Submitter : Dr. Isreal Crespo **Date:** 08/24/2007

Organization : AMA

Category : Physician

Issue Areas/Comments

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

Coding--Multiple Procedure Payment Reduction for Mohs Surgery

I am a physician in a busy endoscopy center seeing over three hundred patients a week. The medicare reimbursement cut has greatly affected the entire facility. As the number of patients we see increased and our reimbursement decreases, it is difficult to keep up the quality of care./ Please support the medicare reimbursement revision. Thanks you.

Submitter : Dr. Jerry Szych **Date:** 08/24/2007

Organization : Dr. Jerry Szych

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

It is a sad day indeed when the well being of the medicare patient is no longer protected by allowing reimbursement for imaging referred by a Doctor of Chiropractic. This is clearly a huge step backwards and will have a devestating negative impact.

Submitter : **Date: 08/24/2007**

Organization :

Category : **Chiropractor**

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,

Dana Matthews

Submitter : **Dr. richard polino** **Date: 08/24/2007**

Organization : **Dr. richard polino**

Category : **Chiropractor**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

Re: TECHNICAL CORRECTIONS

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

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

Sincerely,

dr a richard polino

Submitter : Dr. William Hinkley **Date:** 08/24/2007

Organization : Hinkley Medicine

Category : Physician

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

As a practicing solo cardiologist who offers primary care as well as specialty care to my patients, I submit that echocardiography is an essential tool of my trade. The ACC and AHA several years ago in announcing a new classification system for congestive heart failure wrote that echo is the single most valuable tool for identifying structural heart damage and thus early appropriate treatment. While DRG #127 is the #1 diagnosis for Medicare hospitalizations, consuming > 60 billion of the annual budget, it is now possible, and I pride myself in preventing admissions for CHF thru aggressive use of echo, modern medications, and counselling time with patients.Yet I have had to increase my costs to provide a certified technician (RDCS)in an accredited office (ICAEL) Increased attention is now being paid to color doppler (93325)as a means of refining the assesment of severity of valvular insufficiencies thru mesurements of vena contracta and PISA (proximal isovelocity surface area)maneuvers and calculations which increase technician and physician time. The American Society of Echocardiography writes that the "size of the regurgitation jet by color Doppler and its temporal resolution however, are significantly affected by transducer frequency and instrument settings such as gain, output power, Nyquist limit, size and depth of the image sector. Thus, full knowledge by the sonographer and interpreting echocardiographer of these issues is necessary for optimal image acquisition and accuracy of interpretation." While Congress purportedly "blocked" the fee reduction scheduled for 2007, the allowable for 93325 dropped this year by $21.40, an 18% reduction!! Bundling 93325 in 2008 would result in a further 26% reduction in the allowable for complete echo, while my rent, malpractice insurance, health insurance, secretarial, technical, accounting and supplies expenses steadily increase. Ironically, of the 54 codes in the 5 year review of work relative value units, 93325 which had a requested work RVU increase, was the only one with which CMS disagreed. I, and I am confident my cardiology colleagues, request reconsideration of your proposal.

Submitter : **Mrs. debbie kaufman** **Date: 08/24/2007**

Organization : **american ass. of nurse anesthetists**

Category : **Other Practitioner**

Issue Areas/Comments

Background

Background

August 20, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
__Debbie Kaufman CRNA_____
Name & Credential
___60 Osage Trail_____
Address
_____Louisville,Ky 40245_____
City, State ZIP

Submitter : **Dr. Nadine Coudret** **Date: 08/24/2007**

Organization : **University of Southern Indiana**

Category : **Academic**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

File Code CMS-1385-P: Comments Related to Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2008
I am writing to offer my opinion about the Proposed Rule CMS-1385-P as it relates to the provision of Home INR Monitoring services (G-0248 and G-0249). My perspectives are based on my experience as Dean of the College of Nursing and Health Professions at the University of Southern Indiana.
Our college offers a unique continuing education program for nurses, pharmacists and physicians with responsibility for monitoring and managing outpatient anticoagulation therapy. This program focuses on the physiology and pathophysiology of thromboembolic disorders, patient assessment and management, pharmacology of antithrombotic agents, patient education and program administrative procedures. Over the years, we have been following the development of Medicare s decision to cover of Home INR Monitoring. In fact, we offer a separate program specifically focused on the concepts and practices of Anticoagulation reimbursement. The content for both programs were designed utilizing the competencies for anticoagulation therapy providers developed by the Certified Anticoagulation Provider Working Group and has been reviewed by local and national experts. To date, we have awarded certificates in both programs to over 4,000 health care professionals many of whom use point of care INR monitors for patients on anticoagulation therapy.
I am writing today to express my concerns related to the payment methods used by CMS and a recommendation to ensure that all training services be performed on a face-to-face (rather than an impersonal telephonic) basis.

1. Training Methods (G0248): As the adoption of Home INR Monitoring has grown over the past several years, it has come to my attention that some non-physician providers choose to train patients by telephone or by simply providing the patient a video/DVD to review. I want CMS to be aware that these approaches are inconsistent with recommendations made by our program and with the most recognized guidelines Managing Oral Anticoagulation Therapy published by three members of our National Advisory Board (Jack Ansell, M.D., Lynn Oertell, M.S. and Ann Wittkowsky, PharmD). In my professional opinion I believe that it is not possible to properly train patients in Home INR Monitoring using impersonal telephonic or DVD/video methods. For this reason, I recommend that CMS ensure that the resource-based RVUs for G0248 be based on at least 2 hours of Clinical Staff time and to specifically confirm that payment for G0248 services will not be made for telephonic or other impersonal training methods.

