Submitter : Mr. James Griesi **Date:** 08/21/2007

Organization : Mr. James Griesi

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please see attached letter.

CMS-1385-P-6981-Attach-1.TXT

CMS-1385-P-6981-Attach-2.PDF

#6981

Company Name Here [Click here and type return address]

August 30, 2007

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

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

Dear Sir:

My name is James Griesi and I have been a Physical Therapist and multi site therapy manager for 9 years. I am writing to you to strongly urge that Physical Therapy be removed as a designated health service (DHS) and therefore permissible under the in office ancillary exception of the federal physician self-referral laws. My reasons for this request re based on personal experience. Please see below:

1. Having worked and managed in physician owned physical and occupational sites, I have witnessed how they use their leverage to negotiate higher fees for services than independent PT practices even though all they are doing is collecting reimbursements. It goes something like this: The billing manager tells a prospective insurance company, "If you do not pay "X" rates for therapy services, our Orthopedists will not participate in your insurance plan". In small towns and rural areas, these physician owned practices have an unfair advantage over the Physical Therapists who are independent. Moreover, they are making a sickening profit. I remember that most years in the practice I worked in the MD's were collecting a 20%+ margin. I hope that this is excessive in the eyes of a Medicare policy maker.

2. Having been on the inside of these practices I know that there are competitions to be the best referrals source to the therapy clinics. Of course there is never any mention of whether the referrals are appropriate or justified—just that Dr X had the most referrals. This type of situation ("incident to" and MD owned PT practices) is clearly fraught with potential abuse and misuse of the Medicare health systems purpose and stated goals.

3. Fundamentally, medical disciplines are best managed and owned by those who put in the time to earn degrees and hold a license to practice in good standing. The field of Physical Therapy best serves Medicare (and all) patients when there are checks and balances in the utilization system. A therapist who's license and reputation is on the line has much more invested in making a good clinical decision about appropriateness of therapy than an MD who has a financial incentive to refer.

4. Lastly, as a rational and thinking professional, it has always been an absolute mockery to me that Stark Laws (legislative law—the strongest possible standard) whose stated purpose was to prevent/eliminate MD's in relationships where they could refer for profit to themselves or other family members has all these exceptions built in that fly in the face of the stated goal.

This is a great opportunity for the government to do what's best to patients and not the MD lobby. If you take this commendable step you will effectively decrease cost while increasing quality and accountability. What more could you want?

Thank you for consideration of my comments,

Sincerely,

James V Griesi, Jr. MPT

Physical Therapist/ Director of Operations

RehabCare Group

[Click **here** and type your name]
[Click **here** and type job title]

Submitter : **Date: 08/21/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

i believe that free market economy is the way togo . it gives consumer a choice and competition drives prices down . so a monpoly of physical therapy by one group is bad for pts is bad for competition and drive prices up .therapy offered by drs office allow drs to f/u pts closely and pt a choice to go anywhere they choose .one size fits all is never good and never fits anybody thanks

Submitter : Mr. Earl Tucker **Date:** 08/21/2007

Organization : Medical Diagnostics Inc.

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

"See Attachmcnt"

Submitter : Dr. William Schwark **Date:** 08/21/2007

Organization : Self employed

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs,
I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule.
This will help rectify the continued undervaluation of work performed by anesthesiologists.

Please support CMS-1385-P.

Thank you for your consideration of this serious matter.

Submitter : Mr. Jon Renner **Date:** 08/21/2007

Organization : Advanced Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Dear CMA 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 outpatient therapy services to our elderly patients in our community.

This proposed method for reduction in payment will undoubtedly result in a lack of patient access to necessary medical rehabilitation that prevents higher cost interventions, such as surgery 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.

Submitter : Mrs. Sylvia Zucker **Date:** 08/21/2007

Organization : Mrs. Sylvia Zucker

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Sincerely, Sylvia M Zucker.

