CMS-1385-P-11380

Submitter : **Mrs. Joanna Goldin** **Date: 08/29/2007**

Organization : **Sport and Spine Physcial Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To Whom it May Concern

As the owner of a private outpatient Physical Therapy clinic in Denver, Colorado I have been directly impacted by the physicians who own practices that provide physical therapy services. Firstly they lured away two of my PTs, both of whom eventually returned to me as they dod not approve of the ethics of the practices they went to. Secondly these physicians, prior to hiring their own therapists sent us a fair number of patients, aftr they opened their own practice they referred all their patients to their own clinic, even if it was geographically not ideal and some of these elderly patients had to drive a long way for treatment. The hardship that this caused them frequently undid the good of the therapy!
The potential for abuse in a sitation where you profit from the referral of your patients to PT is huge and I urge you to consider this in your decision making. Many patients go to PT on a regular basis, at least for a period of a few weeks, it is no more convenient for them to go to the Physician office than to their local, independently owned, very competent Physical Therapy clinic.

Tahnk you for considering these comments,

Joanna Goldin PT

Submitter : **Dr. Hiroshi Goto** **Date: 08/29/2007**

Organization : **Dr. Hiroshi Goto**

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.

Hiroshi Goto

CMS-1385-P-11383

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

Organization : **Associated Anesthesiologists, P.A.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

CMS-1385-P-11384

Submitter : Mrs. Sharon Brandt **Date: 08/29/2007**

Organization : Mrs. Sharon Brandt

Category : Health Care Professional or Association

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Sharon Brandt

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

Organization : **Abraxis BioScience**

Category : **Drug Industry**

Issue Areas/Comments

Drug Compendia

Drug Compendia

DRUG COMPENDIA

Abraxis Oncology, a Division of Abraxis BioScience, wishes to submit comments to CMS on the proposed process by which the agency accepts requests for addition and/or elimination of compendia.

As stated in the proposed rule, the United States Pharmacopoeia-Drug Information (USP-DI) Section 1861(t)(2) of the Act provides the Secretary the authority to revise the list of compendia for determining medically-accepted indications for drugs. Due to changes in the pharmaceutical reference industry, fewer of the statutorily named compendia are available for our reference and that Section 6001(f)(1) of the DRA amends both sections 1927(g)(1)(B)(I)(II) and 1861(t)(2)(B)(ii)(I) of the Act by inserting (or its successor publications) after United States Pharmacopeia-Drug Information . We interpret this DRA provision as explicitly authorizing the Secretary to continue recognition of the compendium currently known as USP-DI after its name change if the Secretary determines that it is in fact a successor publication rather than a substitute publication.

We ask that CMS confirm this information in the final rule with specific direction that the successor compendium to the USP DI is DrugPoints/DRUGDEX.

The agency also mentions that In contrast, others have suggested that the Secretary consider elimination of certain listed compendia . We ask that the agency not consider the elimination of a certain listed compendia within the calendar year. Accepting and deleting compendia annually or as CMS internally generates a request at any time causes huge confusion and inconsistency amongst Medicare contractors, providers and beneficiaries. The possibility of constant change in recognized compendium could result in a beneficiary having coverage for their cancer therapy one day and not the next. How do providers work with Medicare contractors to ensure coverage throughout a beneficiary's cancer therapy?

Many Medicare contractors have LCDs with mention of compendia as a source of coverage. There is unnecessary administrative burden on contactors to continually update their LCDs with the most current accepted (or deleted) compendia. The result of continuous compendia change will be numerous outdated LCDs. Changing accepted compendias annually, or anytime during the year as CMS wishes, ensures great confusion and frustration amongst providers and beneficiaries.

Private payers often look to Medicare policy and guidelines. If CMS adopts this annual process of accepting and deleting compendia, private payers will view the accepted compendia data less favorably and all compendia sources will lose credibility.

Lastly, how does the agency plan on communicating the revolving changes in accepted compendia? Even with regular CMS communication it will be unfeasible for each Medicare contractor and providers to monitor the changes and adapt them to their treatment guidelines, internal policies and LCDs.

If CMS wishes to establish a compendia application process new compendia should be considered every five years rather than annually. There should not be an option of deleting accepted compendia unless it is no longer published.

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

Organization : **Dr. James Rawls**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Regarding a proposed decrease in Medicare/Medicaid physician reimbursement: The free market (cash paying patients) have determined the value of service by anesthesiologists to be more valueable than what they are currently paid by government payors. There is currently a shortage of anesthsiologists. Reducing payments to them would surely result in a reduction of quality and/or availability of services for the patients Medicare and Medicaid who deserve to have good care. Do the right thing.