2. Payment Methods (G0248/G0249): I believe that the current method that CMS uses to pay for INR monitoring equipment is confusing for health care providers. By amortizing the capital cost of the INR monitor on a per test basis CMS has inadvertently created a financial incentive for providers to mandate the maximum number of tests per year (i.e. 52) without consideration for the real needs of the patient or the recommendations of the treating physician. Therefore, as an alternative to this approach, I strongly recommend that CMS consider treating the entire cost of the monitor as a one-time upfront cost included in G0248. Doing so would eliminate the incentive for certain providers to over test and would fairly compensate legitimate providers for the cost of the equipment upfront.

I sincerely appreciate the opportunity to comment on these issues and would be happy to provide further information if needed.

Sincerely,

NADINE COUDRET, RN, EdD
Dean, College of Nursing and Health Professions
Professor of Nursing

Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Greetings.
I oppose the physician's abilty to refer their patients for an ancilliary service that has monetory connection to them including ownership. That has a great potential for misuse and substandard care. These include Physical Therpay services, and physicians are known to hire inadequately trained personnel like ATCs, Massage Therapists, to provide these Physical Therapy services. Medicare should not be validating these practices by paying Physicians for these services.
Appreciate your attention.

Submitter : **Mr. David Williamson** **Date: 08/24/2007**

Organization : **Rehab**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician Self-referral Issues: My comment pertains to the 2008, July 12 physician fee schedule rule. In Arkansas, more and more physicians are adding a part-time physical therapist to their staff, performing the lowest standard of care as it pertains to outpatient rehab. This standard of care is low due to the fact that they often provide no treatment area beyond the patient rooms they use for their own medical practice. I have been practicing for 15 years. I have never seen the quality of therapy drop more than in the last few years in regards to outpatient services, mostly due to physicians taking therapy services in-house, but not committing to the financial obligations that a rehab clinic costs to equip and operate. Most of the patients who recieve therapy in a physician's office have to go a second round in a true rehab clinic later, as the quality of therapy is often so low initially, it was of no benefit.

Submitter : Ms. Melody Windrow **Date:** 08/24/2007

Organization : AANA

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

ANESTHESIA SERVICES

Dear Administrator:

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Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments. Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation). America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Melody D. Windrow SRNA
Midddle Tennessee School of Anesthesia

Submitter : **Dr. Richard Whitten** **Date: 08/24/2007**

Organization : **Noridian Administrative Services**

Category : **Physician**

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

Colleagues: In the Federal Register/ Vol. 72, No. 133/ Thursday, July 12, 2007 / Proposed Rules, page 38138 appears the conclusion:

(iii) Equipment and Supplies: We assume that items such as medical equipment and supplies have a national market and that input prices do not vary among geographic areas. As mentioned in previous updates, some price differences may exist, but we believe these differences are more likely to be based on volume discounts rather than on geographic market differences. Equipment and supplies are factored into the GPCIs with a component index of 1.000. (End of quote)

Whereas this may be a logical and reasonable conclusion for much of the contiguous United States, it is manifestly unfair to areas where shipping costs for equipment and supplies are a much more major factor such as the Pacific territories of American Samoa, Guam and the Mariana Islands, and for much of the Hawaiian Islands and large portions of Alaska. As contractor medical director in these regions, I have seen a great many examples where providers are forced to limit services because of the inadequacy of Medicare reimbursements that allow no differential for inadequate shipping costs, commonly by air. Is it not possible to better assess some factor to account for the routine, inordinate shipping differential to these areas, please? Thank you for considering.

Richard W. Whitten, MD, MBA, FACP
Contractor Medical Director, Medicare B for AK, HI & WA

CMS-1385-P-7573-Attach-1.DOC

7573

Re: GEOGRAPHIC PRACTICE COST INDICES (GPCIs)

Colleagues: In the Federal Register/ Vol. 72, No. 133/ Thursday, July 12, 2007 / Proposed Rules, page 38138 appears the conclusion:

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Richard W. Whitten, MD, MBA, FACP
Contractor Medical Director, Medicare B for AK, HI & WA

Honolulu 808 522-1570
Kent, WA 253 437-5402

Submitter : Ms. Katharine Ayres **Date:** 08/24/2007

Organization : Clinical Laboratory Management Association (CLMA)

Category : Health Care Professional or Association

Issue Areas/Comments

Clinical Laboratory Issues

Clinical Laboratory Issues

See attachment

CMS-1385-P-7574-Attach-1.DOC

#7574

CLMA
THE RESOURCE FOR LABORATORY PROFESSIONALS

989 Old Eagle School Rd., Suite 815
Wayne, PA 19087-1704
tel 610 995 9580
fax 610 995 9568
www.clma.org

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
7500 Security Boulevard
Baltimore, MD 21244-8018

Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008;and he Proposed Elimination of the E-Prescribing Exemption for Computer Generated Facsimile Transmission

Introduction:

On behalf of CLMA, the Clinical Laboratory Management Association, an organization of more than 4,300 clinical laboratory professionals and consultants representing hospitals, independent clinical laboratories, physician office laboratories, skilled nursing facilities, and medical device companies, I am writing in response to the July 12, 2007 *Federal Register* notice, Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions. The proposed rule published on July 12, 2007 addresses issues related to the clinical laboratory fee schedule.