Submitter : Dr. Myungsa Kang **Date:** 08/21/2007

Organization : UNC Hospitals

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,
Myungsa Kang, MD, MHS
Assistant Professor
Department of Anesthesiology
UNC Hospitals CB 7010
Chapel Hill, NC 27599-7010
(919) 966-9149

Submitter : Dr. Wade Taylor **Date:** 08/21/2007

Organization : Advanced Revenue Management

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. Luke Osborne **Date:** 08/21/2007

Organization : Dr. Luke Osborne

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I support the increase in CMS payments for anesthesiologists. This lack of funding is crushing academic institutions and limiting the influx of physicians to hosptals that treat community patients.

Submitter : Dr. Weng Thong **Date:** 08/21/2007

Organization : Advanced Revenue Management

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. Robert Valley **Date:** 08/21/2007

Organization : Department of Anesthesiology UNC Chapel Hill

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Sincerely,
Bob Valley

Submitter : Dr. Chyanson Tzan **Date:** 08/21/2007

Organization : Advanced Revenue Management

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Henry Venable **Date:** 08/21/2007

Organization : Advanced Revenue Management

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : Dr. Jenifer Youngblood **Date:** 08/21/2007

Organization : Advanced REvenue Management

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.

Submitter : Dr. William Furman **Date:** 08/21/2007

Organization : UNC-Chapel Hill

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Yours sincerely,
William R. Furman, MD

Submitter : **Date: 08/21/2007**

Organization :

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

See attachment

CMS-1385-P-6997-Attach-1.PDF

#6997

August 7, 2007

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

Issue Identifier: Issues related to Physicians Self-Referral Rules
File Code CMS-1385-P

Dear Sir:

I am writing you regarding self-referral issues. I am a radiation oncologist in practice and have been so since 1989. The dynamics in the marketplace continue to evolve. Numerous doctors are using every way, shape and form to cut through Stark referral rules to gain as much revenue as possible. From the radiation oncologist's point of view, it is okay for a surgeon to own a scalpel, medical oncologist to give chemotherapy, a urologist to use a lithotripser. When it comes to radiation therapy, however, every doctor that we work with wants to own their own linear accelerator whether it be the medical oncologist, urologist, or breast surgeon. This results in tremendous ABUSE if not fraud.

The dynamics regarding urology are particularly appalling. Previously radiation oncologists had worked very hard just to get a patient referred over for a second opinion to give patients the options of radiation therapy management, whether it be external beam radiation or brachytherapy. The urologists would do pretty much what they could to get the patients to go to the operating room. Many of these urologists are not trained to do laparoscopic or robotic radical prostatectomies which is in vogue. Now, however, with the advent of the Uro-Rad model, urologists have found a loophole in Stark law so that as a group practice they may own their own linear accelerator. What we see happening in our area is 40-some odd urologists working up to 30 miles apart getting together and forming a joint practice. Previously they had worked independently and competed against one another for patients. Now all of a sudden they are friends and partners in business. They will build a vault and put a linear accelerator in it and hire a radiation oncologist to treat their patients.

Listening to the urologists is particularly appalling. Many that I know have told me that once you form the Uro-Rad model and purchase a linear accelerator to work within your group practice, you must keep in mind that EVERY single prostate cancer patient is going to receive IMRT (intensity modulated radiation therapy). Previously patients would get an option if they were lucky of surgery vs. radiation therapy, and the radiation oncologist would discuss options regarding brachytherapy, external beam, or combination treatments. Now the urologists are taking every single patient that has prostate cancer and referring them and talking them into IMRT-based radiation therapy to maximize revenue for themselves and put the patient through eight and a half weeks of treatments. Then they talk to one another that they can recoup revenues on the order of $40,000.00 per patient and it is boosting their personal income over a half million dollars each. These doctors in town talk to one another and before you know it, every urologist in your community wants to own their own linear accelerator.

