadows Wellness Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Mary Bennett and I am a Certified Athletic Trainer at Meadows Wellness Center in Vidalia, Georgia. Along with providing outreach services to local high schools, I also provide Athletic Training services to patients in our Rehabilitation Clinic.

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.

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Sincerely,

Mary W Bennett, ATC, LAT

Submitter : **Dr. Beth Ann Traylor** **Date: 08/29/2007**

Organization : **Anesthesia Consultants of Indianapolis**

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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Thank you for your consideration of this serious matter.

Sincerely,

Beth Ann Traylor M.D.

Submitter : **Mrs. beverly barron** **Date: 08/29/2007**

Organization : **Baptist Hospital**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am against Physician Owned clinics. I believe this leads to over utilization of services for the wrong reasons.

Submitter : **Mr. Clint Vogel** **Date: 08/29/2007**

Organization : **Mr. Clint Vogel**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

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Sincerely,

Clint R. Vogel CRNA
Name & Credential

8543 Foal Ct.
Address

Gainesville, VA 20155
city, State ZIP

Submitter : **Date: 08/29/2007**

Organization :

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

I urge you to abolish the amendment that would not allow chiropractors the right to refer a patient to a radiologist or non-treating physician for x-rays. The amendment would not pay for said x-rays and become a hardship to patients. I treat about 40% medicare patients and they really struggle financially. It will keep them from getting needed care and accurate diagnoses.

Submitter : **Dr. Edwin Maldonado** **Date: 08/29/2007**

Organization : **Dr. Edwin W Maldonado, M.D., P.L.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Dr. Edwin Maldonado

Submitter : **Dr. Hong Lam** **Date: 08/29/2007**

Organization : **Dr. Hong Lam**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

Hong Rick Lam MD

Submitter : Ms. Natalie Bumpas **Date:** 08/29/2007

Organization : Appalachian State University

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I am a newly-certified athletic trainer at Appalachian State University providing care to injured students. I became certified this summer after graduating from Indiana University in May of this year. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for patients. As an athletic trainer, I am qualified to perfomr physical medicine and rehabilitation services, which I am certain you know is not the same as physical therapy. My years of education, clinical experience, on-site learning, national certification, and pending state licensure ensure that my students and patients elsewhere receive quality healthcare. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards. Teh lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible of the CMS, whose responsibility is to be concerned wtih 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 to ensuring patients receive the best, most cost-effective treatment available. Since CMS appears to have come to these proposed changes without clinical or finanacial justification, I strongly encourage CMS to consider the recommendations of those professionals that are tasked wtih overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Natalie Bumpas, ATC

Submitter : Mr. Timothy Adams **Date:** 08/29/2007

Organization : Mr. Timothy Adams

Category : Physical Therapist

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Timothy J. Adams. I am a Certified Athletic Trainer and a Physical Therapist. I have been practicing in the state of Maine for the last 28 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,
Timothy J. Adams, M.P.A., P.T., A.T.C.
Director of P.T. & Sports Medicine
Colby College
Waterville, ME. 04901

Submitter : **Mr. Todd Gaddis** **Date: 08/29/2007**

Organization : **Kansas Orthopaedic Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am a Certified Athletic Trainer, licensed in the state of Kansas that works for Kansas Orthopaedic Center in Wichita Kansas. I work as a physician extender in the clinic for one of the orthopedic surgeons as well as serving as a outreach athletic trainer to a local public high school five days a week. I provide many quality therapy services in both areas of my job.

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 Gaddis, ATC, LAT

Submitter : Mr. **Date:** 08/29/2007

Organization : Mr.

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Shawn Hendi and I am a Certified Athletic Trainer working at the University of Maryland - College Park. I have been a certified ATC for nine years after receiving my Master of Science degree in Health and Human Performance. My employment in those nine years have involved 7 years in the University setting and two years in the secondary school 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.

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,

Shawn Hendi, MS, ATC

Submitter : Mr. Gregory Janik **Date:** 08/29/2007

Organization : King's College

Category : Other Health Care Professional

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Gregory Janik, MS, ATC, and I am an Associate Clinical Professor and Head Athletic Trainer at King s College in Wilkes-Barre, Pennsylvania.