Thanks for your time and efforts to discern the best path,

James T. Rawls MD

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

Organization : **Mr. Rick Scott**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Rick Scott

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

Organization : **PT Northwest**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-11389-Attach-1.DOC

#11389

Dear Sir or Madam:

I am currently an athletic trainer at an outpatient physical therapy clinic in rural Oregon and also the certified athletic trainer at a local high school covering all sporting events, and providing injury prevention, immediate first aid, injury evaluation, referral and rehabilitation. I have been a certified athletic trainer for six years and received my bachelor's degree from Oregon State University and my Masters degree from Oklahoma State University. I have maintained my certification in good standing and continually exceed the 80 hours of continuing education that is required every three years to maintain this certification.

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,

Jeremy Ainsworth MS, ATC
Head Athletic Trainer
Central High School
Office (503)838-4244
Mobile (503)881-7671
Email: jainsworth@ptnorthwest.com

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

Organization : **Mr. Davin Cronin**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Davin Cronin

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

Organization : Lake City VAMC

Category : Other Health Care Provider

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

I have been a Kinesiotherapist at the LC VAMC. I have ben treating our veterans for over 22 years.

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

Organization : **james tobin**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Christy Cronin** **Date: 08/29/2007**

Organization : **Ms. Christy Cronin**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Sincerely,

Christy Cronin.

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

Organization : **Blake Reuter**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Miss. Kristen Prentiss** **Date: 08/29/2007**

Organization : **Miss. Kristen Prentiss**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

I object to the proposed "Therapy Standards and Requirements" in the CMS regulations (docket 1385-P.

Submitter : **Ms. Jacquelynn Davis** **Date: 08/29/2007**

Organization : **Children's Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jacquelynn Hope Davis, an athletic trainer that works for Children s Hospital in Columbus, Ohio. My job is multi-faceted and am used in many different ways. I work along with the physicians as a physician extender helping in sports medicine clinics, also I am a clinical trainer running patients through functional rehabilitation programs, and working as a traditional trainer at the high school setting doing training room hours and event coverage. I have my Bachelor of Science in Education/Sports Medicine & Athletic Training (University of Akron), Bachelor of Arts/Dance (University of Akron), and my Master of Science in Education/Exercise Physiology & Adult Fitness (University of Akron). I am certified by the NATABOC and licensed by the State of Ohio. I am a member of the NATA, OATA, GLATA, ACSM, & IADMS.

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,
Jacquelynn Hope Davis

CMS-1385-P-11397

Submitter : Ms. Catherine Cronin **Date:** 08/29/2007

Organization : Ms. Catherine Cronin

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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Thank you for your consideration of this serious matter.

Sincerely,

Catherine Cronin

Submitter : **Ms. Kathy Scott** **Date: 08/29/2007**

Organization : **Ms. Kathy Scott**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Sincerely,

Kathy Scott

CMS-1385-P-11399

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

Organization : Stephen F. Austin State University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Sanford (Sandy) Miller, I am the Head Athletic Trainer at Stephen F. Austin State University, I am certified athletic trainer and a member of the NATA in good standing.

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,

Sanford (Sandy) Miller ATC, LAT

CMS-1385-P-11400

Submitter : Ms. Joyce Klee **Date:** 08/29/2007

Organization : Clinton Physical Therapy Center

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Administrator,
As a Physical Therapist for over 20 years I have seen many changes in the practice of physical therapy including the rules and regulations by which we practice. I have co-owned a private practice physical therapy clinic for over 19 years in east Tennessee and my clinic has been directly affected by several of these changes. The most disturbing has been the loopholes in the Stark physician self-referral law that has prompted a proliferation of physician owned referral-for-profit physical therapy offices not only in my geographic area but also around the country. The plain, simple fact is that physician owned physical therapy offices create an inherent incentive for physicians to refer to their own facilities for financial gains instead of referring to non-physician owned facilities that might otherwise be more qualified, economical and/or convenient for the patient. The Florida OIG report clearly identified over-utilization in the 1990 s and it is apparent that today s trend has not changed.

When one of the local orthopedic offices in the next town opened their own physical therapy office, my referrals dropped a whopping 70% from one of the physicians in that office with a 30%-50% drop from 3 of the other physicians. These patients are not patients that live any closer to the orthopedic office. These are patients that had they been given a choice would probably not have chosen to travel farther to obtain physical therapy services. Some of these patients have been previous patients at my facility and feel guilty afterwards for allowing the physician to convince them to attend the physician owned office.

It has been sad to hear how physicians have manipulated their patient s into attending physical therapy at the physician owned offices. Comments by the physicians have included such phrases as You need to go to my office so I can keep track of you, I can t be your doctor anymore if you don t come to my physical therapy office. It is difficult to fathom why physicians would utter these comments if none other than financial gains.

