Submitter : **Dr. Moises Lustgarten** **Date: 08/16/2007**

Organization : **Dr. Moises Lustgarten**

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.

Moises Lustgarten, MD

Submitter : **Dr. Richard Silverman** **Date: 08/16/2007**

Organization : **University of Miami**

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.
Richard Silverman, MD
1800 Jefferson Avenue
Miami Beach, Fl. 33139

Submitter : **Date: 08/16/2007**

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please remove Physical Therapy from the in-office ancillary services exception to Physician self-referral bill. I am a PT and I know that physicians that have their "OWN PT" send more marginal cases for evaluations and that their charges are higher. There is minimal Physician oversight of or involvement in the delivery of services in these settings. I also believe that the skill level of staff in these settings include more unlicensed personnel.
Removal of this exception should be beneficial to health care consumers from a cost savings perspective as well as improved efficiency of care.
Thank-you, PT in Virginia

Submitter : **Dr. Steven Sheinman** **Date: 08/16/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Ycar Review)

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Thank you for your consideration of this serious matter.

Sincerely,

Steven Sheinman, MD
Medical Director
North Miami Beach Surgical Center
120 NE 167 Street
North Miami Beach, FL 33162

Submitter : Dr. Mary Etta King **Date:** 08/16/2007

Organization : Dr. Mary Etta King

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

RE: File Code: CMS-1385-P, Coding Additional Codes from 5-year Review

To CMS:

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

As a pediatric cardiologist, this is of particular concern to me because the assignment of specific RVU and reimbursement for this particular aspect of an echocardiographic examination needs to reflect the cost of providing this essential aspect of cardiac ultrasound diagnosis to pediatric patients. Color flow mapping is a crucial element of accurate diagnosis of many types of heart disease that affect children. Proper performance and interpretation of this portion of the exam is critical for accurate diagnosis. The color flow Doppler portion of an echocardiogram (93325) requires the expense of purchasing equipment with optimal color flow imaging capability, maintenance of this equipment for the color flow feature, proper training of sonographers and physicians in its use and interpretation, increased time for the examination to include careful interrogation with color Doppler in all views, and increased interpretation time to include assessment of the color Doppler information.

With 30 years of experience in echocardiography, I have seen the change which has occurred in performance and interpretation of echocardiograms with the addition of color flow Doppler. While it has added immeasurably to our diagnostic capability, there is no question that it has substantially increased the time required to perform a study and the time required to interpret the study. As is frequently stated, time is money , and this time requirement for color flow Doppler needs to be accounted for in the reimbursement for this portion of the echo study.

In my ycars of experience, I havc also seen many examples of misuse of echocardiography to the disservice of the patient. The creation of one bundled code for all aspects of echocardiography with the same reimbursement fee regardless of the echo modality employed will result in more limited cchocardiographic studies being performed by those who are attempting to minimize their own costs and time while maximizing their reimbursement. This will serve to inadequately diagnosis and inappropriately manage children with heart disease.

I am also concerned that this change would adversely impact access to care for pediatric cardiology patients. Pediatric cardiology programs provide care not only to patients with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for pediatric cardiology services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to all patients will not be sufficient to continue to do so should the proposed change to bundle 93325 with other pediatric cardiology echocardiography codes be implemented.

Thus the effect of this change on pediatric cardiology programs throughout the country will be an increase in the need for subsidies from already resource-challenged children s hospitals and academic programs, or a significant increase in Medicaid reimbursement for the proposed bundled services.

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

Thank you for your consider of this matter.

Sincerely,

Mary Etta E. King, MD

Submitter : Mr. Scott Gibson **Date:** 08/16/2007

Organization : Goldsboro Orthopaedic Associates

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The purpose of the Stark Law is to prevent fraud and abuse with self referrals for financial gain. I am a physical therapist working for a physician owned physical therapy clinic. Our patients are given a choice by the physicians as to where they would like to receive their physical therapy services. We act in a very ethical manner and as professionals, we should continue to have the opportunity to act ethically with our patient care. The benefits of having a physician owned clinic are: patient convenience; immediate resolution to adverse patient symptoms ie infection; enhanced professional respect between the medical and physical therapy professions; and general enhancement of the continuity of patient care with federal and state regulations.
Please do not prohibit this type of practice setting as this would limit my ability to work in a setting that is the very best for patient care. Unethical behavior should be dealt with swiftly and severely, but in the absence of unethical behavior, those law abiding practitioners should be allowed to continue providing the highest quality of care possible.
Thank you for your consideration.
Scott Gibson, PT
Director of Rehabilitation
Goldsboro Orthopaedic Associates
Goldsboro, North Carolina 27534

Submitter : Dr. bruce Chipkin **Date:** 08/16/2007

Organization : NAPA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

August 16, 2007

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Ms. Elizabeth Ferro** **Date: 08/16/2007**

Organization : **Sheridan Healthcorp**

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-Ycar Review)

Dcar Ms. Norwalk:

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

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

Thank you for your considcration of this serious matter.

Submitter : Dr. Alan Nastir **Date:** 08/16/2007

Organization : Millennium Anesthesia Care Tampa, FL

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.

I am an Anesthesiologist working for 12 years serving a tertiary-care urban hospital. In the past 2 years we have lost about 1/3 of our Physician and CRNA anesthesia providers to more lucrative outpatient surgery eenters, targeting a younger and better insured patient population. Our group has NOT been able to successfully recruit and retain quality replacements. Those of us remaining have been working 60-70+ hours a week, struggling to provide quality care to our aging and underinsured patient population. This situation is untenable.

Our ability to continue providing quality care to our patients hinges upon implementation of CMS rule CMS-1385-P, as a first step in rectifying decades-old undervaluation of Anesthesia services.

My group, and all others who primarily serve an aging Medicare/Medicaid population, need to have the resources to continue providing outstanding care to those patients. If not, the future for our aging population, to eventually include our families, and ourselves, is dire indeed.

Thank you for your consideration of this serious matter.

Alan Nastir, M.D. Millennium Anesthesia Care Tampa, FL

Submitter : **Date: 08/16/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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

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 carc, 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,

Suzanne Hamilton

Submitter : **Dr. Ihab Toma** **Date: 08/16/2007**

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Ihab Toma,M.D.

Submitter : **Dr. Lola Rosenbaum** **Date: 08/16/2007**

Organization : **Dr. Lola Rosenbaum**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

8/16/2007

Please remove physical therapy services from the allowed list of in-office ancillary services on the physician fee schedules. I am a physical therapist with 21 years of experience and have previously worked in two physician-owned physical therapy practices. I have seen the abuse and overuse that takes place first hand. Patients were not allowed their choice of PT providers and when a patient asked the physician to go to another PT provider, the patient was told that the other PT provider they wanted to see was not "as good as" the physician's PT provider. Most patients believe and do not question their physician's statements and will do what their physician wants them to do.

In my previous employment in a physician-owned PT practice, I was occasionally asked and pressured by the physician to continue seeing patients after I had decided that they had reached their maximum PT potential. It is difficult to refuse when the physician is your employer and the patient has ulterior motives (i.e. Worker's compensation situations) to continue receiving PT services.

Currently I am employed by a physical therapist-owned PT clinic and have also been employed by three hospitals at other times in my career. The differences in how I function as a PT in a private practice setting or hospital as opposed to the physician-owned practice are remarkable. In the hospital or private practice area I am seen as the "authority" on PT matters. My decisions regarding patient care are the final decision. In the physician-owned PT practice, the physician is the "authority" and he decides which patients need continued physical therapy services. The fact that the physician puts money in his pocket for every patient he refers for physical therapy in his own office setting should be a wake up call for insurance companies.