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,

Gregory K. Janik, MS, ATC

Submitter : **Mr. Thomas Morgan** **Date: 08/29/2007**

Organization : **Archbishop Spalding High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Thomas Morgan. I am the Head Athletic Trainer at Archbishop Spalding High School. I am certified by the NATABOC and hold a Bachelor and Master of Science Degrees 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 opportunity to state our professional education,qualifications or credentials. I, however am more concerned that these proposed rules will create additional lack of access to quality health care for all 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. 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,

Thomas J. Morgan, MS, ATC, PES(and/or other credentials)

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Administrator,

Thank you for your time. With the case of Physician self-referral, the 'in-office ancillary services' exception, due to it's broad definition, facilitates the creation of abusive referral arrangements. Physicians use this loop-hole to sequester patients from their right to choose the quality of care they deserve.

I've personally had patients tell me that they liked the care they received from our facility better than that at their physicians office but that the physician told them they 'had to go to their physical therapist.' These patients told me that they felt 'intimidated' by their physicians. I was also told that more often than not the physician was not present in the building that these services were rendered.

I can only speak from my own personal experience when I say that such arrangements do not serve the public interest in the realms of quality of care and the fiscal responsibility of the government to manage the cost health care through its services.

Once again, thank you for your time.

A concerned physical therapist.

Submitter : **Dr. James Schlesinger** **Date: 08/29/2007**

Organization : **Dr. James Schlesinger**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter
James Schlesinger, MD

Submitter : **Mr. Elton Hawley** **Date: 08/29/2007**

Organization : **Carolinas HealthCare System**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

August 29, 2007

Dear Sir or Madam:

I am an athletic trainer employed by Carolinas HealthCare System. I have been a NATABOC certified athletic trainer for thirty seven (37) years and was the 10th person in the state of NC to be licensed as such upon passage of our licensure bill in 1996. I have seen growth in our profession from a point in which you could recognize and call by name almost everyone in the profession to our current state of nearly 30,000 members world wide. I have worked as an athletic trainer in the secondary school setting, in professional football, and currently in the hospital setting.

I am writing to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P. While I am concerned these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create an additional lack of access to quality health care for 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 my patients receive quality health care. I function under NATABOC practice guidelines, NC Board of Athletic Trainer Examiners guidelines, and a rigid set of protocols under the license of our Directors of Sports Medicine for Carolinas HealthCare System who helped develop the protocols and annually review and edit the protocols for content relative to changes that come about in patient care. As you can see, what I do for patients is regulated at the National, State, and local levels. By virtue of passing the national certification exam, attaining state licensure, and being deemed qualified by hospital medical professionals to perform the services of an athletic trainer it appears the propose regulations are an attempt to circumvent those standards. The proposed regulations will create an even greater deficit or workforce shortage of therapists than currently exists and this translates into a lack of access to necessary patient care. It will also legislate many athletic trainers out of a job. 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 you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital rehabilitation facility.

Sincerely,

Elton G. Hawley, ATC, LAT
Carolinas HealthCare System

Submitter : **Dr. James Schlesinger** **Date: 08/29/2007**

Organization : **Dr. James Schlesinger**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter,
James Schlesinger, MD
James3220@comcast.net

Submitter : Dr. Barry Brasfield, M.D. **Date:** 08/29/2007

Organization : Anesthesia Business Management, LLC

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Regarding the proposed increase in payment for anesthesiology services, I have been in practice for 19 years, now running practices in five locations (3 hospitals, 2 ASCs). While the payer mix in the ASCs is sufficient to support the staff there (because Medicare and Medicaid populations are low there), in all three hospitals, there is substantial subsidy support from the hospital coffers to pay anesthesia providers (all 3 have Anesthesia Care Teams in ratios of about 3 CRNAs per anesthesiologist) due to the low reimbursement from government payors. The best current estimate from the American Society of Anesthesiologists is that about 3 out of every 4 hospitals subsidize their anesthesia departments! Medicare currently pays about 20-22% of 'full charge,' and about 35-40% of Blue Cross Blue Shield reimbursement rates in Tennessee. If anesthesia is to survive as a specialty without burdening their hospitals to find willing providers in this market, Medicare rates need desperately to be increased; otherwise, providers will continue to flock to ASCs and office based practices, leaving our cash-strapped, low margin hospitals struggling for anesthesia staff. Thank you for your consideration of this vital need for our hospitals.