As if manipulating patients isn t enough, the physician offices have devised ways to arrange roadblocks for us to access these patients. One physician office has used HIPAA as a way to circumvent referrals to our facility. They have stated that it would be a violation of HIPAA to call or fax a referral to my physical therapy clinic. Of course, they have no problem arranging appointments at their own physical therapy office. I have never encountered a HIPAA problem when my own family physician has sent a referral for tests or a consult with another physicians. I do not think HIPAA only applies to physical therapy referrals to non-physician owned facilities.

Physician self-referral to physician owned physical therapy facilities is a blatant abuse of the in-office ancillary services exception to the federal physician self-referral laws. It is obvious that physical therapy services should be included in the in-office ancillary service exception.

Sincerely,

Joyce S. Klee, PT
TN Lic# 1501

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

Organization : **Mr. Chad Cronin**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P
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,

Chad Cronin

Submitter : **Dr. Stanley Miller** **Date: 08/29/2007**

Organization : **Johns Hopkins Hospital**

Category : **Physician**

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

August 29, 2007

The Honorable Herbert Kuhn
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Washington, D.C. 20201

RE: CMS 1385-P; 2008 Medicare Fee Schedule
Coding Multiple Procedure Payment Reduction for Mohs Surgery

Dear Acting Administrator Kuhn:

I am writing to express my deep concern about the above-noted proposed ruling, specifically section II.E.2 (P-122) of the 2008 Medicare Fee Schedule Proposed Rule. I would add at the outset that hundreds of my Medicare aged patients have written to our Maryland legislators to express their identical concerns during these past few months.

This proposal represents a dramatic reversal of sixteen years of the Centers for Medicare and Medicaid Services (CMS) own determination that the Mohs codes are and should be exempt from the Multiple Procedure Reduction Rule (MPRR). Furthermore, because of the dual components of surgery and pathology associated with each Mohs surgery procedure, there is no gain in efficiencies when multiple separate procedures are performed on the same date, making application of the reduction inappropriate.

This rule will negatively impact the care of Medicare beneficiaries with skin cancer who require Mohs surgery. These patients will be required to return to their Mohs surgeons office multiple times for treatment of multiple cancers, and multiple times if surgical reconstruction of the resulting defects are required, because it can no longer be performed on the same day. This places a tremendous burden on the patients and their families, in terms of both time and money (travel and wages lost) that is not currently calculated in any meaningful fashion. In the process, no financial gains for CMS will be obtained. Surgery for additional skin tumors and surgery for reconstructive closures will simply be performed on additional days, which the patients will be required to return for.

I urge you strongly to consider negating this proposed new ruling, and reinstate exemption of the Mohs surgery codes from the MPRR.

Sincerely,

Stanley J. Miller, M.D.

Submitter : Mrs. Donna Sullin **Date: 08/29/2007**

Organization : Mrs. Donna Sullin

Category : Health Care Professional or Association

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter

Sincerely,

Donna Sullins.

Submitter : **Ms. Kristen Scott** **Date: 08/29/2007**

Organization : **Ms. Kristen Scott**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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Thank you for your consideration of this serious matter.

Sincerely,

Kristen Scott

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

Organization : **University of Maryland**

Category : **State Government**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:
My name is John J. Bush. I am a certified Athletic Trainer working at The University of Maryland in College Park, Maryland. I have been employed here since July 1972. I thoroughly enjoy my job as an Athletic Trainer and feel that over the past 34 years I have had a positive influence on a great number of young men and women
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,
John J. Bush, ATC

Submitter : **Ms. Douglas Sullins** **Date: 08/29/2007**

Organization : **Ms. Douglas Sullins**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Douglas Sullins

CMS-1385-P-11407

Submitter : Dr. vernon merchant **Date:** 08/29/2007

Organization : greenville anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Sincerely,

Vernon E. Merchant MD

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

Organization : **Manhattan College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

My name is Douglas Straley. I am a Certified Athletic Trainer, currently licensed in the State of New York, and employed as the Director of Sports Medicine at Manhattan College in Riverdale, New York. I recieved my Bachelors Degree at Northeastern Univeristy, in Boston, Massachusetts, and my Masters of Science Degree at the University of Tennessee at Chattanooga.

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,

Douglas Straley MS, ATC, CSCS
Director of Sports Medicine

Submitter : **Mr. Booker Brown Jr.** **Date: 08/29/2007**

Organization : **Champion Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I am a practicing Athletic Trainer who works in the clinical and outreach setting. Changes to the Medicare/Medicaid rule would highly effect my career as well as income. I am ruling against this change and hope to hear ALL of our voices and decide to listen.