CLMA's comments address issues in the following sections:

G. Issues Related to the Clinical Laboratory Fee Schedule

1) **New Clinical Diagnostic Laboratory Test**
2) **Technical Revisions**

New Clinical Diagnostic Laboratory Test

Reconsideration Process:

The proposed rule includes a reconsideration process that would apply to new tests on or after January 1, 2008. Comments in response to a new test that is cross-walked would be accepted for 60 days after a payment determination is posted. Any changes to the payment determination would be final and applied to the next year. If a gap filled test is changed to a test that is cross walked, the new cross walk would not be subject to further reconsideration.

New tests that are gap filled would be subject to reconsideration within the first year. Comments would be accepted for 60 days after carrier-specific payment amounts are posted on April 30th of each year. Changes would be used to adjust the National Limitation Amount (NLA) for the next year. If a new test is changed from being cross-walked to gap filled, it would be subject to the reconsideration process.

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Regarding the proposed reconsideration process, CLMA supports the recommendation proposed by the Advanced Medical Technology Association (AdvaMed) of more than one public meeting per year, in addition to the CMS public meeting on payment determinations typically held in July each year, to discuss comments under the reconsideration process. We also support not limiting oral comments at the public meetings only to those who submitted written comments.

CLMA would also like to recommend that CMS allow comments under the reconsideration process in response to both the carrier-specific amounts posted on April 30th of the first year, and the final amounts posted on September 30th. Although we understand and appreciate CMS' time constraints and the attempt to confine the process to within a year, we believe the laboratory community should be afforded maximum opportunities to comment during the reconsideration process utilizing all available data.

Cross Walks:
CLMA also supports AdvaMed's recommendation of when cross-walking payment for a new test, to set the payment amount at the national limitation amount (NLA) of the test on the clinical laboratory fee schedule to which the new test is cross-walked.

CLMA believes cross walks to the NLA will avoid inappropriate cross-walks, which may be based on erroneous historical pricing of the tests being cross walked to. This will also avoid perpetuating an already irrational clinical laboratory fee schedule.

Gap fill:
Regarding the gap fill process, CLMA supports the following general recommendations put forth by the Advanced Medical Technology Association (AdvaMed) during the July 16, 2007 public meeting to discuss payment determinations for new 2008 Current Procedural Terminology (CPT) codes for clinical laboratory tests:

1. Contractors that are familiar with a test, and are responsible for areas where a new test will be performed and claims would be processed, should be chosen to gap fill that test
2. Contractors chosen to gap fill a new test should receive clear instructions from CMS and consider a number of factors, e.g., resources needed to perform the test, staff expertise, time needed to perform the test and its potential value
3. CMS should publish the gap fill prices determined by contractors and an explanation of the price
4. An expert advisory committee, broadly representative of the laboratory industry should advise CMS, on cross walks and gap fill pricing

CLMA would also like to reiterate our comments in response to the 2007 PFS. For gap filling, CLMA recommends that CMS establish requirements for documentation and standardize the sources and quantity of data that contractors use in gathering the charge and cost information.

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We believe that if the gap filling process was clearly defined and rational, it could truly be considered as an option by the laboratory community in making recommendations for payment determinations for new CPT codes.
In order to avoid a full year of potentially inappropriate gap fill amounts set by individual carriers, CLMA would also like to specifically recommend that CMS establish a temporary NLA based on the carrier-specific amounts posted on April 30th within the first year of the gap fill process.

Technical Revisions
This section of the 2008 PFS proposed rule would define the term "new test" in regulation using the statutory definition of "any clinical laboratory test for which a new or substantially revised HCPCS code is assigned on or after January 1, 2005."
CLMA supports this technical revision as proposed.

In closing, CLMA appreciates the opportunity to comment on these important issues. Our members and staff stand ready to answer any questions or concerns that you may have regarding these comments.
Please contact Katharine I. Ayres, CLMA Director of Legislative and Regulatory Affairs, at kayres@clma.org or 610.995.9580 for further assistance.
Sincerely,

JoAnne Milbourn

JoAnne Milbourn, President

Submitter : **Dr. John Vu** **Date: 08/24/2007**

Organization : **St. John's Health System**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am an anesthesiologist in Anderson, Indiana. Most people in Anderson receive the medical benefits thru medicare or medicaid. For this reason, it is very difficult to recruit new anesthesiologist to come to this city to provide anesthesia to patients who need surgery. Who wants to come to Anderson if they could not make decent income? It will be very helpful if the reimbursement to the anesthesiologist from CMS is increased so that those who are providing anesthesia to the medicare and low-income population will not leave this area; and new anesthesiologists have more incentives to come to this area.

If you have any question or suggestion for me, please call me at 765-646-8490. Thank you for reading this comment and thank you for your support.

John T. Vu

Submitter : Mary Albert **Date:** 08/24/2007

Organization : Resurgens Orthopedics

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Physician owned PT and imaging is BENEFICIAL TO THE PATIENTS. Patients have the right to choose who provides their medical services and many prefer a PT facility that is affiliated with their treating physician. Physician owned facilities allow the MD to more closely monitor their patients during the course of care. An additional benefit is increased competition in the physical therapy arena which results in decreased costs. And, there is a higher ratio of therapists to patients-something which can only benefit patients.

Please consider these issues and do not ban referrals to physician-owned physicial therapy facilities.