In the private practice and hospital settings, I bill for the time I see a patient and am not pressured to bill a certain number of units per patient. If I see a patient for 30 minutes then I only bill for 30 minutes and I do not receive incentives for production. In a physician-owned PT practice approximately one block from our practice, the PTs and PTAs are "asked" to bill at least 3 units for each patient and are offered pay incentives for increased billing.

I decided 15 years ago that I would not work for a physician again and have honored that decision even though I am married to an orthopedic surgeon. My husband refers many of his patients to physical therapy services and lets them choose which service is most convenient to them. Patients should be able to decide for themselves where they want to receive their physical therapy services and physical therapists should be the final "authority" on physical therapy services. I urge you to remove physical therapy services from the allowed list of in-office ancillary services on the physician fee schedules.

Lola Rosenbaum, PT, DPT, MHS, OCS
Doctor of Physical Therapy
Orthopaedic Certified Specialist

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physicians should not be able to profit off the services of an "in house" Physical Therapist. The PT that is employed by a physician or physician group is under too much ethical pressure. The physician may refer patients that aren't appropriate for PT just to increase revenue. The PT is then under unspoken pressure to put patients on program that aren't appropriate or keep patients on therapy program longer than appropriate as it will make more money for the physician and likewise keep the PT's job safe. Physical Therapists have the training to be autonomous practitioners and should not be directly supervised or influenced by a physician. Our training in rehabilitation assessments and techniques exceeds that of the physician and we should be acting as such. As stated above, physicians should not be able to profit from our services just as we don't profit from those services provided by the physician.

Submitter : Dr. Irwin Weinstein **Date:** 08/16/2007

Organization : Orlando Cardiovascular Center

Category : Other Health Care Provider

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

Please see attached letter

CMS-1385-P-6003-Attach-1.DOC

#6003

Orlando Cardiovascular Center
1405 South Orange Avenue
Suite 120
Orlando, FL 32806-2147

August 15, 2007

Herb B. Kuhn, Deputy Administrator (Acting)
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: Proposed Revisions to Payment Policies Under the Physicians Fee Schedule, and Other Part B Payment Policies for CY 2008

Dear Mr. Kuhn:

On behalf of the Orlando Cardiovascular Center and our twenty (20) individual practicing cardiologists, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the ***"Resource-Based PE RVU's"*** section of the above referenced July 2, 2007 Proposed Rule. We are specifically concerned with the 2008-2010 PE RVU's established for non-facility outpatient cardiac catheterization procedure codes and the significant negative impact that could result for our practice and our patients if these values are finalized for the 2008 Physicians Fee Schedule.

The Orlando Cardiovascular Center is an outpatient cardiac catheterization lab located in Orlando, Florida. This facility has been providing cardiac catheterization services to the community since 1991. The facility is designated an IDTF by Medicare and has always maintained accreditation with either JCAHO or AAAHC. This single cath lab facility performs 800-1000 high quality procedures annually. The patient feedback has continually demonstrated appreciation for the excellent patient care provided by this facility.

The Orlando Cardiovascular Center is a member of the Cardiovascular Outpatient Center Alliance (COCA) and as such we have actively been involved in the work that COCA has accomplished this year to collect and submit direct and indirect cost data to the AMA's Practice Expense Review Committee (PERC) of the Relative Value Scale Update Committee (RUC). Unfortunately, this process did not allow all of COCA's data to be considered and resulted in PE RVU recommendations to CMS that severely undervalued the direct and indirect costs associated with providing these procedures to our patients.

It is apparent from the July 2, 2007 Proposed Rule that CMS has accepted the RUC recommendations without considering the detailed direct cost information that COCA provided to CMS in May 2007. The PE-RVU values set out in the July 2 Proposed Rule would result in a draconian cut in reimbursement for cardiac catheterizations performed in practice or IDTF locations. For example, if the 2007 conversion factor is applied to the technical component of the primary three CPT codes for a Left Heart Cath (93510TC, 93555TC, and 93556TC) the reimbursement in 2008 would be cut by **32%** and when fully implemented the total reimbursement would be reduced by **49%**. These reductions would undoubtedly result in the closing of the majority of non-facility outpatient cardiac catheterization labs in the country forcing all patients who now benefit from improved access and lower costs into more acute hospital settings.

We request that CMS review the additional cost data provided by COCA and establish PE RVU's for outpatient cardiac catheterization procedures that more reasonably reflect the direct and indirect costs of providing these procedures. If the proposed RVU's are allowed to stand, the outcome will inevitably that will cost the Medicare program more in direct APC payments **and** Medicare patients more in higher deductibles and co-insurance.

Thank you for this opportunity to comment on this important issue.

Sincerely,

Irwin R. Weinstein, M.D.
Medical Director, President

Submitter : Dr. Michael Amoroso **Date:** 08/16/2007

Organization : Jersey Shore Anesthesiology Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Steve Hyman** **Date: 08/16/2007**

Organization : **Vanderbilt University School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

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

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Thank you for your consideration of this serious matter.

Steve Alan Hyman, MD

Submitter : Mr. Jamie Schounard **Date:** 08/16/2007

Organization : Mr. Jamie Schounard

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing to encourage you to close the loophole to the Stark Law allowing in-office Physical Therapy by physician practices. I am a physical therapist with 21 years of experience in hospital, private practiee and administrative experience. I firmly believe that PT services are abused by physician practices as a revenue stream. My personal experience with this proves my belief. I work in a community based hospital that has 2 large physician practices making up a majority of our medical staff. They are not employed by the hospital. We had located several smaller outpatient PT clinics close to one clinic's offices around our service area. The clinic decided they wanted to own their own rehab and informed us that we could either sell them the clinics or continue to operate with no referrals from them. We decided to sell them the clinics as we would not have been able to continue without the referrals. For the first year, we continued to staff these programs, while they were owned by the physician clinic. In each location, in less than 6 months we saw a 30-40% increase in the volume of PT referrals coming into the clinics. There was no work on our part to encourage or generate more rcferrals. I can only contend that this increase, which was mostly from non-orthopedic physicians that historically used minimal rehab, was due to the new revenue stream created by now owning Physical Therapy. Since the year ended, we have also had numcrous patients tell us that thc practicc as a whole makcs it very difficult for a patient to go outside of the clinic when they get a PT order written. The physicians have, in my opinion, used their influence with their patients to steer them to their PT service, despite patient requests to come to our hospital clinics where they have had past success.

While I do not fault physicians from needing to maximize their earning potential, I sce this practice as an abuse of the intent of the Stark Law. The practice of Physical Therapy must be protected in order to ensure the highest quality service for our patients. There is little incentive for a Physician-owned service to strive to excellence, when they have a captive audience of patients. For the long-term success of the PT profession and for the health and wellness of our patients, I encourage you to prevent this manipulation of the system to continue.

Thank you for your consideration.