Submitter : **Dr. Donna Fasanello** **Date: 08/29/2007**

Organization : **Dr. Donna Fasanello**

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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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.

Donna Fasanello M.D.

CMS-1385-P-11410-Attach-1.DOC

Submitter : **Dr. Sally Nogle** **Date: 08/29/2007**

Organization : **Michigan State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer who has been working in the health care field for over 25 years. I have spent most of my career at Michigan State University where I work with a variety of athletes. I have been asked by many people over the years to let them know if I ever switch jobs and start working in a clinical or hospital setting. They are very interested in having me help them with their injuries. They recoginze the value of a certifed athletic trainer. I feel these individuals and the many others who seek the services of a Certified Athletic Trainer should not be denied that opportunity.

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

Sally Nogle, PhD, ATC
Michigan State University

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

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29, 2007
Ms. Leslie Norwalk, JD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES

Dear Ms. Norwalk:

As a student 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%. I am a student at Middle Tennessee School of Anesthesia in Madison, Tennessee. This will effect my future career as an anesthetist. 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,

Rhonda Hendon, RN, SRNA
Name & Credential
122 West Harbor
Address
Hendersonville, TN 37075
City, State ZIP

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

Organization : Mr. Mark McGinnis

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Mark McGinnis

Submitter : **Ms. Wanda Gordon** **Date: 08/29/2007**

Organization : **Ms. Wanda Gordon**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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Thank you for your consideration of this serious matter.

Sincerely,

Wanda Gordon

CMS-1385-P-11419

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

Organization : **Metroplex Hospital**

Category : **Nurse Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Passage of this bill will enable our hospital to bring more anesthesia providers on board giving us more flexibility and safety. To many hours with no rest is not safe, but we no resources to bring more CRNAs to our hospital. Thank you for passage. Warren Voegele

Submitter : **Mrs. Bonnie McGinnis** **Date: 08/29/2007**

Organization : **Mrs. Bonnie McGinnis**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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Thank you for your consideration of this serious matter.

Sincerely,

Bonnie McGinnis

Submitter : **Dr. rhett dodge** **Date: 08/29/2007**

Organization : **greenville anesthesioilogy pa**

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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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.

Thank you,

Rhett A. Dodge MD

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

Organization : **Stephen F. Austin State University**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

As a nationally ecrtified and state licencsed athletic trainer at Stephen F. Austin State University responsible for the healthcare of 300 athletes, I am writing today to voicc 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 thesc proposed rules will ereate 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,

G.W."Trey" Younger III, ATC, LAT, NASM-CES

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

Organization : **Mr. Tres Benifee**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P
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

Tres Benifee

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

Organization :

Category : **Health Care Provider/Association**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

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

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.

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.
Kinesiotherapy is a recognized allied health profession per the AMA, and like other health practioners, we carry National Provider Numbers.
In addition, 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.

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 decreases in patient quality, safety or access. What organization is driving these significant changes? Who is demanding these?

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.

Submitter : **Ms. Nikita Henderson** **Date: 08/29/2007**

Organization : **Ms. Nikita Henderson**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter

Sincerely

Nikita Henderson.

Submitter : **Ms. Vicky Maple** **Date: 08/29/2007**

Organization : **Ms. Vicky Maple**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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Thank you for your consideration of this serious matter.

Sincerely,

Vicky Maple

CMS-1385-P-11428

Submitter : **Ms. Barbara Nichols** **Date: 08/29/2007**

Organization : **CGFNS International**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1385-P-11428-Attach-1.PDF

#11428

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August 29, 2007

VIA EXPRESS MAIL

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

RE: COMMENTS ON PROPOSED RULE CMS-1385-P

Dear Ms. Norwalk:

CGFNS International submits the following comments on the Proposed Rule CMS-1385-P, which was published on July 12, 2007 in the Federal Register at Volume 72, at pages 38152-38160, on the subject of "Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions".

Our comments are focused specifically on the provisions of section 484.4 of the Proposed Rule, regarding "Personnel Qualifications." Our comments can be briefly summarized as follows:

- The regimen proposed in section 484.4 for establishing the credentials of the five categories of healthcare professionals covered by section 484.4 is duplicative and needlessly complex;
- For persons educated within the United States, the presentation of a state license provides sufficient documentation of the individual's credentials and qualifications;
- For persons educated outside the United States, or trained by the US military, the requirement should be revised to include the individual's state license and presentation of a certificate issued in accordance with the requirements of Federal immigration law by either CGFNS International (for all covered professions), or NBCOT (for occupational therapists) or the FCCPT (for physical therapists). These three organizations have been specifically approved to provide this credential-certification function in regulations published by the Department of Homeland Security.