Submitter : **Mr. Kenneth Kron** **Date: 08/24/2007**

Organization : **Physical Therapy Plus**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 23, 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 21244-8018

Re: Physician Office PT/OT Services

Dear Mr. Weems;

I am writing this letter to express my concern regarding the in-office ancillary service arrangements that have impacted the delivery of quality physical and occupational therapy.

The in-office ancillary services exception has created a loophole which has resulted in many physician-owned arrangements that provide substandard physical and occupational services.

Physicians are in a position to refer Medicare beneficiaries to in-office physical and occupational services in which they have a financial interest. There is an inherent financial incentive to overutilize services under the in-office ancillary services option.

Therapy treatments are repetitive in nature. Patients receiving outpatient physical and occupational therapy can just as easily return to a therapy clinic as to the physician office.

I have been made aware of situations by patients of abusive arrangements by physician offices who have pressured patients into receiving physical therapy treatment in their facility even when the patient has requested to go to another facility such as the one that I manage. These physician offices pressure patients into receiving treatment in their own facility, and deny patients their right to treat at the facility of their choice.

Thank you for considering these comments and eliminating this in-office ancillary services .

Sincerely,

Kenneth Kron, MPT, CSCS

Submitter : Mr. Justin Lawson **Date:** 08/24/2007

Organization : Elite Sports Medicine and Orthopaedic Center, PLC

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Re: Section II.M3; In-Office Ancillary Services Exception.

The current Stark Laws should remain intact with regard to the physician's ability to meet the Safe Harbor exclusion for providing Physical Therapy Services. The physician must have the ability to impact the course of care and should be accessible to the physical therapist to promote and improve communications - through face-to-face interaction - regarding patients and their progress. All barriers in communication should be removed and locating physical therapy clinics within physician practices improves the quality of care and can make the rehabilitation process more efficient and less costly. Physical therapists working under physicians are also not motivated, in most circumstances, to improve their personal profits by over-billing and increasing the length of stay. Finally, physical therapists working with physicians have a unique opportunity to spend time with the physician in the clinical and surgical environment, which clearly improves the communication, education and treatment process and results in happier patients that feel more comfortable with a therapist who is working under the direction and supervision of their trusted physician.

Submitter : Dr. Richard Whitten **Date:** 08/24/2007

Organization : Noridian Administrative Services

Category : Physician

Issue Areas/Comments

Beneficiary Signature

Beneficiary Signature

Colleagues: In this section of the Proposed Rule it is proposed to waive the requirement for a beneficiary signature under certain emergency conditions. This is logical and appropriate. It should, however, apply only when the transport is to the closest facility equipped and able to handle the emergency condition (a requirement for Medicare payment). In circumstances where transport is to any more distant facility, the ambulance provider or supplier should continue to be required to otain a beneficiary's (or other authorized) signature. In these circumstances the signature will evidence an understanding and acceptance of the condition that the beneficiary is responsible for the excess transportation cost to the more distant facility. Thank you for considering. Richard W Whitten MD, Contractor Medical Director for AK, HI & WA.

Submitter : **Ms. Joan Dobbins** **Date: 08/24/2007**

Organization : **Ms. Joan Dobbins**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

August 24, 2007
Office of the Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8018 RE: CMS 1385 P (BACKGROUND, IMPACT)
Baltimore, MD 21244 8018 ANESTHESIA SERVICES
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ı First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
ı Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007. However, the value of anesthesia work was not adjusted by this process until this proposed rule.
ı Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.
Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation).
America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.
Sincerely,
Joan Dobbins, CRNA, MS, APRN
323 Thistle Lane
Southington, CT 06489

Submitter : **Date: 08/24/2007**

Organization :

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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Sincerely,

__Eric Toohey _____
Name & Credential
__2204 Crescent Valley Lane_____
Address
__Hermitage, TN 37067_____
City, State ZIP

Submitter : Dr. John Sherry II **Date:** 08/24/2007

Organization : American Society of Intrventional Pain Physicians

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Payment cuts presently planned will be devastating to my medical practice.

Submitter : **Mr. Alan Howell** **Date: 08/24/2007**

Organization : **Howell Rehabilitation, Inc**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 16, 2007

Carey N. Weems
Administrative Designate
Centers for Medicare and Medicaid Services
US Department Health and Human Services
Attn: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

RE: Medicare Program, Proposed Revisions to Medicare Policies under Physician Fee Schedule, and other Part B payment policies for CY 2008; proposed rule

Dear Mr. Weems,

I am a physical therapist practicing here in Cincinnati, Ohio. I have been practicing physical therapy for over 30 years in this current region. My first 15 were in physician-owned physical therapy clinics, and then the rest have been independent practice. During this past 3 years I have noticed a significant change in the climate of physical therapy, specifically in referral for profit situations. During my years in a physician-owned physical therapy practice, specifically one physician owned the physical therapy practice where the other four or five at the time did not. The referral pattern was significantly different based on who owned the physical therapy and not. The potential for fraud and abuse in this situation was great.

As for the climate in Cincinnati today based on the Stark II laws, Cincinnati has approximately 70 orthopedic surgeons, of which five have chosen not to own their own physical therapy. Three years ago we built out space in a physician-owned building that housed five orthopedic surgeons. These orthopedic surgeons charged a fair market rate for the rent. We saw it as an excellent opportunity to move into a building where orthopedic surgeons are located due to the patient flow. At that time these physicians did not own physical therapy and did not care to. We did have a well established practice at that time since we were in that area for approximately 5 years prior to moving to this new

location. Approximately 1 ? years after being in this location and realizing a significant traffic flow of patients, including referrals to physical therapy, these including patients that were the physician s family members. Since that time this group has joined another orthopedic group that owns their own physical therapy. Our referrals are less than half. Patients have requested us and were told that they must attend physical therapy at the physician-owned practice location that is much further away.