As a citizen of the United States, this would seem to game and abuse the system and cause costs to go way up. Furthermore and most importantly it is NOT good patient care. I think it is fine for patients in certain circumstances to have surgery, external beam radiation therapy, brachytherapy, or combinations thereof. It is not proper for the urologists just because they diagnosed a patient and see the patient first, to talk each and every individual into getting radiation therapy. In particular these same doctors weren't really interested in radiation therapy until they owned their own linear accelerator and they gamed and abused the system to do IMRT to recoup the most maximum reimbursement possible to pad their pocket books.

I am certainly not strong enough and powerful enough to overcome this but something needs to be done and said. It is my understanding that if one owns a linear accelerator, the referring doctors can operate it if is in their own building. One could understand this with five or six doctors getting together and wanting to do a group practice model. This is not what is taking place. This is 40-some odd doctors purchasing a linear accelerator some place and running it under their tax ID number to get it through the loopholes of the Stark amendments and referring the patients there to recoup as much money as possible. NONE of these urologists work in the same office as the linear accelerator. I am urging you to evaluate this practice. The dynamics are very sad. Furthermore, as a clinician and a practicing doctor I find it appalling.

For the profession of radiation oncology, it seems as time goes on more and more individuals find loopholes in the Stark amendment to refer only to places where they have ownership interest. What this will do is ruin the profession of Radiation Oncology. The radiation oncologists will be in business for awhile, be run out of business due to this kind of event and have to find another place to work. This has happened to me twice in practice already and I am certainly not strong enough to overcome it. Furthermore, the radiation oncologists cannot leave the office during the day given incident to coverage laws unlike these owner-referring doctors.

Thank you so much for looking into this situation. I urge you to close these self-referring loopholes. I think it is fine for the urologists to make a good living being urologists. I don't see why they have to be radiation oncologists in addition to that. Clearly they have no training in radiation oncology, have never done a residency and are not dedicated to our discipline. These individuals have contributed nothing to the medical literature for radiation therapy yet they are being put in a position to control the profession just because they make the diagnosis and see the patients first

Submitter : **Date: 08/21/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I worked in an orthopedic physician-owned physical therapy practice (POPS) for over 6 years in Maryland. During this time we mostly saw the patients referred to us by the physician owners, but not entirely, as we had several outside referrals. We were hardly a large profit-maker as we had a lot of overhead. They then hired an MBA who was successful in making another well-known large orthopedic group in Maryland make over a million dollars/year from their PT practice. After she was hired, a complete overhaul of the physical therapy clinic was done. Her goal, which she also was told she would profit from, was to have their PT clinic 'make at least 1 million dollars per year.' I left the practice before the overhauling had been done, but continue to be aware of and know some of those who continue to be employed there. The PT practice is now what PT's call a 'mill' which means they turn patients in and out at a rapid pace, with lack of personalized physical therapist intervention. Not only is a patient's care possibly being compromised because of self-referral, but charging Medicare might be an alarming and possibly fraudulent issue. A Medicare patient must be seen by a licensed Physical Therapist to be charged as such; Use of aides and certified Athletic trainers to work with these patcints may be compromising their coding and charging. This is common in many physician owned clinics. I 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. In addition, due to the repetitive nature of physical therapy services, it is no more convenient for the patcint to recieve services in the physician's office than an independent PT clinic that might be much closer to home, and of their own choice. There is no need for direct supervision by a physician to administer physical therapy. Thank you for the consideration of my comments.

Submitter : Dr. Holly Muir **Date:** 08/21/2007

Organization : Duke University

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please register my support of raising the conversion factor in anesthesia professional payments by CMS. Thank you

Submitter : Dr. Christopher Litynski **Date:** 08/21/2007

Organization : West Coast Anesthesia

Category : Physician

Issue Areas/Comments

Physician Scacity Areas

Physician Scacity Areas

Dear Sir/Madam:
I am writing this letter to request that CMS accept the RUC recommendation for increasing anesthesia conversion factor.
I practice Anesthesia in West Michigan, where majority of my
patients are Medicare and Medicaid recipients. Because of Anesthesia work undervaluation we are not able to recruit and replace leaving
Anesthesiologists and CRNA's to meet increasing demand from growing
elderly population.
Correcting Medicare's anesthesia conversion factor will significantly
increase our chances to attract new anesthesia providers and guarranty
timely service for all Medicare recipients.