Submitter : **Date: 08/29/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Gainesville, FL as part of the Section of Dermatopathology at the University of Florida Department of Pathology, Immunology and Laboratory Medicine.

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

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

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

Sincerely,

Vladimir Vincek, M.D., Ph.D.
Professor and Director, Dermatopathology
Department of Pathology, Immunology and
Laboratory Medicine
College of Medicine

CMS-1385-P-10734-Attach-1.PDF

10734

UF | UNIVERSITY of FLORIDA

College of Medicine
Department of Pathology, Immunology and Laboratory Medicine

PO Box 100275
Gainesville, FL 32610-0275
352-392-3741
352-392-6249 Fax

August 6, 2007

Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled "Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008." I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Gainesville, FL as part of the Section of Dermatopathology at the University of Florida Department of Pathology, Immunology and Laboratory Medicine.

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

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Sincerely,

Vladimir Vincek, M.D., Ph.D.
Professor and Director, Dermatopathology
Department of Pathology, Immunology and
Laboratory Medicine
College of Medicine

Submitter : **Date: 08/29/2007**

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.

Submitter : Mr. Richard Bryant PT **Date:** 08/29/2007

Organization : APTA

Category : Comprehensive Outpatient Rehabilitation Facility

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

APTA strongly supports any efforts to eliminate abusive financing arrangements under the Stark law that are created solely for profit without regard to the best interest of the Medicare beneficiary. The Association strongly urges the CMS to remove physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws.

Submitter : **Date: 08/29/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

see attached

Submitter : **Dr. David McFarland** **Date: 08/29/2007**

Organization : **Washington University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Landirs Williams **Date:** 08/29/2007

Organization : NorthEast Anesthesia and Pain Specialists, LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

this is for the revisions of payment policies under the physician fee schedule.

CMS-1385-P-10739-Attach-1.DOC

Submitter : **Mr. Joel Langemaat** **Date: 08/29/2007**

Organization : **STAR Physical Therapy**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am an Athletic Trainer that works with STAR Physical Therapy. We are a company that employs over 60 Athletic Trainers in the Tennessee, Kentucky, and Indiana areas. We have over 60 Physical Therapy clinics in these areas also. I graduated from Purdue University with a bachelors degree in athletic training and have been working with STAR Physical Therapy for two and a half years in an outpatient clinic.

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,

Joel Langemaat, ATC
STAR Physical Therapy

Submitter : **Mrs. Kelly Harrison** **Date: 08/29/2007**

Organization : **East Stroudsburg University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

As a certified athletic training in the state of Pennsylvania I have worked for many years providing care for physically activity individuals of all ages. I am both nationally and state certified, holds a Master s Degree in Health Sciences, and am currently pursuing my Doctor of Science 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.
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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,
Kelly Harrison, MS, ATC

Submitter : Ms. Christine Nelson **Date:** 08/29/2007

Organization : Lynden Therapy Specialists

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam: My name is Christine Nelson and I am a Certified Athletic Trainer. I have a BA in Exercise Science and have been Certified for 16 years and co-own 2 Physical and Occupational Therapy private practices which are both Certified Rehab Agencies. I work with local high schools to provide onsite emergency medical coverage for all athletic events as well as assisting with the rehabilitation of our patients within our clinics. It is astounding to me that we deem PTA's and COTA's as qualified to provide rehab services in this country but choose to exclude ATC's who have significantly more schooling, extensive training and proven skills to provide these services.

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 Nelson, ATC

Submitter : **Date: 08/29/2007**

Organization :

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

'MEI'

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. Both patient and Doctor will suffer by taking away this diagnostic tool as you open every Doctor of Chiropractic to malpractice lawsuits by not having the ability to identify many bone disorders associated with advanced age or cancerous conditions that may be present.

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,

Helen D

Submitter : **Dr. Jon Halling** **Date: 08/29/2007**

Organization : **Dr. Jon Halling**

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.

Jon D Halling MD

Submitter : **Mr. Wesley Adams** **Date: 08/29/2007**

Organization : **Trinity School of Midland, TX**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Wesley Adams. I am a contract athletic trainer at Trinity School in Midland, TX. I have a B.S. in Athletic Training/Clinical Management and a Master's degree in Business Administration. I am certified by the National Athletic Trainers' Association and licensed by the state of Texas.