As we will describe in greater detail below, Federal immigration law has already established a process by which the credentials of foreign healthcare professionals are reviewed, verified and certified before these professionals may be granted authorization to enter the United States on an occupational visa. We

INTERNATIONAL
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believe that that verification and certification process, which is carried out by CGFNS International and the other "equivalent" organizations named above, can be effectively utilized in this context to eliminate duplicative and/or multi-tiered requirements and satisfy the certification of professional qualifications that section 484.4 is seeking to ensure.

A. The Regimen Proposed in Section 484.4 duplicative and needlessly complex; For Persons educated within the United States, presentation of a valid State License should be sufficient.

CGFNS will not make its own arguments in support of this point, as we believe that other commenters will make the same or a similar point in considerable detail. It would not serve a useful purpose to duplicate the comments that we expect others will offer on this point. We note only that we offer our support for the point of view that a valid state license should be sufficient in the occupations of occupational therapist, physical therapist and speech-language pathologist. A valid state license should also be sufficient in the occupations of OT assistant and PT assistant, if licenses are granted in those fields.

In the case of persons educated outside the United States or trained by the U.S. military, Section 484.4 should require a state license and a CGFNS VisaScreen certificate, or similar certificate issued pursuant to the immigration laws at 8 U.S.C. 1182(a)(5)(C).

B. CGFNS International Has Thirty Years of Experience in Evaluating the Credentials and Qualifications of Foreign Healthcare Professionals, and has been Designated by Congress and the Department of Homeland Security to Examine, Verify and Certify the Credentials of Healthcare Professionals Coming to Work in the U.S.

CGFNS International is a not-for-profit corporation based in Philadelphia, PA, which has for the past 30 years examined, verified and certified the credentials of foreign-educated health care professionals. CGFNS International (formerly known as the "Commission on Graduates of Foreign Nursing Schools" and hereafter referred to as "CGFNS) has been statutorily designated in Federal immigration law to certify the credentials of foreign health care professionals (other than physicians) who are seeking to enter the United States to work as health care professionals in the United States. Its jurisdiction under this statutory mandate (8 U.S. Code section 1182(a)(5)(C)) includes the professional categories of nurse, occupational therapist, physical therapist, speech language pathologist and audiologist, physician assistant, medical technologist (also known as "clinical laboratory scientist") and medical technician (also known as "clinical laboratory technician").

The Federal immigration statute requires that before a foreign (i.e., non-U.S. citizen) healthcare professional in any of the seven specified occupations can be granted a work visa or work authorization as a Lawful Permanent Resident ("green-card holder"), CGFNS (or an equivalent organization, see "B" below) must review that individual's credentials and certify that:

"(i) the alien's education, training, license and experience –

(I) meet all applicable statutory and regulatory requirements for entry into the United States under the [employment] classification specified in the application;
(II) are comparable with that required for an American health-care worker of the same type; and
(III) are authentic and, in the case of a license, unencumbered [by disciplinary or similar action];

"(ii) the alien has the level of competence in oral and written English . . . appropriate for health care work of the kind in which the alien will be engaged . . .; and

"(iii) if a majority of States licensing the profession in which the alien intends to work recognizes a test predicting the success on the profession's licensing or certification examination, the alien has passed such a test or has passed such an examination."

In carrying out these statutory requirements, CGFNS:

- Obtains direct from the source a copy of the foreign health care worker's transcript of professional education;
- Verifies that that education is comparable to that required of an American health care worker in the same field;
- Requests and obtains verification of licensure from the foreign licensing authority, and determines whether the individual's license is authentic and unencumbered;
- Obtains proof of the applicant's English language proficiency as tested by designated tests of English language proficiency approved by the Department of Homeland Security and the Department of Health and Human Services, with advice from the Department of Education;
- In the case of nursing applicants, CGFNS requires evidence of passage of either the CGFNS Qualifying Exam or the NCLEX-RN exam.

Once an applicant has met these requirements, the International Commission on Healthcare Professions ("ICHP"), a division of CGFNS, issues a "VisaScreen"™ certificate. The VisaScreen certificate is valid for a period of five years from date of issuance.

Federal Regulations issued by the Department of Homeland Security outlining CGFNS International's authority and responsibility under this legislation can be found at 8 Code of Federal Regulations 212.15.

C. Other Organizations Have also Been Authorized to Certify the Credentials of Occupational Therapists and Physical Therapists.