Thank you for your consideration.

Christopher Litynski,MD

Submitter : Doug Simpson **Date: 08/21/2007**

Organization : meridian Physcial Therapy

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a pt and I have been in practice for 14 years. I have observed an increase in abuse of PT services when physcians have a financal incentive to refer to their own practice. Physcians that rarely refer to PT have started to refer to their own PT services because of the financal gain. They also require thier patient to be seen by their therapist. I stongly encourage CMS to no longer allow Physical therapy services to be provided under the In - office ancillary service exception.

Submitter : Mr. James Burdumy **Date:** 08/21/2007

Organization : Medicare Recipient

Category : Individual

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 a Medicare Recipient writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue. When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just $16.19 per unit. This amount does not cover the cost of caring for our nation s seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations. In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule. and I support full implementation of the RUC s recommendation. To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC. Thank you for your consideration of this serious matter.

James T. Burdumy

Submitter : Ms. Cindy Herold **Date:** 08/21/2007

Organization : St. Charles Clinic Medical Group

Category : Other Health Care Professional

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

CODING-ADDITIONAL CODES FROM 5-YEAR REVIEW: As a cardiac sonographer for the past 20 years I oppose to the mandate that will allow Medicare to "bundle" color flow Doppler into the other echo based codes. Each technique has it's own purpose and the doctor that is requesting the test specifically orders each technique for the patients pathology. We do not routinely do a color flow doppler with a spectral doppler study. Sometimes just a 2 dimensional picture is used to follow up on pericardial effusions etc. So if you are grouping all the charges, it will take more time on the technicians part as well as the physicians time to read the doppler portions. Hopefully you will reconsider and reevaluate the need for us to differenciate between all modes for the comfort and quality of the test we provide to the patients. Thank you very much for your consideration.

Submitter : **Date: 08/21/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

The potential for fraud and abuse exists whenever physicians are able to refer Medicare beneficiaries to entities in which they have a financial interest, especially in the case of physician-owned physical therapy services. Physicians who own practices that provide physical therapy services have an inherent financial incentive to refer their patients to the practices they have invested in and to overutilize those services for financial reasons. By eliminating physical therapy as a designated health service (DHS) furnished under the in-office ancillary services exception, CMS would reduce a significant amount of programmatic abuse, overutlization of physical therapy services under the Medicare program, and enhance the quality of patient care. I don't beleive that one profession should own rights or privledges to another profession and proffit as a result of having said privledges. This greatly affects the autonomy of the Physical Therapy Profession.

Submitter : Mrs. Miryam Simonovis **Date:** 08/21/2007

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-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.

Mireyam Simonovis

Submitter : Dr. Allan Goldstein **Date:** 08/21/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

August 21, 2007

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.

Yours truly,

Allan Goldstein, M.D.

Submitter : Dr. Eugene Lee **Date:** 08/21/2007

Organization : University of North Carolina

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.

Sincerely,
Eugene Lee M.D.

Submitter : Mrs. Janice Conway **Date:** 08/21/2007

Organization : Mrs. Janice Conway

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

This increase in Medicare payment is important for several reasons.

- First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
- Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
- Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).

America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Submitter : **Dr. Thomas Bride** **Date: 08/21/2007**

Organization : **Dr. Thomas Bride**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

Re: CMS-1385-P

Anesthesia Coding (Part of a 5-Year Review)

Dear Ms. Norwalk:

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation- a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC;s recommendation.
To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.
Thank you for your consideration of this serious matter.
Sincerely, Thomas P. Bride D.O.

Submitter : Dr. Michael Petrover **Date:** 08/21/2007

Organization : Anesthesiologist

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

I want 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 consideration of this serious matter.