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,

Wesley Adams, MBA, ATC/L

Submitter : **Mr. Philip Russell** **Date: 08/29/2007**

Organization : **South Texas Radiology Group**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attached Word file.

CMS-1385-P-10746-Attach-1.DOC

CMS-1385-P-10746-Attach-2.DOC

Submitter : **Dr. Jacob Cornett** **Date: 08/29/2007**

Organization : **Dr. Jacob Cornett**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-10747-Attach-1.DOC

CMS-1385-P-10747-Attach-2.DOC

10747

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.

Our seniors deserve the best possible medical care. My colleagues and I have trained long and hard to develop the expertise necessary to provide that care. Although we work with the simple goal of helping others, just compensation for our efforts is only fair. The conversion factor adjustment takes an important step in rectifying a very unfair situation.

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. dawn thrasher** **Date: 08/29/2007**

Organization : **Henry Ford Health system/ Marian high school**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-10748-Attach-1.WPD

CMS-1385-P-10748-Attach-2.WPD

#10748

Dear Sir or Madam:

My name is Dawn Thrasher, and I work for Henry Ford Health Systems as a clinical/outreach athletic trainer. I am providing rehabilitation to our patients and my students at my high school.
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,

Dawn Thrasher, ATC , PES-NASM

PHYSICIAN SELF-REFERRAL PROVISIONS

We laud CMS attempts to address self-referral issues that are undoubtedly a leading cause of overutilization of imaging services. We have some comments and concerns about specific provisions in the Proposed Rule:

1. **Changes to Reassignment and Physician Self-Referral Rules Relating to Diagnostic Tests (Anti-Markup Provision)**

a) We strongly urge you to impose an anti-markup provision for the TC of medical imaging services. It appears that the best way to do this is with a simple regulation that prohibits billing Medicare for any amount in excess of what was paid by the billing entity. (As you point out in the Proposed Rule, you will need to make the language somewhat more complex to prohibit those who would "game" the system with rent kickbacks and the like.) This removes all profit-motivated incentives to purchase TC. Such a regulation, working in unison with "Stark" prohibition on referral of patients to an entity in which an ownership position is held, would appear to preclude the referring physician from profiting from referrals except by way of the in-office exception.

b) You are proposing in §414.50 that - …."(2) the anti-markup provision for the TC and PC apply to all arrangements not involving a reassignment from a ***full-time employee*** of the billing entity;

Our concern here is with the use of the phrase "*full-time employee*", particularly without defining the term. The term "full-time" can mean many different things to many people and can be twisted in a fashion to skirt the rules.

Ours is a professional radiology practice. We have a number of employed radiologists who are not considered to be full-time employees. Some work as little as 12 hours each week and others work only a few weeks per year. We do not believe it is your intent to disqualify them from being able to reassign their benefits to our incorporated practice, simply because they are nearing retirement or because they are women who choose to work partial schedules while rearing children. We suggest that you alter the proposal to ***exclude only TC and PC furnished by providers who are employed to provide services exclusively to the billing entity***. Thus, you would establish that: (a) the provider must be an employee of the billing entity, and (b) the provider cannot be producing services for more than one billing entity. This accomplishes your purpose, without imposing unwanted constraints on how the physician labor force is contracting for work in the free market.

There is an additional facet to this issue that is somewhat unique to radiology practices, since they are not in a position to refer patients. Many professional radiology practices have entered into joint venture business arrangements with

hospitals to own and operate outpatient medical imaging centers. This is an important trend to allow, since the profits generated by the ventures give financial stability to community hospitals that would otherwise see these revenue streams evaporate entirely as outpatient imaging continues to migrate out of the hospital walls. Due to the corporate practice of medicine doctrine, these joint ventures do not directly employ physicians, but they typically contract with the professional radiology practice to provide the PC for these services. Clearly, the radiologists in the professional practice group are neither *"full-time employees"* nor *"exclusively employed"* by the imaging center to whom they are currently reassigning their benefits for providing these services. Therefore, you need to allow an exception for enterprises located outside of hospital walls, that are jointly owned by radiologists and hospitals, and to which the partial-owner radiologist physicians are exclusive providers of the professional services.

3. **In-Office Ancillary Services Exception**
Your statement that "In sum, these types of arrangements appear to be nothing more than enterprises established for the self-referral of DHS." is right on the mark!