At another location we had patients actually scheduled for post-operative visits and called to cancel based on the physician demanding that his patients stay in his practice even though our location is far more convenient to their home and the patient knows of our reputation for quality care. The patient was told they are not to attend therapy here outside of his office. This past year seven (7) private practice physical therapy locations have closed due to referral for profit, thus limiting access to independent physical therapists.

These are real examples since the Stark II laws have come into play. The choices patients used to enjoy in seeking the best care, as well as the most convenient location, are no longer being allowed. I see a tremendous potential for abuse that may occur from these types of services in physician-owned offices and I would hope that you would consider these points.

Thank you Mr. Weems for your consideration of my comments and would hope that if you have any questions you would not hesitate to contact me.

Sincerely,

Alan J. Howell, PT, SCS, ATC

AJH/blh

CMS-1385-P-7584-Attach-1.DOC

#7584

August 16, 2007

Carey N. Weems
Administrative Designate
Centers for Medicare and Medicaid Services
US Department Health and Human Services
Attn: CMS-1385-P
PO Box 8018
Baltimore, Maryland 21244-8018

RE: Medicare Program, Proposed Revisions to Medicare Policies under Physician Fee Schedule, and other Part B payment policies for CY 2008; proposed rule

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Sincerely,

Alan J. Howell, PT, SCS, ATC

AJH/blh

Submitter : Mrs. diane simon **Date:** 08/24/2007

Organization : Mrs. diane simon

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

It is so important to keep these services acsessable especially to those patients who are older and those patients for whom traveling to another facility would prove to impose an unnessisary hardship-thank-you in advance for your consideration regarding this very crucial matter.

Submitter : **Mr. Anthony J. Lewandowski** **Date: 08/24/2007**

Organization : **Mr. Anthony J. Lewandowski**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

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

Dear Ms. Norwalk:

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Sincerely,

Anthony J. Lewandowski, CRNA
42 Rosemont Ave.
Rosemont, Pa 19010

Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

If fee-splitting and referral for profit remain an obvious major issue for concern, how is physician self-referral any different? Any motivation other than ensuring patients receive excellent care should be suspect. Physical and Occupational Therapy services should remain under the control of those who practice in these fields, not with physician practices trying to fatten their bottom line.

Submitter : Dr. David Woodward **Date:** 08/24/2007

Organization : Irvine Anesthesiology Consultants

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 cautiously optimistic about the proposal to increase anesthesia payments in the 2008 Physician Fee Schedule. Anesthesia services for Medicare patients have been grossly undervalued for far too long.

Anesthesiologists complete twelve years of rigorous education and training in order to practice one of the most demanding, stressful, and important occupations in the country. This training requires huge sacrifices as it encompasses nearly all waking hours. In my case, I also had to join the military to pay for medical school. This added three additional years before I could begin my practice.

As you are aware, we act as the patient s advocate pre-operatively assuring that their health issues have been optimized to minimize their risk of surgical complications (death, heart attack, stroke, etc.).

During surgery, we function as the patient s cardiologist, internist, pulmonologist, nurse, ER physician, psychiatrist, and all else necessary to keep them alive and well while surgeons dissect their hearts, livers, brains, etc.

Postoperatively, we serve as their pain specialist while continuing to address their individual medical needs.

With all these functions and responsibilities comes extraordinary stress (and lawsuits).

It is unfair that our hourly wage for these efforts is less than mechanics, plumbers, or even nurses working in the same OR. It s about one fifth of our lawyer s hourly fee.

Our senior patients require the best and brightest anesthesiologists to achieve optimal outcomes. However, Medicare s absurdly low reimbursement to anesthesiologists has resulted in many good anesthesiologists choosing to work in Medicare-free locations.

As the Chairman of our Anesthesiology Department, I observe with dismay as excellent anesthesiologists leave our hospital (where their skills are critically needed) and practice in less demanding settings where they are reimbursed fairly. Some have left the field of anesthesiology entirely for occupations that contribute significantly less to our society.

It is obvious that the present formula used to establish anesthesia conversion rates is grossly flawed. I encourage you to implement the anesthesia conversion factor increase as recommended by the RUC as soon as possible!
Sincerely,
David Gwyn Woodward M.D.

CMS-1385-P-7588-Attach-1.DOC

#
7588

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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Sincerely,

David Gwyn Woodward M.D.

Submitter : Dr. Anu Chirala **Date:** 08/24/2007

Organization : Anu Chirala M.D.

Category : Physician

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

"see attached comment"

CMS-1385-P-7589-Attach-1.PDF

7589

Anu Chirala M.D., F.A.C.C
Board Certified in Cardiovascular Diseases
& Nuclear Cardiology

18550 DePaul Drive, Ste 109
Morgan Hill, CA 95037
(408) 779-9422
(408) 779-4113 (Fax)

9460 No Name Uno, Ste 115
Gilroy, CA 95020
(408) 842-4066

August 23rd, 2007

Amy Bassano
Director, Division of Practitioner Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, C4-01-26
Baltimore, MD 21244

Re: CMS-1285-P: CY 2008 Physician Fee Schedule Proposed Rule
Practice Expense -- Equipment Usage Percentage

Dear Ms. Bassano:

Thank you for considering this comment on the 2008 Physician Fee Schedule Proposed Rule. I am a Board Certified Cardiologist (and Nuclear Cardiology), and I am writing to discuss payment for Microvolt T-wave Alternans (MTWA) diagnostic test. MTWA is an important tool to determine a patient's risk of sudden cardiac death. I am concerned that Medicare payment for physicians for MTWA is based on an incorrect utilization assumption that results in a significantly lower payment. CMS should consider the actual utilization of MTWA when calculating the practice expense for MTWA.