Submitter : Dr. Louis Susman **Date:** 08/21/2007

Organization : New York Hospital Queens

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 21, 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 Flushing, NY as an employee of New York Hospital Queens

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,

Louis K. Sussman, M.D.

Submitter : Dr. Daniel Thomas **Date:** 08/21/2007

Organization : Duke Anesthesiology Residency Program

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 : Mrs. Marlette Williams **Date:** 08/21/2007

Organization : Mrs. Marlette Williams

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

Dear Ms. Norwalk,

I am writing to support the CMS proposal to boost the value of anesthesia work by 32%. If adopted, CMS' proposal would help to ensure that CRNA as Medicare part B providers can continue to provide Medicare beneficiaries with access to anesthesia services
First medicare under reimbureses for anesthesia services putting at risk the availability of anesthesia and other healthcare services for Medicare. reserach shows some services are reimbursed at 80% whereas anesthesia is only reimbursed at about 40% of private market rates. Second proposed rule review and adjusta are for 2008. Most were effective January 2007. Third CMS proposed change in relative value of anesthesia work would help correct the value of anesthesia services which have longed slipped behind inflationary adjustments.
Medicare and healthcare delivery depend on our services
I supportthe agency's acknowledgement that anesthesiapayments have been undervalued and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payments.

Submitter : **Date: 08/21/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

As a physical therapist with 20 years of experience in the southwestern Michigan area, I would like to comment on the proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception. For those of us who practice in an independent, therapist-owned setting, it is easy to see the potential for abuse and overutilization of therapy services in a setting where the physician has ownership interest in those services.

In the State of Michigan, a physician's prescription is required for a patient to receive physical therapy services. Therefore, the doctor has a significant amount of influence on where they wish to send the patient for therapy treatment. In a self-referral arrangement, the physician usually directs the patient to their "in-house" facility that they own, stating that they will be able to "stop in and check on them" or interact with their therapist directly. Quite often, the facility is a significant distance from the patient's home, requiring them to drive several miles 2-3 days per week for treatment when there may be a clinic such as ours located within their own community. On many occasions I have heard patients say "I wish I could have come to your office for treatment since it is so close to my home, but my doctor told me to go to HIS therapist". I also have yet to hear a patient testimony stating that the doctor "stopped in to check on them" during therapy sessions.

Another concern regarding the self-referral arrangement is in regard to quality of services. I know that many of the physician-owned clinics in our area are staffed primarily with physical therapy assistants rather than physical therapists, and patients are not always made aware of the credentials of their treating clinicians.

Yet another concern is in regard to the autonomy of our profession. Physical therapy educational programs in Michigan have been elevated to a doctorate level, providing graduates with a high level of expertise in their field. In the physician-owned setting, it would be very easy for therapy clinicians to become complacent and rely on the clinical decision-making efforts of the physicians or the use of their pre-established protocols, thus becoming a "puppet", so to speak. The self-referral arrangement also discourages competitive pricing of services, comparison of outcomes with other providers,etc. Physician-owned therapy services seem to be developing at a rampant pace in our area and I am very concerned about the effect it will have on the physical therapy profession as a whole.

Your time is certainly appreciated in reviewing these comments. I would encourage you to seriously reconsider the proposed legislation regarding physician self-referral and the "in-office ancillary services" exception in order to continue to promote the highest quality therapy services available and to discourage potential abuse of those services.

Submitter : Mrs. Michelle Henley **Date:** 08/21/2007

Organization : Mrs. Michelle Henley

Category : Physical Therapist

Issue Areas/Comments

TRHCA-- Section 201: Therapy CapS

TRHCA-- Section 201: Therapy CapS

Putting a cap on OP PT services rendered by private practice is unethical. There should be no cap on outpatient services or everyone should abide by the same cap. I think it is safe to say that the highest quality of therapy is received through private practices and it is not right to eliminate this as an option for our patients.