Submitter : **Dr. Ruben Davila-Perez** **Date: 08/16/2007**

Organization : **University of Rochester**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Connie Keehn** **Date: 08/16/2007**

Organization : **Dr. Connie Keehn**

Category : **Physician**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 16, 2007
Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I practice in Altamonte Springs, FL as part of a 4-member pathology group for Dermpath Diagnostics.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology services. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary services exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.
Sincerely,
Connie Keehn, MD

Submitter : Dr. Stuart Seides **Date: 08/16/2007**

Organization : Cardiology Associates, PC

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

August 16, 2007

To Whom It May Concern:

I am the founder and president of Cardiology Associates, P.C., the largest and most comprehensive provider of cardiovascular care in the Nation s Capital and the adjacent Maryland suburbs. We have been delivering state-of-the-art care since our founding in 1979, and we have continuously strived to provide the most technologically advanced diagnostics for our patients. I believe that the proposal to bundle reimbursement for color flow Doppler into the basic echocardiography examination is seriously misguided.

Historically color flow Doppler has provided significant additional information above that provided by 2D echo and Doppler technology alone. It traditionally has aided in the assessment of valvular lesions, directionality of cardiac flow, and was originally intended to visually quantify blood flow velocity in the heart and vascular systems. In recent years however, the use of Color Doppler in the assessment of cardiovascular abnormalities has become more complex and provides new and evolving tools for the noninvasive cardiologist. Now more than ever, it is being used to improve the assessment of more cardiovascular abnormalities seen on echo. The technology for the assessment of diastolic dysfunction is rapidly progressing and color flow mitral propagation velocity is just one example of a valuable, newer technique which requires specialized technologist training to perform and sub-specialized non-invasive cardiology training to interpret. PISA (proximal isovelocity surface area) is another example critical to the quantification of regurgitant and stenotic lesions. Obtaining accurate images is extremely operator dependent and requires extensive technologist training to perform these measurements accurately. It also requires additional training for those physicians who wish to interpret and utilize these results properly. Color Doppler has moved beyond simple visual analysis of regurgitation. This technology requires complex calculations from fluid dynamic equations, and a thorough understanding of it benefits and limitations to be used accurately.

For this reason, it is imperative that Doppler technology be a separate entity that physicians can rely on as we advance our ultrasound technology to aid in the correct diagnosis and management of cardiac diseases. As these subspecialty technologies evolve, physicians and technicians alike, must continue to learn new skills, and elevate their level of training to match these advances. The fact that national CME courses exist in Echocardiography specifically designed to teach practicing cardiologists out of fellowship this technology speaks to the importance of this rapidly evolving field. The fact that ultrasound technicians also require specialized training to perform these examinations further confirms that color flow Doppler represents a distinct and valuable diagnostic entity.

Based on the aforementioned facts, I believe it is critical that color Doppler not be bundled with 2D echo reimbursement. It is a technology that requires additional training and expertise to perform and interpret and since it is not used in every study, and will not be part of the standard exam, it should continue to be reimbursed as a separate additional procedure that enhances the diagnostic utility of the basic echocardiographic exam.

Please feel free to contact me if I can provide any further clarification. Thank you for your consideration.

Sincerely,

Stuart F. Seides, MD
President, Cardiology Associates, P.C.
(202) 723-5524

CMS-1385-P-6009-Attach-1.PDF

#6009

Stuart F. Seides, MD
Joel Rosenberg, MD
James W. Ross, MD
Elizabeth M. Kingsley, MD
Benjamin I. Lee, MD
Jonathan A. Altschuler, MD
Mitchell B. Schwartz, MD
John J. Kennedy, MD
Edward J. Morris, MD
Susan K. Bennett, MD
Robert A. Gallino, MD
Matthew J. Connolly, MD
Kelley W. Sullivan, MD
Jay A. Mazel, MD
William C. Maxted, Jr., MD
Reginald L. Robinson, MD
Robert A. Lager, MD
Barbara L. Bean, MD
Reed M. Shnider, MD Allison W. Richardson, MD
Bernard M. Wagman, MD
Lawrence D. Jacobs, MD
Stephanie S. Jacobs, MD

Vascular Surgery
John D. Martin, MD
Jon A. Hupp, MD
Stephen E. Stanziale, MD

Nurse Practitioners
Janeen E. Constantine, ACNP
Deborah A. Dwyer, GNP
Louise C. Burns, CRNP
Louise O. Hanson, CRNP

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(410) 643-3186
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www.heartcapc.com

CARDIOLOGY ASSOCIATES, P.C.

August 16, 2007

To Whom It May Concern:

I am the founder and president of Cardiology Associates, P.C., the largest and most comprehensive provider of cardiovascular care in the Nation's Capital and the adjacent Maryland suburbs. We have been delivering state-of-the-art care since our founding in 1979, and we have continuously strived to provide the most technologically advanced diagnostics for our patients. I believe that the proposal to "bundle" reimbursement for color flow Doppler into the basic echocardiography examination is seriously misguided.

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Please feel free to contact me if I can provide any further clarification. Thank you for your consideration

Sincerely,

Stuart F. Seides, MD

Submitter : Mrs. Nora Cascardo **Date:** 08/16/2007

Organization : Premier Therapy Centers, Inc.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The future of Physical Therapy is to be employees of physician owned centers as more and more physicians open their own centers, this practice was initially to provide a direct supervision for patient care, it is now considered a means to increase their revenue as a business endeavor with little regard to the quality or level of skill given to the patients. It has made independent PT practices at risk of extinction, while the demands for skilled training increase to the doctoral level the opportunities will be employees of physician owned therapy centers,only. This will have a diastrous effect on profession of Physical Therapy. The opportunities to benefit the professional growth toward direct ownership will diminish and the appeal of this profession will be less. Physicians are not able to own a pharmacy as they would have an external gain, what is the difference than the external gain which is much larger with 12-24visits @ $86-125+/visit of therapy vs. 1 prescription @ $100-200/prescription. The professional organizations and schools of therapy are directly apposed to physician owned and there is a good reason for this, it will destroy the profession of therapy and all the opportunities for therapist. I have not and will not take students from schools that affiliate with physician owned therapy centers. I would be available for further comment and debate if necessary at 248 538 5165.

Sincerely,

Nora Cascardo PT, OMPT
Premier Therapy Centers, Inc.

Submitter : **Dr. Jonathan Singer MD** **Date: 08/16/2007**

Organization : **Dr. Jonathan Singer MD**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Aaron Friedman **Date:** 08/16/2007

Organization : Rhode Island Hospital/Hasbro Children's Hosiptal

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#6012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mrs. Kathryn Petuchov **Date:** 08/16/2007

Organization : Comprehensive Pain Medicine

Category : Individual

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

RE:CMS-1385-P Anesthesia Coding (Part of 5-Year Review)
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 underevalations of anesthesia services, and that the Agency is taking steps to address this complicated issue. This proposal is very important for access to care.

Submitter : Dr. Timothy Walsh **Date:** 08/16/2007

Organization : American Society of Anesthesiologists

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-6014-Attach-1.WPD

#6014

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.

Timothy W. Walsh, MD
13221 Cedarwood Ave
Clive, Iowa 50325

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physicians should not be allowed to own PT and OT clinics. Studies show it creates overutilization.

Submitter : Dr. Aaron L. Friedman **Date:** 08/16/2007

Organization : Hasbro Children's Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-6016-Attach-1.DOC

#6016

Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
A Lifespan Partner

Lifespan

The Warren Alpert Medical School of Brown University

Department of Pediatrics

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Aaron L. Friedman, M.D.
Pediatrician-in-Chief
Rhode Island Hospital

Medical Director
Department of Pediatrics
Hasbro Children's Hospital

Sylvia Kay Hassenfeld Professor of Pediatrics and Chairman
Department of Pediatrics
The Warren Alpert School of Medicine at Brown University

August 15, 2007

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

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

To CMS:

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

As a Chair of Pediatrics, this is of particular concern to me because:

1. I do not believe the appropriate process has been followed with respect to this change. After significant interaction and research between the RUC and the appropriate specialty societies (in this case The American College of Cardiology and the American Society of Echocardiography), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that the list of above echo codes be bundled as well with the 93325.