In patients at high risk for sudden cardiac death, Medicare has expanded coverage of implantable cardioverter defibrillators (ICDs) as a preventive measure. MTWA is extremely valuable in identifying which patients will benefit most from an ICD. Published data indicates that patients with negative MTWA tests will typically receive no significant reduction in cardiac arrest-related deaths, allowing us to identify patients who are more likely to benefit from an ICD.

MTWA testing is a non-invasive procedure that takes about [60] minutes. Unfortunately, the Medicare Practice Expense formula significantly decreases physician payment for MTWA. Reimbursement for MTWA is calculated using an "equipment usage assumption" of 50 percent. The assumption that the MTWA equipment is used 50 percent of the time is inaccurate and results in an inappropriately low payment. In my practice, MTWA is typically used only for the specific high-risk patients who will benefit greatly from its analysis. On average, we use MTWA several times per week, but significantly less than 50 percent of the time.

In order for Medicare to pay appropriately for this valuable technology, and to ensure that physicians continue to use it for their patients when appropriate, CMS should use the actual usage rate when available. I would be happy to provide documentation to demonstrate our actual utilization rate. Please do not hesitate to contact me for this information or if I can answer any other questions about MTWA.

Sincerely,

Anu Chirala MD, FACC

Submitter : **Ms. Barbara Marone** **Date: 08/24/2007**

Organization : **American College of Emergency Physicians**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-7590-Attach-1.DOC

7590

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

August 20, 2007 **Attention: CMS-1385-P**

Herb B. Kuhn, Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1385-P: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for 2008

Dear Mr. Kuhn:

On behalf of the American College of Emergency Physicians (ACEP), I am pleased to submit comments on the proposed rule for Medicare physician payment for 2008 that was published in the *Federal Register* on July 12, 2007.

ACEP is a national medical specialty society with more than 25,000 members, dedicated to improving the quality of emergency care through continuing education, research, and public education. We appreciate the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with our comments on fee schedule payment policy and its effects on the practice of emergency medicine.

WASHINGTON D.C. OFFICE
2121 K Street, NW
Suite 325
Washington, D.C. 20037-1801

202-728-0610
800-320-0610
202-728-0617 (FAX)
www.acep.org

Impact

After seven years of reductions or updates significantly less than the rate of inflation or zero percent, physicians are now faced with the largest payment reduction ever (9.9%). Each year, ACEP works with the Administration and Congress to urge rescinding of the SGR and replacement with a formula that recognizes reasonable inflationary costs, using similar mechanisms that are employed in all of the other Medicare payment systems. This proposal has been repeatedly recommended by the Medicare Payment Advisory Commission (MedPAC) and other policy experts.

TRHCA – Section 101(d)

While the most salient challenge is on Congress to act, CMS has done nothing to ameliorate the growing cost of the SGR fix and has repeatedly refused to take drugs out of the SGR pool while continuing to under-estimate the costs of new Medicare benefits. This year, CMS proposes to take the $1.35 billion that Congress set aside in the TRHCA legislation of 2006 and use it for the physicians' quality reporting initiative, rather than for an offset to the SGR which would benefit all physicians.

ACEP strongly supports use of these funds as a down payment for a longer term change in the reimbursement formula for physicians, as does MedPAC. CMS should overcome its "legal and operational" problems associated with applying the funds to the negative update, as the situation posed by the harmful cuts prevails over the potential obstacles. Use of these funds to offset a portion of the cost of replacing the SGR will have a more positive impact on all physicians than a reporting program whose value has not yet been demonstrated.

As you know, fee schedule cuts affect emergency physicians disproportionately. While physicians in other types of practice can limit their financial losses in ways considerably more subtle than dropping participation in the Medicare program, emergency physicians will continue to see everyone who comes to the emergency department, regardless of ability to pay. Emergency physicians provide care 24 hours per day, 7 days a week to an ever-growing population demanding their services.

According to the latest CDC survey data, emergency physicians provided care to over 115 million patient visits in 2005. Nearly 17 million visits represented Medicare patients and 51 out of every 100 Medicare patients had at least one visit to an emergency department that year. In response to shrinking practice revenues, physicians will generally not drop out of the Medicare program, they will explore other means to limit their exposure to continuing losses, which in turn forces more beneficiaries to seek care in the emergency department.