The Department of Homeland Security ("DHS"), in the Federal Regulations cited immediately above, has also authorized the National Board for Certification in Occupational Therapy ("NBCOT"), in addition to CGFNS, to conduct the credentials review and certification in the field of occupational therapy. DHS has also authorized the Foreign Credentialing Commission on Physical Therapy ("FCCPT"), in addition to CGFNS, to conduct the credentials review and certification in the field of physical therapy.

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In the case of nurses and the four other healthcare professions covered by the verification and certification requirement and listed above, CGFNS is the sole certifying authority. (8 CFR 212.15(e))

C. Comments on Section 484.4 "Personnel Qualifications" of the Proposed Rule.

CGFNS believes that this process for the review, verification and certification of the credentials of non-U.S. citizen healthcare professionals, already well established in the Immigration and Nationality Act (the nation's immigration law), offers to CMS a useful tool for establishing and documenting the credentials of healthcare professionals educated outside the United States, as CMS is seeking to do in Section 484.4 of the Proposed Rule.

Section 484.4 deals with five occupations: Occupational therapist; occupational therapy assistant; physical therapist; physical therapy assistant; and speech-language pathologist.

CGFNS issues VisaScreen certificates for three of those occupations: occupational therapist, physical therapist, and speech-language pathologist. Federal immigration law does not authorize CGFNS to issue VisaScreen certificates for OT assistants or PT assistants. CGFNS has the capacity, however, to examine the credentials of such workers and verify whether they are comparable to the credentials of a US-trained worker in these professions, if that is the desire of CMS.

Federal immigration law requires CGFNS to issue its VisaScreen certificates to non-U.S. citizens, regardless of whether they received their professional education outside or inside the United States. In the context of Section 484.4, however, CGFNS believes that the most important and best use of the VisaScreen certificate is to require that it be presented by all persons educated outside the United States, if those persons began their U.S. practice on or after January 1, 2003. The Department of Homeland Security issued its Final Rule designating CGFNS and the other named organizations to examine, verify and certify the credentials of non-U.S. citizen healthcare professionals in this rule, which took effect on this date. This rule is found at 8 C.F.R. 212.15.

CGFNS believes that its VisaScreen certificate provides reliable and Federally-mandated documentation of precisely the sort of information that CMS is seeking to obtain from healthcare workers educated outside the United States or trained by the U.S. military. To be specific, requiring that such a worker present a VisaScreen certificate would establish, for both the worker and CMS, the following facts:

- That CGFNS has obtained, examined and assessed documentation regarding the worker's education, training, license and experience, and has determined that the worker's education, training, license and experience–
a) meet all applicable statutory and regulatory requirements for entry into the United States under the appropriate employment classification;

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b) are comparable with that required for an American health-care worker of the same type;[1] and
c) are authentic and, in the case of a license, unencumbered by disciplinary or similar action; and

- That the worker has a work-appropriate level of competence in oral and written English, as established by the worker's scores on standardized English language proficiency tests designated by the Secretary of Health and Human Services in consultation with the Department of Education.

Those are the critical facts which the VisaScreen (or equivalent) certificate establishes. We believe that requiring such a VisaScreen certificate from a healthcare professional educated outside the U.S. is a simple and ideal way to establish the worker qualifications that CMS is seeking to establish in Section 484.4.

CGFNS therefore proposes that that CMS inserts at the appropriate place in the Proposed Rule that a worker educated outside the United States or trained by the U.S. military present a valid state license and:

> "an authentic VisaScreen certificate in the field of ____(occupation)___ issued within the past five years by the International Commission on Healthcare Professions, a division of CGFNS International, under the authority of 8 U.S.C. 1182(a)(5)(C), or an equivalent certificate issued by a credentialing organization authorized by the Department of Homeland Security under the statutory authority of 8 U.S.C. 1182(a)(5)(C)."

E. Federal Law Mandates that Healthcare Credentialing Organizations be "Independent" with no conflicting interests.

Federal regulations require that uncertified foreign health care workers be certified by CGFNS or an equivalent "independent credentialing organization..." See 8 U.S.C. Code section 1182(a)(5)(C). To qualify as a credentialing organization under federal regulations, certifying organizations must be "independent of any organization that functions as a representative of the occupation or profession in question or serves as or is related to a recruitment/placement organization." (See 8 C.F.R. §212.15 (k)(1)(ii) (A) -(D)).[2] Furthermore, the rule provides that "the DHS shall not approve an organization

[1] The comparability of Philippine Nursing licenses to U.S. licenses has recently proved important to U.S. public health and patient safety. Pursuant to CGFNS's actions, it was determined that over 4,000 Philippine nurses had improperly passed a Philippine exam that had been marred by exam fraud.
[2] (k) Standards for credentialing organizations. . . . . . All organizations will be reviewed, including CGFNS, to guarantee that they continue to meet the standards required of all certifying organizations, under the following:

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that is unable to render impartial advice regarding an individual's qualifications regarding training, experience, and licensure."