   This new code is fully expected to address any outstanding issues relative to Medicare utilization of 93307, and has been analyzed at length by appropriate national medical societies, the CPT editorial panel, and the RUC. However, as a result of this proposed regulatory action by CMS, we are faced with resolving, in an accelerated timeframe of less than two months, an issue that directly impacts a distinctly non-Medicare population - namely, pediatric cardiology practices - and which is normally addressed over a multi-year period. Further, because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

2. The surveys performed to set the work RVUs for almost all of the echo codes utilized specifically by pediatric cardiologists and affected by this proposed change were performed more than 10 years ago. As a result, with respect to the 93325, the RVUs are reflective of a focus on the cost of the technology and not the advances in care that have been developed as a result of the technology. Focusing on pediatric cardiologists, much needed new surveys would provide evidence that the work and risk components of the procedures that involve Doppler Color Flow Mapping have

evolved to the point where the relative value of the procedures have shifted to a significantly greater work component and a lesser technology component.

This shift is reflected in the development of national standards such as those present in the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL) initiative to develop and implement an echo lab accreditation process. The focus of this initiative is on process, meaning work performed, and not on the technology associated with the provision of echocardiography services. This echocardiography accreditation initiative will be mandated by many payors within the next year.

In 1997 there were specific echocardiography codes implemented in CPT for congenital cardiac anomalies to complement the existing CPT codes for echocardiography for non congenital heart disease. "The codes were developed by the CPT Editorial Panel in response to the American Academy of Pediatrics and the American College of Cardiology's request to delineate more distinctively the different services involved in *assessing* and *performing* echocardiography on infants and young children with congenital cardiac anomalies." (*CPT Assistant 1997).*

Consistent with this, I have significant concern with the continued approach (of which this bundling proposal is an example) of placing adult and pediatric patients in the same grouping when it comes to evaluation of the work associated with providing care to these significantly different patient populations. Because the adult cardiology population is much larger than the pediatric population, the RVUs for procedures that are common to both are established exclusively using adult patients as the basis. The work and expense associated with providing care to pediatric patients is not considered. The inaccuracies that result from this approach can be linked to anatomical differences between pediatric and adult patients (size, development, etc. - see references from the CPT Assistant below) as well as the basic issue of getting a child to be still while performing complex imaging procedures.

CPT Code 93325 describes Doppler color flow velocity mapping. This service is typically performed in *conjunction* with another echocardiography imaging study to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow velocities.

Pediatric echocardiography is unique in that it is frequently necessary to use Doppler flow velocity mapping (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 for the pediatric population stating that Doppler color flow velocity is "... even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." It should also be recognized that Doppler flow velocity mapping is an essential medical service being provided to patients with congenital and non-congenital heart disease in the pediatric population.

The following vignettes will illustrate the importance of the Doppler color flow velocity mapping (93325) remaining as a separate and distinct medical service and as an add-on code (+) for pediatric echocardiography services. These are just a few examples of the many complex anatomic and physiologic issues that we as pediatric cardiologists face on a daily basis when performing echocardiograms on infants, children, and adults with complex congenital or non-congenital heart disease. These are not unusual cases for us.

Vignette 1 (*quoted from CPT Assistant 1997*) (example of Congenital Heart Disease)

"A three-day-old neonate with transposition of the great vessels was initially treated with an atrial septostomy with a planned arterial switch procedure at seven days. On the third day post Raskind balloon septostomy increasing cyanosis is seen with saturation dropping to the low 70s. A repeat transthoracic echocardiography (93304) with color flow Doppler study is performed *(color flow Doppler is coded in addition as a 93325).* The physician reviews the echocardiographic images and prepares a report. The echocardiogram shows a closed patent ductus arteriousus and a small atrial septal defect. The child is returned to the cath-lab for a repeat septostomy and prostaglandin is restarted."

Vignette II (example of non-congenital heart disease)

A two-month-old infant is referred by the pediatrician to a pediatric cardiologist for a persistent murmur in an otherwise healthy infant. The pediatric cardiologist is concerned about a patent ductus arteriousus as a possible diagnosis. A ductus arteriousus, connecting the pulmonary artery and the aorta, is an essential structure during fetal life. Normally, the ductus arteriousus closes in the first few days after birth in healthy term infants. A persistent ductus arteriousus can give rise to long-term complications and needs to be followed carefully to evaluate if further intervention is needed (medical vs. surgical). Echocardiography permits an accurate diagnosis of a patent ductus arteriousus with assessment of both the hemodynamic impact if there is a shunt. Estimated pulmonary artery pressure is obtained by Doppler imaging and can exclude other associated defects also. Color flow Doppler will be able to outline the flow of a patent ductus arteriousus from the aorta to the pulmonary artery. Color flow Doppler in this baby revealed no cardiac defects or patent ductus arteriousus and the murmur was determined to be innocent.

Vignette III (example of congenital heart disease)

An eight year-old child (or a 23-year-old young adult), with complex cyanotic congenital heart disease (functional single ventricle) is post-op completion of a fenestrated Fontan procedure several years ago. He has had a progressive decrease in saturations over the last year. There are several possible explanations and the pediatric cardiologist performs an echocardiogram to help determine the etiology. Color flow Doppler (93325) is essential to help elucidate the postoperative anatomy and blood flow patterns, but the process is complex and time-consuming involving assessment of the surgically constructed lateral tunnel or extracardiac conduit searching for a residual fenestration shunt or obstruction to flow, assessment of flow patterns through the previously surgically constructed Glenn anastomsis between the superior vena cava and pulmonary artery, assessment for obstruction to flow through the bulboventricular foramen, assessment for significant AV valve or semilunar valve insufficiency, and assessment for collateral vessels directing venous (desaturated blood) into the heart that may have developed over time. Any or all of these findings will then help dictate the next step in the care of this patient.

3. I am concerned that this change would adversely impact access to care for pediatric cardiology patients. Pediatric cardiology programs provide care not only to patients with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for pediatric cardiology services across all payor groups, the resources available today that allow us to support programs that provide

this much-needed care to our patients will not be sufficient to continue to do so should the proposed change to bundle 93325 with other pediatric cardiology echocardiography codes be implemented.

Thus the effect of this change on pediatric cardiology programs throughout the country will be an increase in the need for subsidies from already resource-challenged children's hospitals and academic programs, or a significant increase in Medicaid reimbursement for the proposed bundled services, in order for pediatric cardiology patients to have the same access to care and resources that they do today.

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

Thank you for your consideration of this serious matter.

Sincerely,

Aaron L. Friedman, M.D.
Sylvia Kay Hassenfeld Professor of Pediatrics
Chairman, Department of Pediatrics
The Warren Alpert Medical School
of Brown University
Pediatrician-in-Chief, Rhode Island Hospital
Medical Director, Hasbro Children's Hospital

Submitter : Mr. Scott Voshell **Date:** 08/16/2007

Organization : Mr. Scott Voshell

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am writing to voice my opinion on the physician self referral issue. There are multiple studies often quoted about the overuse of services when a physician has the power of the pen as it relates to referral of services when the potential for profit is present. Using the issue that the Supreme Court studied regards to the recognition of pornography Chief Justice Steward stated I may not be able to define pornography but if I saw it I would recogonize it. This is similar in nature, you can see the problem as it is in front of you and you must realize the impact not only on a profession but on CMS's cost of providing this service. The studies of additional costs and overutilization are there to quantify this issue, but look at the increase in services since the initiation of Stark II. Thank you for your consideration of this regulation.