Budget Neutrality Adjustment

ACEP strongly objects to using physician work relative values as a mechanism to preserve budget neutrality and again urges CMS to make any budget neutrality adjustment for 2008 to the conversion factor. From 1998 to 2006, CMS achieved budget neutrality requirements by adjusting the Medicare conversion factor, after rejecting adjustments to work as "undesirable policy". Therefore, we were shocked by CMS' decision to make the budget neutrality adjustment to the work values for 2007, particularly after an overwhelming majority of physician specialties asked CMS to make this adjustment to the conversion factor. During the course of this past year, CMS spokespersons publicly touted the increases given to primary care work values for evaluation and management services, without mentioning that a substantial portion of the increase was actually taken away by the budget neutrality adjustment. Given that CMS has never satisfactorily explained the policy rationale for this decision, a nearly -12 percent adjustment to the 2008 work values on top of a 10 percent cut will literally wipe out all of the E/M work gains that CMS accepted last year from the Relative Value Scale Update Committee (RUC). The conversion factor, as the monetary multiplier in the Medicare payment formula, is the most appropriate place to adjust for budget neutrality, and it would result in much more transparent payment mechanism for Medicare as well as other payers.

TRHCA –Section 101(b) Physician Quality Reporting Initiative (PQRI)

ACEP has been actively engaged in the development of physician-level performance measures at the American Medical Association's Physician Consortium for Performance Improvement (Consortium) since its inception, providing physician expertise to inform the development for emergency medicine as well as other specialty measures. ACEP has also been an active participant in the endorsement and adoption processes of the National Quality Forum and the Ambulatory Quality Alliance consensus bodies, working to ensure that measures for emergency medicine and other specialties were appropriate for inclusion in the 2007 PQRI. ACEP continues to work closely with external stakeholders to develop measures at the physician, hospital and system level that will help us continue to make quality improvements in a more systematic way while reducing redundancy of reporting.

We are concerned, however, that the process for developing the 2008 PQRI is advancing despite the 2007 PQRI having only just started July 1. This timeframe leaves scant opportunity to evaluate the most basic elements of the 2007 PQRI program, such as impact

on patient care, physician participation rates, and implementation costs before moving forward. While we understand that CMS is required by TRHCA to implement the 2008 program, we urge the agency to use its discretion to closely review the 2007 program before moving ahead, which is why we support S. 1519/ H.R. 2749, The Voluntary Medicare Quality Reporting Act which allows time for an evaluation of the effectiveness of the program that will help inform and improve the program as it evolves.

In addition, we believe that the requirement that measures for the 2008 program be developed "through the use of a consensus-based process" is too broad. For any reporting system to improve quality, the measures must be meaningful to clinical care and relevant to the specific specialty physicians. Therefore, direct physician involvement in the development, testing and implementation of quality measures is the only way to ensure measures are appropriate and clinically-relevant. While we appreciate that the proposed rule recognizes the Consortium as a source for the development of quality measures eligible for inclusion in PQRI 2008, we urge CMS to go further and consider the Consortium as the ***only*** entity appropriate for the development and updating of physician-level quality measures. The Consortium process is consensus-based and physician-led. This characteristic will ensure physician buy-in on measures which is essential for an effective quality reporting program. Further, tasking the Consortium as the only group for developing physician measures significantly reduces the risk of duplicative or contradictory measures.

Please do not hesitate to contact Barbara Marone, ACEP's Federal Affairs Director at (202) 728-0610 ext. 3017 if you have any questions about our comments and recommendations.

Best wishes,

Brian F Keaton MD

Brian F. Keaton, MD, FACEP
President

Submitter : Mari Piasecki **Date:** 08/24/2007

Organization : Medical Office Management

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

IDTF Issues

IDTF Issues

See Attachment

CMS-1385-P-7591-Attach-1.DOC

MARI PIASECKI
MEDICAL OFFICE MANAGEMENT

August 24, 2007

Proposed Provisions to Payment Policies Under the Physician Fee Schedule for 2008

I am writing in this open comment period in regards to IDTF. I realize that there are many different types of medical services that fall under this CMS listing. The specific issue that I want to comment about is in regards to diagnostic polysomnography.

I have read the Federal Register dated July 12, 2007 that lists the proposed performance standards. First of all, I agree with the proposed performance standards. I believe in providing quality of care and the sleep center that I work for we met the CMS requirements in 2000 and received American Academy of Sleep Medicine Accreditation in 2005. All processes included site visit. I know CMS is working with the AASM to maintain these high quality standards. The only thing is, this proposed performance standard is lacking, it is not inclusive enough. The writings state "operation to another individual or organization." To me there needs to be clarification of the word "organization".

Organization to me must be inclusive of the hospitals nationwide that are also performing the same testing. I know they fall under Medicare Part A, but the physicians rendering the services are paid under Part B. I feel that the proposed performance standards must equally apply for hospitals also. Hotel and motel rooms are not appropriate places for diagnostic testing to take place, but hospitals are utilizing these venues also. The other performance standards regarding staffing, equipment, commingling office space and number of sites must also apply to the hospitals.

By making these performance standards apply equally to both Part A and B, this will assure that there would be equality across the board for equal reimbursement for AASM accredited Sleep Center across the nation no matter if they fall under Part A or B. This will lend itself greater autonomy to reimburse only AASM accredited Part A and B providers.

Sincerely,

Mari Piasecki RN
Business Manager for
Michiana Regional Sleep Disorders Center

820 Lester Ave Suite B 15 St. Joseph, MI 49085 Phone 269-982-7099 (Private Line) Fax: 269-429-7046 (Private Line)

Submitter : **Mrs. Laura Stillman** **Date: 08/24/2007**

Organization : **AANA**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

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

Dear Ms. Norwalk:

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

This increase in Medicare payment is important for several reasons.

First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.

Second, this proposed rule reviews and adjusts anesthesia services for 2008. Most Part B providers services had been reviewed and adjusted in previous years, effective January 2007.However, the value of anesthesia work was not adjusted by this process until this proposed rule.