The purpose of this immigration rule is to avoid vesting the accreditation or certification process in a U.S. trade and professional organization that would have an economic interest in keeping foreign trained individuals out of the profession. In addition, professional and trade organizations have conflicting interests to protect and serve its members, *and* service the interests that are extrinsic to the purposes and aims of CMS. Therefore, these organizations would not be able to render "impartial advice" as required by federal regulations.

The proposed CMS rule appropriately vests accreditation authority for occupational therapists in the World Federation of Occupational Therapists, and credentialing authority in the National Board for Certification in Occupational Therapy (NBCOT), both independent organizations for occupational therapists that are not directly connected to a professional or trade association of occupational therapists.

However, the proposed rule inappropriately grants certifying authority for physical therapists to the American Physical Therapy Association (APTA), an organization that is ***not*** independent for purposes of the federal regulations. The APTA is the leading national professional organization representing physical therapists in the United States. The APTA website notes that the APTA represents more than 66,000 members and that its "goal is to foster advancements in physical therapy practice, research, and education." Furthermore, its website notes that the APTA is "the principal membership organization representing and promoting the profession of physical therapy."[3] Clearly, this organization "functions as a representative of the occupation" and therefore, cannot be vested with

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(1) Structure of the organization. (i) The organization shall be incorporated as a legal entity. (ii)(A) The organization shall be independent of any organization that functions as a representative of the occupation or profession in question or serves as or is related to a recruitment/placement organization.

(B) The DHS shall not approve an organization that is unable to render impartial advice regarding an individual's qualifications regarding training, experience, and licensure.

(C) The organization must also be independent in all decision making matters pertaining to evaluations and/or examinations that it develops including, but not limited to: policies and procedures; eligibility requirements and application processing; standards for granting certificates and their renewal; examination content, development, and administration; examination cut-off scores, excluding those pertaining to English language requirements; grievance and disciplinary processes; governing body and committee meeting rules; publications about qualifying for a certificate and its renewal; setting fees for application and all other services provided as part of the screening process; funding, spending, and budget authority related to the operation of the certification organization; ability to enter into contracts and grant arrangements; ability to demonstrate adequate staffing and management resources to conduct the program(s) including the authority to approve selection of, evaluate, and initiate dismissal of the chief staff member.

(D) An organization whose fees are based on whether an applicant receives a visa may not be approved.

[3] See American Physical Therapy Association (APTA) website at http://www.apta.org/AM/Template.cfm?Section=About_APTA&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=41&ContentID=23725

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independent credentialing authority. Furthermore, APTA has an economic interest to ensure that foreign trained physical therapists do not enter the profession and has a conflict of interest in protecting its members and serving the interests of CMS. Therefore, the APTA does not qualify as an independent or impartial credentialing organization under federal immigration law, and it would be unwise to provide it with such authority for Medicare or Medicaid payment purposes.

CGFNS therefore proposes that the appropriate independent organizations within the physical therapy profession be referenced in the Proposed Rule as follows:

1. Proposed changes in the language re Physical Therapists

(1) Requirements for individuals beginning their practice on or after January 1, 2008.

(ii) If educated outside the United States or trained **by** the United States military--

(A) Graduated after successful completion of an education program that, by a credentials evaluation process approved by the Federation of State Boards of Physical Therapy or its credential subsidiary, the Foreign Credentialing Commission on Physical Therapy or the International Commission on Healthcare Professions, a division of CGFNS International, as allowed under 8 C.F.R. §212.15 (e)(1), and is determined to be comparable with respect to physical therapist entry level education in the United States; and

(B) Passed the National Examination approved by the Federation of State Boards of Physical Therapy or its credential subsidiary, the Foreign Credentialing Commission on Physical Therapy, as allowed under 8 C.F.R. §212.15 (e)(1),

Conclusion

Our proposed amendments are necessary to help CMS and the foreign healthcare worker establish the credentials that CMS has required in section 484 and to maintain the federally-mandated impartiality of independent credentialing authorities.

Sincerely,

Barbara Nichols

Barbara L. Nichols
Chief Executive Officer
Director/bn/corres/07/norwalkhhscntrmedicaremedicaid0807

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

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

August 29th, 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.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,

Guy T. Hornig CRNA, MS
#14 Thicket Lane
Lancaster,PA 17602

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

Organization : **Mr. Jonathan Lankford**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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

Thank.you for your consideration of this serious matter

Sincerely,

Jonathan Lankford.