Submitter : Dr. Stephanie Carter **Date:** 08/16/2007

Organization : Dr. Stephanie Carter

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Weems,
I am a physical therapist of 17 years currently working in Ohio. I have practiced clinically in the outpatient setting but my primary job has been teaching in academic medical centers. I have also done research on outcomes of outpatient physical therapy in which I have studied average cost of care and number of visits.

I would like to comment about my experiences with physician self-referral and in-office ancillary services . Since I have not been in the clinic for a few years, my experience comes from educating and advising family members about the use of physical therapy services. I am newly married and have had the recent opportunity to educate my husband s family. My mother in-law (of Medicare age) had rotator cuff surgery a few years ago (before I met her) and she received post-operative physical therapy at the physician s office. When I asked her why she chose to go there for therapy, she stated that she feared that her ongoing care by this surgeon would have been jeopardized had she chosen to go elsewhere. While the state of Ohio has a disclosure law and the physician should have informed her that she could go anywhere for her therapy, this was not done. When I asked her about the therapy that she had, she said that she had a normal routine 3 times per week consisting of exercises, thermal modalities and electrical stimulation. When I asked her what the purpose of the thermal modalities were (heat at the beginning and cold at the end) she did know. She stated that she had very little pain. She also did not know why she was getting the electrical stimulation. She also stated that the exercises never changed and she felt as though she could have done them at home.

This situation, I believe, highlights the abuse of physical therapy when provided in a referral-for-profit situation:
1) patients feel coerced to use physical therapy services provided in the physician s office
2) quality of care may be compromised by not progressing interventions or discharging the patient when necessary
3) overutilization of services by providing interventions with no therapeutic purpose but possibly for financial gain

My parents live in a rural part of Ohio and they have very little choice of where to receive medical services. Physical therapy is provided by a large physician owned practice. The quality of care seems to be good, however when I compared the cost of services provided by this practice, they were 5 times more (per visit) than I had seen in my research. Again, this is an example of the abuse when therapy is provided in a referral-for-profit situation.

Thank you for the opportunity to make comments on this important policy.

Sincerely,
Stephanie Carter, PT, PhD

Submitter : Dr. Alice Hammer **Date:** 08/16/2007

Organization : Sweetbay Pharmacy

Category : Pharmacist

Issue Areas/Comments

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Proposed Elimination of Exemption for Computer-Generated Facsimiles

Our pharmacy relies heavily on faxes and has found it to be more reliable than e-prescribing at this time. Although we use e-prescribing, software problems are a concern. We have experienced transmission problems and problems with prescriptions getting "stuck" in the computer system. There is also a great deal of confusion about the legality of prescribing controlled substances electronically, so we prefer faxes for controls so we have a signature that is not electronically generated.
Thanks,
Alice Hammer, PharmD

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician Self-Referral Issues

I am a Physical Therapist in a privately owned outpatient facility and I have been practicing for 5 years. I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception. PT services should be removed from permitted services under the in-office ancillary exception due to high potential of fraud and abuse whenever physicians are able to refer Medicare beneficiaries to a facility in which they have a financial interest. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices, which results in over-utilization of services. During my five years of practice I have had several incidents in which Physical referral for profit has affected both our clinic and my patients. One incident occurred last year when I was seeing a patient under referral from their PCP for a strained HS and after evaluating the patient I referred the patient to a local Orthopedic Surgeon as a possible surgical candidate for a suspected HS tear and torn meniscus, the patient had surgery that week and was supposed to return to me for rehab, however the patient did not return and when I called the patient he was very upset as his surgeon had told him to D/C PT from us and to go to the PT clinic in his office because he had a 'special protocol' with them for Post-op arthoscopic surgery. The patient was upset due to the fact that he was already comfortable with me and we were much more convenient but he thought he had to do what his Ortho prescribed and we did not push the issue as it was in the pts best interest to get PT as soon as possible. I confronted the MD and got the same 'special protocol' response. Then again two months later a similar incident happened when a Therapist here referred a patient to an Orthopedic Surgeon. Over the past 5 years we have had a significant drop in referrals from Orthopedic Surgeons due to the fact that most, if not all, now have PT clinics on site. 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. Thank you very much for your time and consideration of this issue.

Submitter : **Dr. John Zanella Jr** **Date: 08/16/2007**

Organization : **Univ. of Tennessee Health Science Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mrs. Bettyann Shuert** **Date: 08/16/2007**

Organization : **Mrs. Bettyann Shuert**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

I am a Physical Therapist and have been in practice for 35 years. I currently practice in a hospital environment (which includes Outpatient services as well as Inpatient services.) I have grave concerns regarding the Part B payment policies which essentially allow Physicians to refer patients to their own offices (physician-owned physical therapy services - POPTS), or practices which may provide opportunity for financial incentives.

I believe it is critical to make the laws regarding physician self referral stricter, without loopholes that allow potentially abusive practices. Without these safeguards, it is possible for physicians to not only profit from the provision of therapy services, but also to provide services administered by personnel other than a physical therapist and still bill as "physical therapy." This deprives the beneficiary of his rights to a competent and educated physical therapist who will thoroughly evaluate his condition and recommend the most efficacious care.

Specifically, I want to ask that you remove the "in-office ancillary services" exception from the 2008 physician fee schedule rule, in order to remove the potential for fraud and abuse. Please make certain that Stark Phase III also thoroughly addresses these issues and makes it clear that physicians may not profit through self-referral in the provision of Physical Therapy or other services.

Thank you for your consideration of these issues.

Sincerely,
Bettyann Shuert

Submitter : Mrs. Kristi Harris **Date:** 08/16/2007

Organization : Five Rivers Therapy Services

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-6023-Attach-1.DOC

#6023

FIVE RIVERS
THERAPY SERVICES

August 16, 2007

Re: CMS-185-P

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

Dear CMS Representative:

I am writing this letter to express my concern regarding the proposed Medicare Physican Fee Schedule (MPFS) revision that will dramatically affect the reimbursement of Physical and Occupational Therapy services provided to elderly patients in my community.

This proposed method for reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care.

I understand that the AMA, the American Physical Therapy Association and the American Occupational Therapy Association, as well as other organizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these patients' right to adequate and necessary medical care.

Sincerely,

Kristi Harris, MS, PT
Clinic Director
Five Rivers Therapy Services

Submitter : Mrs. CHARITY ADAMS **Date:** 08/16/2007

Organization : Mrs. CHARITY ADAMS

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

THIS WILL ALLOW FOR ABUSE OF THE PATIENT DUE TO THE FACT THAT THE PHYSICIAN COULD OVER CHARGE PROCEDURES TO INCREASE HIS OWN PROFITS. WE MUST PROTECT THE PATIENTS BY ALLOWING THEM TO BE TREATED BY NON-BIASED THERAPIST WHO HAVE NO FINANCIAL CONNECTION TO THE ORDERING PHYSICIAN.

Submitter : Mrs. Linda D Detwiler **Date:** 08/16/2007

Organization : Mrs. Linda D Detwiler

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician ownership will bombard the medical system with overused services and open the flood gates for fraud and abuse. It is our moral and ethical responsiblity to protect the consumer - the everyday man.