In response to your solicitation of comments, we offer the following possible solution, modeled after the logic of the supervision rules for medical imaging tests. Divide DHS into three or more categories. Possible categories are:

- Assign to one category those services that are of a non-complex nature. (e.g. simple tests exempt from CLIA) These services are eligible for billing to Medicare when provided anywhere.
- Assign to the next category those services that require interpretation by a trained physician, but that do not require patient preparation, do not require expensive equipment (i.e. cost <$250,000 when purchased new) or complex evaluation. (e.g. a CBC or a chest x-ray) These services are eligible for billing to Medicare when provided by a licensed physician in a centralized building.
- Assign to the highest category those services that are most complex and require patient preparation, and/or that do require expensive equipment (i.e. cost >$250,000 when purchased new) and where board certification in a medical or surgical specialty is considered a standard for interpreting the examination.

5. **Unit-of-service (Per-Click) Payments in Space and Equipment Leases**
Your concerns are warranted, as the types of arrangements cited are abusive in nearly every setting. If someone owns equipment, then he needs to compete in the marketplace and try to make a profit. If he is unable to do so, he should not be saved by a false demand that rewards the referring physician financially for having requested a service for his patient. The corollary is that if a referring

physician wants to make profits on imaging, he should do as others have done and be at risk for a capital investment. He should not be rewarded with profits for intermittent referrals when he has no capital at risk.

a) Absolutely, you should prohibit unit-of-service payments to a physician lessor when patients he refers receive services on the equipment that is subject to such a lease.
b) And yes, you need to promulgate a rule whereby it is illegal for a physician to lease equipment from a hospital lessor for use on a patient that the physician has referred. Since we should anticipate that some physicians and attorneys might scheme with a hospital to set up "cross-referral" arrangements, the only sure mechanism to prevent abuse is to entirely prohibit unit-of-service lease arrangements for physicians who are either lessors or lessees directly, or indirectly as owners of a lessee or lessor entity.

6. **Period of Disallowance for Noncompliant Financial Relationships**
Generally, you could consider setting up two alternatives for defining the period of disqualification, which period should begin within 6 months of the publication of the Final Rule:

a) No trailing period of disqualification- When the parties sign a document setting forth their belief that the arrangement had an appearance of non-compliance, AND they revise the financial arrangement substantially.
b) Trailing three year period of disqualification- Many contracts for services, lease space and equipment leasing have terms of 3 to 5 years. If the parties do not select option a), above, then they must be willing to live with a period of disqualification of three years from the effective date of the options.

11. **Services Furnished "Under Arrangements"**
We have witnessed in our own local market what we believe to be the type of abusive arrangement described in the Proposed Rule. Referring physicians were invited to invest in a "Services Company" that purportedly leased employees and equipment to an imaging center and provided management services to the center. By virtue of a sliding scale of compensation, the Services Company had more profit to distribute with increased referrals.

Rare would be circumstance that a hospital or a free standing imaging center would need the capital of referring physicians to finance its operations, if it has a solid business model and provides good services. All such arrangements should be considered thinly disguised forms of kickbacks and need to be banned entirely.

Submitter : **Mrs. Cindy Binkley** **Date: 08/29/2007**

Organization : **American Kinesiotherapy Association/CPW Rehab**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 29, 2007

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

BRIEF INTRO ABOUT SELF: I am a kinesiotherapists and the administrator at CPW Rehab in Toledo, Ohio. I received a Bachelor in Education, with specialization in Kinesiotherapy from the University of Toledo in 1988 and am certified by the American Kinesiotherapy Association. Throughout my career I have had extensive continuing education to advance my clinical knowledge as well as in Business Management and Leadership.

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 #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. 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,

Cindy M. Binkley, RKT
Administrator

Submitter : **Dr. John Dallman** **Date: 08/29/2007**

Organization : **Dallman Chiropractic**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

To not be able to refer to a medical facility for X-rays will only cause a reduction in the quality of care given to our senior's. X-ray reveals more than just subluxations. Pathologies can be detected that will help insure proper care for these individuals. No Doctor of Chiropractic takes X-rays for the sole purpose of subluxation detection. We are held accountable to the reasonable and appropriate care that any other provider is responsible for, therefore we take X-ray's to help determine the best diagnosis and care plan for our patients.

Dr John Dallman, D.C.