Submitter : **Dr. Theodore Rothman** **Date: 08/29/2007**

Organization : **greenville anesthesiology pa**

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.

Theodore E. Rothman MD

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

Organization :

Category : **Chiropractor**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (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 diagnostie testing, i.e. MRI or for a referral to the appropriate specialist.

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

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

Submitter : **Mrs. Abby Edgar** **Date: 08/29/2007**

Organization : **College Setting**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:
My name is Abby Edgar. I'm a certified athletic trainer working in a college setting in Minnesota. I have a BA in Athletic Training/Health Education, and a MS in School Health Education.

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

Submitter : **Mrs. Anna Koranyi** **Date: 08/29/2007**

Organization : **Mrs. Anna Koranyi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely Yours,
Anna Koranyi

Submitter : **Mrs. G Par** **Date: 08/29/2007**

Organization : **Mrs. G Par**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

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

Subject: Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Rule

Dear Mr. Kerry Weems,

My name is Gina, I have a Master s Degree in Physical Therapy, and enrolled as a Doctoral Student at the University of St. Augustine. My husband and I started 2 private physical therapy practice in 1999.

We are currently in serious business trouble, as most of the large family practices and orthopaedic clinics have opened their own physical therapy offices in their building and engaging in self referral in Pinellas County.

For example, Diagnostic Clinic in Largo just opened their physician-owned PT clinic and our Largo office went from 5 days a week of operation to 2 days a week.

Nearly every Orthopedic Clinic in north Pinellas county also self refer to themselves. We have had employees who have been employed with us for years leave us to go and work for them as they promise easy referrals. We had employeed 5-6 physical therapists at a time and now employee 2 full time.

The potential for fraud and abuse exists whenever physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to over utilize those services for financial reasons. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, over utilization of physical therapy services under the Medicare program, and enhance the quality of patient care.

Please consider this&..

" The in-office ancillary services exception has created a loophole that has resulted in the expansion of physician-owned arrangements that provide physical therapy services. Because of Medicare referral requirements, physicians have a captive referral base of physical therapy patients in their offices.

" Due to the repetitive nature of physical therapy services, it is no more convenient for the patient to receive services in the physician s office than an independent physical therapy clinic.

" Physician direct supervision is not needed to administer physical therapy services. In fact, an increasing number of physician-owned physical therapy clinics are using the reassignment of benefits laws to collect payment in order to circumvent incident-to requirements.

This physician owned physical therapy services is abusive in nature. I support and urge you to consider supporting PT services removal from doctors office.

Thank you for your time and consideration.

Sincerely,

Gina Parsonis, MPT, MTC

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

Organization : Mr. Samuel Howeth

Category : Individual

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

Re: CMS-1385-P
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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Sincerely,

Samuel Howeth

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

Organization : **Northwest Community Hospital**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Becky Talizin and I am a certified athletic trainer. I work for Northwest Community Hospital's Outpatient Physical Medicine and Rehabilitation department. At the clinic, I treat patients with orthopedic injuries rehabilitating them back to normal function. At this point in time, I can only see patients who are under the age of 65 who aren't on Medicare. I am also contracted out to a local high school, where my two colleagues and I, who are also athletic trainers, can evaluate and treat any orthopedic "issue". Athletic trainers are allied health professionals qualified to treat anyone with an orthopedic issue from a 15 year old that wants to return to football to a 90 year old who just wants to walk again.

With what I have stated in mind, 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,

Rebecca L. Talizin, ATC

Submitter : **Ms. Susan Batiste** **Date: 08/29/2007**

Organization : **James A Haley VA Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

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

I graduated with a Bachelor of Science degree from the University of Southern Mississippi. Since, I have worked as a Registered Kinesiotherapist at James A Halcy VA Medical Center in Tampa, FL.

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

Sincerely,
Susan Batiste, RKT

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

Organization : **David Meinhardt**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

I support the increase in anesthesia fees being proposed for Certified Registered Nurse Anesthetists, of which I am one. In my current practice, I take on a great amount of responsibility for sick patients, yet receive only about $80 for the anesthetic they receive for sight saving eye surgery. We CRNAs provide a very VALUABLE service to patients all across the USA.

Please treat CRNAs fairly and increase the fees we receive for our work.

Thank you

David Meinhardt, CRNA

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

Organization : **Mr. Adam Koranyi**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.
Sincerely Yours,
Adam Koranyi

CMS-1385-P-11441

Submitter : **Mrs. Edith Wells** **Date: 08/29/2007**

Organization : **Mrs. Edith Wells**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

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Thank you for your consideration of this serious matter.

Sincerely,

Edith Wells