Submitter : Mr. Stephen Mavrakes **Date:** 08/16/2007

Organization : Mr. Stephen Mavrakes

Category : Other Practitioner

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physical therapy services should be excluded from the in-office ancillary exception of the Stark rule. My experience has been that that this exception has created an environment for physicians to overutilize therapy services. When OIG has looked at utilization patterns they've found that therapy episodes of care provided in physicians' offices had more patient visits and more procedures billed per visit without any difference in outcomes when compared to therapy serviees provided in other settings. Unfortunately, there are physicians that view provision of therapy services only as a way to augment their practice's revenue. There are practice management companics that market provision of therapy services as a revenue enhancement.

It also creates an anti-competitive business environment that harms the consumer. In my practice, I've met many patients that have been hesitant to make an appointment because, as they tell me, "my doctor told me I have to go to this place". The patient rarely knows that the referring physician has a business interest in the practice they're being referred to. The patient then ends up going to the physician's practice because they "don't want to upset the doctor". This gives the referring physician an unfair competitive advantage and limits the consumer's choice of therapy provider.

Eliminating this exception will save money for CMS (and ultimately, the taxpayers) and will increase patient access to care. The care they receive is more likely to lead to better clinical outcomes and be delivered in a cost effective, CMS compliant treatment program. I feel these are compelling reasons to exclude physical therapy services from the in-office ancillary exception to the Stark Rule. Thank you for the opportunity to comment on this proposed rule change.

Submitter : **Dr. David Nusz** **Date: 08/16/2007**

Organization : **Dr. David Nusz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Alan Reitz** **Date: 08/16/2007**

Organization : **Anesthesia Associates of St. Cloud**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.
Alan D. Reitz, M.D.

Submitter : **Dr. Michael Spradlin** **Date: 08/16/2007**

Organization : **Johnson County Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Kevin Healy** **Date: 08/16/2007**

Organization : **McFarland Clinic**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

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

Dear Ms. Norwalk:

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

I practice in Ames, Iowa, a community of 25 000 people. Iowa has the third oldest population in the United States and our Medicare compensation is one of the lowest in country. An increase in medicare payment for anesthesia services will go a long way toward insuring access to care for the over-65 Iowan.

Thank you for your consideration of this serious matter.

Kevin Healy MD
McFarland Clinic
Mary Greeley Medical Center
Ames IA 50010

Submitter : Ms. Rebecca Wilson **Date:** 08/16/2007

Organization : Ms. Rebecca Wilson

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physical Therapy should be eliminated from the in office ancillary services exception to the federal physician self referral laws. Patients not only are not given the right to choose their provider but physicians are over utilizing services for their own profits. My patients who were referred to these physicians for medical services were told by those physicians that they no longer could recieve care from me if they were to continue with that physcian. The patient had to see that Drs. PT. A new physician owned therapy service in Tucson refused to post signage informing patients that it was physician owned. Physical Therapists are now Drs. of PT they are not ancillary services or incident to services. We do not work off of prescriptions. Patients can see us directly prior to seeing a physician.

Submitter : Dr. James Chiadis **Date:** 08/16/2007

Organization : Sacred Heart Hospital, Allentown, Pa.

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

To whom it may concern,
Thank you for the opportunity to submit comments on the Physician Self-Referral Provisions of CMS-1385-P entitled Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008. I am a board-certified pathologist and a member of the College of American Pathologists. I am also President of the Pennsylvania Association of Pathologists, an organization which represents over 300 pathologists. I practice in Allentown, Pennsylvania as part of a three-person hospital-based pathology group.
I applaud CMS for undertaking this important initiative to end self-referral abuses in the billing and payment for pathology serviees. I am aware of arrangements in my practice area that give physician groups a share of the revenues from the pathology services ordered and performed for the group s patients. I believe these arrangements are an abuse of the Stark law prohibition against physician self-referrals and I support revisions to close the loopholes that allow physicians to profit from pathology services.
Specifically I support the expansion of the anti-markup rule to purchased pathology interpretations and the exclusion of anatomic pathology from the in-office ancillary serviees exception to the Stark law. These revisions to the Medicare reassignment rule and physician self-referral provisions are necessary to eliminate financial self-interest in clinical decision-making. I believe that physicians should not be able to profit from the provision of pathology services unless the physician is capable of personally performing or supervising the service.
Opponents to these proposed changes assert that their captive pathology arrangements enhance patient care. I agree that the Medicare program should ensure that providers furnish care in the best interests of their patients, and, restrictions on physician self-referrals are an imperative program safeguard to ensure that clinical decisions are determined solely on the basis of quality. The proposed changes do not impact the availability or delivery of pathology services and are designed only to remove the financial conflict of interest that compromises the integrity of the Medicare program.
Sincerely,
James M. Chiadis MD

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

In regards to the Stark Law, it is my belief that physicians are abusing the medical system by referring patients only to their own physicain owned physical therapy clinics for revenue purpose. In addition it has been relayed to myself by patients and nurse case managers that physicians, even when asked by patients to attend physical therapy elsewhere, will be sent only to the physicain owned clinic.
I feel that this is wrong secondary to the fact that: one, the patient should be given the choice of where to attend as a private insurance patient, and a work comp. patient should be directed by the nurse case manager not a physician that is looking after their own bottom line.
As well, in our area since a local orthopaedic group opened up their own Physical Therapy clinic, it has been rumored that some doctors that rarely used PT services are now using and ordering PT for their own clinie quite often with their patients.
This concerns me for a couple of reasons. One, as a physical therapist in a private PT elinic my job is definitely at jeopardy if physicians own their own clinic and self-direct their patients to their own clinic. Two, patients are not allowed thier own choiee of provider by a physician as they self direct them to thier own clinic. Three, patient care could suffer if all patients are directed to certain clinics and cared for in the same way for all diagnosis. Fourth, quality of care decreases with the eye only being on net revenue and not treatment outcomes.

In Summary, it would behoove congress to look at the Stark Law again and disallow physieian owned clinics for a number of reasons. One, being the fact that without a physician owned clinic there will be less chance of abusing the referral number of patients to a Physician Owned Physical Therapy clinic by a physician and in turn those patient only needing PT services will be referred to PT clinics. Two, competition between privately owned PT clinics will be based on quality of care and outcomes, not revenue generated for physicians as with a physician owned clinic. Three, by keeping the Stark law intact as it is meant to be the physicains will focus on the area of patient care as is meant for their profession and Physical Therapists will be focused on the area of patient care as they are supposed and the patient which should be everyone's number one priority will get the best care from both medical fields.

Submitter : Dr. Joel Arney **Date:** 08/16/2007

Organization : Dr. Joel Arney

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

CMS-1385-P

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Barbara DeRiso** **Date: 08/16/2007**

Organization : **Dr. Barbara DeRiso**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

To the Director,

I am writing in strong support of CMS proposal to increase anesthesia payments under the proposed 2008 Physician Fee Schedule.

In the past 15 years, Anesthesiology has been unfairly singled out for a number of payment cuts. In absolute dollars, the CF for anesthesia services is approximately the same in 2007 as it was in 1997. In inflation-adjusted dollars, we have lost considerable ground since 1992.

While most other specialties collect payments from CMS that are approximately 80% of the rates paid by commercial payers, anesthesiologists payment from CMS are less than 40% of commercial rates. This gap has made our specialty far less than competitive in attracting new physicians.

In an area like southwestern Pennsylvania, with our predominantly older population and high percentage of Medicare beneficiaries, salaries based on the revenues that come from Medicare payments are substantially lower compared to areas with younger populations. This discrepancy has made it extremely difficult to attract new anesthesiologists, since we are competing in a national market. Such trends are not sustainable.

A recent analysis by the Relative Value Scale Update Committee (RUC) recently determined that the work component of the payment was undervalued by 32%. Correcting this discrepancy will increase the unit value paid for Anesthesia services by approximately $3.30, an amount that will begin to correct the historical payment problems which have evolved.

We appreciate that CMS has recognized the payment problems we anesthesiologists have been facing, and are trying to correct. We want our senior patients to have unfettered aceess to high quality anesthesology care. To this end, it is essential that CMS carry out the proposal in the Federal Register and implement the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this matter.

Submitter : Mr. Leo Credit **Date:** 08/16/2007

Organization : Gray Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am in favor of changing the self referral rule that will prohibit the delivery of PT services within a physician's office. The potential for fraud and abuse - either through overutilization of services or the provision of care by non skilled / non licensed providers remains far too great as the rule currently stands. The quality of skilled services provided to the public is of utmost importance to me and to my professional colleagues. However, with the rule as it currently stands, the quality of so called 'physical therapy' provided in a physician's office is in question as the services can often be provided by individuals without adequate training to care for patients in all age ranges with a wide range of needs. The application of therapeutic modalities such as ultrasound, electrical stimulation, iontophoresis and mechanical traction for example, is not and should not be considered 'therapeutic' if applied by non skilled individuals and thus should not be a chargeable fee forwarded to the insurance company for reimbursement. The skills of a licensed physical therapist or physical therapy assistant (under the direct supervision of a physical therapist) are required for the above mentioned modalities to be appropriately charged to the insurance company provided that they are in the realm of a comprehensive plan of care for that patient.

Please consider changing the policy and rules that will effectively discontinue the practice of in house 'PT' services within a physician's office. Its the right thing to do and will help assure greater patient safety and quality of care without the potential for healthcare fraud and abuse.

Submitter : **Dr. Jason Byers** **Date: 08/16/2007**

Organization : **Summit Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : Mr. Kevin Baker **Date:** 08/16/2007

Organization : Memorial Hospital

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Many physicians defer to the physical therapist to determine the treatment plan (Evaluate and Treat), when to progress a treatment program (therapist's discretion), and when maximum benefit from therapy has been achieved (let me know when therapy is done). This is counter to the position of orthopaedic surgeons.

Physican/therapist consultation is as close as a phone. This negates the orthopaedic physicians arguement that physical proximity improves care.

Physician Self-Referral Provisions

Physician Self-Referral Provisions

A physician-owned physical therapy service is comparable to a physician owned pharmacy. Referral to either service financially rewards the physician-owner. Since physican owned pharmacies are banned, why does the same ban not apply to physicial therapy?

Submitter : **Date: 08/16/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physical Therapy services should not be allowed under the in-office ancillary services exception, because the physicians are the only ones benefiting from this type of arrangement. I have worked in a rather large orthopedic facility in Columbus, Georgia where the doctors refused to refer to outside physical therapy services - even when the staff requested it and could not handle the census. It got to the point where I was seeing 24+ patients per day including walk-ins and multiple initial evaluations. I resigned from that practice secondary to not feeling that I could work ethically under those conditions. Many other therapists have done the same. This practice will pay a new grad $80,000 a year to work under those conditions! I was pushed to my limits but the patients were the ones who ultimately suffered from those physicians' greed. An evaluation and/or treatment that lasts a mere 15 minutes in no way could encompass a patients complex medical problems, needs and provide the services for which he and/or his insurance company is paying. Needless to say, I quit that job after a couple of months. It is blatant self-referral for personal gain!

The stark law has an apparent loophole that needs to be closed as it is allowing an environment for fraud and abuse to thrive. Regretfully during this day and age apparently political and local attachments are what drive the medical industry.

Submitter : **Dr. William Gurley** **Date: 08/16/2007**

Organization : **UAB Department of Anesthesiolody**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely,
William Quinton Gurley, Jr., M.D.

Submitter : **Ms. Amber Hasenmyer** **Date: 08/16/2007**

Organization : **US Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

August 16, 2007

Re: CMS-1385-P

Dear CMS Representative:

I am writing this letter to express my concern regarding the proposed Medicare Physician Fee Schedule (MPFS) revision that will dramatically affect the reimbursement of Physical and Occupational Therapy services provided to elderly patients in my community.

This proposed method for reduction in payment will undoubtedly result in lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery and/or long term inpatient care.

I understand that the AMA, the American Physical Therapy Association and the American Occupational Therapy Association, as well as other organizations are preparing an alternative solution to present to Congress. Please give this information much consideration and preserve these patients right to adequate and necessary medical care.

Sincerely,

Amber R. Hasenmyer, MSPT

Submitter : **Mrs. Rachel Turner** **Date: 08/16/2007**

Organization : **Mrs. Rachel Turner**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I beleive that Physician Ownership of Physical & Occupational Therapy
services would lead to treatments of non-necessity and extended services after goals of recovery have been met.
Extended services for further profits.

Submitter : **Dr. Mark Warner** **Date: 08/16/2007**

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Sincerely,

Mark Warner

Submitter : Dr. **Date:** 08/16/2007

Organization : Dr.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the in-office ancillary services exception. Physician-owned physical therapy services is a blatant abuse of the referral process and I support PT services removal from permitted services under the in-office ancillary exception.

Submitter : **Dr. Joel Ackerman** **Date: 08/16/2007**

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

Background

Background

Please increase medicare fee schedule. Thank you.

Submitter : Mr. Eric Lisitano **Date:** 08/16/2007

Organization : Mr. Eric Lisitano

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a practicing Physical Therapist for 17 years. I work in the hospital setting. I wish to comment on the July 12 proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. I am writing to strongly urge CMS to remove physical therapy as a designated health service (DHS) permissible under the in-office ancillary exception of the federal physician self-referral laws.

Our profession is working hard to move toward autonomous practice. Even once reached, our practice will continue to rely heavily (as it does entirely now) on physician referral. Simply stated, our practice is currently at the mercy of physicians who will refer patients to us. We stuggle on a daily basis to squeeze referrals from the local physicians. The law is set up now so that it provides a loophole for physicians to abuse the current system and as a result are able to significantly gain financially. There is currently no reason for physicians to refer their patients, who require physical therapy, outside of their own office. The argument the physicians sometimes use is that they can better follow the patients if they receive therapy in their office. But this argument is not valid, because of the way the law describes "centralized building", as many if not most physicians that have their own physical therapy practices have them off site of their main office. They actually have multiple PT practice locations. Physicians can simply send their protocols to local PT practices. It is standard practice for Physical Therpists to send routine and timely progress notes to the referring physicians on the patients status and progress. I know at my hospital, our outpatient physical therapy clinic only gets one or two referrals from those physicians (mostly orthopedic) who have their own physical therapy. The referrals we get are usually those with no insurance, or very weak policies, or those whose insurance policies that dictate they must come to our facility (or at least cannot use the physicians). I have personally spoken with one of the local physicians office referral coordinators who told me that they are held accountable by the physicians to send the patients to their own physical therapy practice (that is, the physician office owned), and that they have to "justify and provide a reason" to the physician partners when the patients are sent elsewhere. This, in and of itself, is abuse of a system making it financially profitable for them.

Due to the repetitive nature of Physical Therapy, it is no more convenient for the patient to recieve serviees in the physicians office than an independent physical therapy clinic. Physical Therapy is not a serviee that is needed at the time of the physician office visit in order to assist the physician in his/her diagnosis or plan of treatment. I would challenge any physician who argues otherwise. Physical Therapy is ordered by the physician once the diagnosis is made and it is determined that the patient could benefit from the service.

The current system provides a loophole to allow physieians to gain financially with no effort at all, while it presents significant barriers and challenges for physical therapists stuggling to practice what they love. Physicians are being allowed to, essentially, take over our professional territory.

Thank you for your consideration of my comments.

Sincerely,

Eric Lisitano PT

Jacksonville, Florida

Submitter : Mr. Jody Taylor **Date:** 08/16/2007

Organization : Providence Health Center - Waco TX

Category : Other Health Care Professional

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

As a registered echo cardiographer (RDCS), I do not usc color flow Dopplcr on all studies, therefore it should not be bundled into all other echo-based codcs. Additional time [both for the sonographer and physician] is taken not only to perform, but also diagnose patients with location of murmurs, shunts and septal defects. Also additional information is given when using Doppler as a diagnostic tool such as aliasing velocities [used to calculate effective regurgitant orifices], turbulence, direction of jets, which may demonstrate an adverse hemodynamic effect, etc. Many echoes performed on patients do not require the use of color flow Doppler (CFD) if the diagnosis codes used do not reflect the need for CFD. Examples of these eodes may be concerned with effects of lightening, shock, localization of thrombus formation, wall motion abnormalities, ejection fraction calculations, etc

Submitter : **Mr. Jacob Reitz** **Date: 08/16/2007**

Organization : **Centra Care**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

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

Thank you for your consideration of this serious matter.
Jacob P. Reitz

Submitter : **Dr. Lisa Newsome** **Date: 08/16/2007**

Organization : **Wake Forest University**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for consideration of this serious matter.

Lisa Newsome, MD

Submitter : Dr. Patrick Forte **Date:** 08/16/2007

Organization : University of Pittsburgh

Category : Physician

Issue Areas/Comments

GENERAL

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

Thank you for your consideration of this serious matter.

Submitter : Dr. frederick J mcKibben, M.D. **Date:** 08/16/2007

Organization : Dr. frederick J mcKibben, M.D.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment, previous comment issued mistakenly without attachment

CMS-1385-P-6052-Attach-1.DOC

#6052

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:

First let me thank you and Medicare for recognizing this longstanding disparity that has demonstrated attenuated recognition of our significant role in the care of our nation's elderly. As a population, those covered by Medicare routinely present a much higher risk for the administration of anesthesia, and yet they more frequently require surgical procedures that at best greatly improve their lives (e.g. Joint Replacements, Coronary Artery Bypass) and at worst are required to save their lives (e.g. Ruptured Aneurysm's, Acute Gastrointestinal Perforations, Trauma).

As the person responsible for the care of my mother, who is in the late stages of Alzheimer's, I am extremely aware of how little physicians are paid by Medicare and of the increasing difficulty of finding competent physicians willing to accept such low reimbursements. These physicians, who are being reimbursed at a relatively higher rate compared to Anesthesiologists, are taking steps to decrease the number of Medicare patients in their practices, because they cannot continue to care for these patients at their current rates of reimbursement. Anesthesiologists. who provide a required, very critical skill, that to be safely administered must similarly attract highly competent physicians are again being penalized further. How in this climate are anesthesiologists to sustain a viable practice, so critical to our Seniors?

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 serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am very pleased that the Agency accepted this recommendation in its proposed rule, and I strongly support full implementation of the RUC's recommendation.

To ensure that our patients continue to have access to expert anesthesiology 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.

Again, thank you for considering this complex and serious matter.

Sincerely,

Frederick J McKibben, M.D.
Staff Anesthesiologist
Huntington Hospital
Pasadena, California

Submitter : **Mr. sean hayes** **Date: 08/16/2007**

Organization : **first colony aquatic and rehab. center**

Category : **Physical Therapist**

Issue Areas/Comments

TRHCA– Section 201: Therapy CapS

TRHCA-- Section 201: Therapy CapS

A randomly selected Therapy cap for outpatient physical therapy services is ludicrous. The fact that outpatient hospital setting can furnish the same services in the absence of a cap is equally as confounding. Why would Medicare want its most needy beneficiaries to go to the least qualified place of service? Shouldn't clinics that make their way in the the world by getting results and fostering referral arrangements with superior care be the ones exempt from the cap?
Let's face it. The hopsital outpatient clinics are there because they have to be. They arc not set up to deliver the best care, they are set up to handle the in-house referrals of the doctors on staff. Results don't matter because the hospital isn't going to close down its PT clinic. They just tell the docs, "hey if you want to continue having cheap, on-location office space, and privileges at our hospital, you keep sending your patients to our clinic."

Submitter : **robert gorkiewicz** **Date: 08/16/2007**

Organization : **robert gorkiewicz**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a Physical Therapist, practicing in the state of Michigan. I feel very strongly that Physical Therapy services should NOT be allowed under the in-office ancillary services exception, as this promotes non compedative and therefore poor rehabilitation services.

Physical Therapy services should be provided on a free trade, compedative basis, to insure the highest quality of care without the risk of over utilization for profit.

Submitter : **Robert Jordan** **Date: 08/16/2007**

Organization : **Jordan Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a licensed physical therapist and have owned and operated a private clinic for the past 17 years. I am also the president of the Arkansas Physical Therapy Association. I writing to offer my stronges support to any revisions of CMS policy which strengthen language which prohibits physician self-referral. In my community, I see daily the abuses of self-referral. It is currently illegal for a physician or group of physicians to own their own pharmacy--for obvious reasons. Similarly, it should be illegal for a group of physicians to own physical therapy.

In such settings, the physicians are simply referring patients to in-house (employed) physical therapists simply to pad their own pockets. There is no accountability in these referral for profit arrangements and patients are not informed of their rights. I frequently have patients tell me that they were told they did not have a choice. Other patients are informed that outside providers do not have the same qualifications or expertise. When patients are injured or mistreated, the physician (owners) help to cover up the infractions with favorable medical opinions.

The facts are simple. Physicians need to practice medicine. They should not be allowed to benefit financially every time they make a referral for physical therapy, diagnostic testing, or laboratory services. The reality is that they are currently hiding beneath the guise that such services are being provided "incident to" the medical care they are rendering in their offices. This is simply a loophole that allows them to abuse a system for financial gain. The patients do not benefit and CMS foots the bill.

Referral for profit in all of its presentations is damaging our healthcare system and the government funded programs that support it. We must stop all such abuses and simply disallow any practices that allow one profession to profit from the exploitation of anther.

Sincerely,

Robert Jordan, PT, GCS, OCS
President, ArPTA

Submitter : **Dr. Jeff E Mandel** **Date: 08/16/2007**

Organization : **Hospital of the University of Pennsylvania**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Jeff E Mandel MD MS

Submitter : **Dr. David Selig** **Date: 08/16/2007**

Organization : **Brigham and Women's Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Submitter : **Dr. Stephen Ternlund** **Date: 08/16/2007**

Organization : **Dr. Stephen Ternlund**

Category : **Physician**

Issue Areas/Comments

GENERAL

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