Third, CMS proposed change in the relative value of anesthesia work would help to correct the value of anesthesia services which have long slipped behind inflationary adjustments.

Additionally, if CMS proposed change is not enacted and if Congress fails to reverse the 10% sustainable growth rate (SGR) cut to Medicare payment, an average 12-unit anesthesia service in 2008 will be reimbursed at a rate about 17% below 2006 payment levels, and more than a third below 1992 payment levels (adjusted for inflation). America s 36,000 CRNAs provide some 27 million anesthetics in the U.S. annually, in every setting requiring anesthesia services, and are the predominant anesthesia providers to rural and medically underserved America. Medicare patients and healthcare delivery in the U.S. depend on our services. The availability of anesthesia services depends in part on fair Medicare payment for them. I support the agency s acknowledgement that anesthesia payments have been undervalued, and its proposal to increase the valuation of anesthesia work in a manner that boosts Medicare anesthesia payment.

Sincerely,
Laura I. Stillman, RN-BSN, RNAS
3401 Brentwood Dr.
Flint, MI 48503

Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I have been practicing Physical Therapy in the state of TN since 1997 at a hospital based outpatient P.T. Clinic. I would like 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 have lived in this mid sized community all my life and I have always felt our health care system has served this community with excellent high quality health care with 2 hospitals and multiple physician Clinics that take care of practically any health issue. However over the last few years a dark cloud has settled over our community in the form of contracted Physical Therapy Clinics that have aligned with physician groups with the primary purpose of monetary gain despite all the well thought out advantages they would lead one to believe. This is the first time I have ever written a letter of this type but I have become so discouraged and appalled at the abusive practices of Physician Owned P.T. Clinics in our community that I feel I must express my concerns in hope that you will take necessary steps to stop the injustice to patients, insurance companies, and the physical therapy profession. Our community supports several Orthopedic Clinics that have recently contracted with outside Physical therapy agencies that are obviously running a business with financial gain as the priority while good patient care is being neglected. These reports are coming to me directly from patients who were coerced by their physician to stay at the in house P.T. Clinic because the physician would be available to monitor their progress, which patients state never happens. They also state that the treatment they received was sub standard due to the high patient volume and were often instructed to lay on a mat with several other patients and perform exercises with very minimal supervision and usually received no hands on care. This strongly speaks of over utilization of PT services for financial gain. Also I have spoken personally with more than one Physical Therapist who was lured to these Clinics due to higher wages and later resigned due to being unable to adequately treat such high volumes of patients or provide one on one quality care the patient is entitled and their insurance is paying for. They also became concerned over ethical issues when forced to charge for services the patient did not need or write notes about a patient s progress when they were unable to spend any quality time with the patient. One would hope integrity would reign over greed but the potential for fraud and abuse is so apparent that action must be taken to stop this harmful practice. I strongly urge you to remove physical therapy as a designated health service permissible under the in-office ancillary exception of the federal physician self-referral laws. I want to thank you for your careful attention to this matter for the future of good quality healthcare in our community and our state.

Submitter : **Ms. Debra Shannon** **Date: 08/24/2007**

Organization : **Metrowest Anesthesia**

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
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Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

TRHCA– Section 201: Therapy CapS

TRHCA-- Section 201: Therapy CapS

Physical therapy must be included in the exceptions for in- office ancillary services. The current pracice allows a referral for profit situation which can only increased Medicare's overall cost. In Missoui, where a law exists ot prevent physician owned therapy services, physicians arc constantly attempting to get the law revoked or to work around it, so evidently they feel they can make an impac on their own bottom line by providing this service. There is also ample evidence to indicate that there is overutilization of PT in thcse circumstances.
Thank you.

Submitter : Dr. James Acree **Date:** 08/24/2007

Organization : ARANA/AANA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Action is needed by the Office of the Administrator, at the Centers for Medicare & Medicaid Services (CMS) to direct finalize its proposal to increase the value of anesthesia work by 32%, and to increase the anesthesia conversion factor by up to 25% in 2008.

If this proposal is approved, it will help to correct the value of anesthesia services which have long been undervalued and have slipped behind inflationary adjustments.

However, 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).

Thank you,
J R Acree, PhD, CRNA, ARANA/AANA

Submitter : Mrs. Nancy Payne **Date:** 08/24/2007

Organization : Allina Hospitals and Clinics

Category : Hospital

Issue Areas/Comments

Geographic Practice Cost Indices (GPCIs)

Geographic Practice Cost Indices (GPCIs)

We have grave concerns about geographic payment variances. GPCI is a dinosaur-a very old methodology that is no longer founded on a solid principle. Local and regional markets are no longer well defined. The market that influences our costs is increasingly based on national costs. Recruitment is in a national market and purchasing in now through large national groups. The level of cost variation considered in the payment structure is no longer valid. An equalization or standardization of payment rates across the country would eliminate the unequal impact of government manipulation in the social welfare programs and simplfiy the administration of the same programs. We recognize that malpractice expense creates a need for small variation but it is not signficant enough to support the level of variation in payments currently proposed. It is very difficult to understand why the same care provided in Florida is paid three times higher than if provided in Minnesota. We urge CMS to eliminate the GPCI or at least reduce the level of variation it creates and work to develop standard rates between the states.

Impact

Impact

We vehemently oppose the proposed 9.9% reduction in physician rates. A payment reduction of this magnitude will only serve to drive physicians away from taking Medicare patients and reduce access for the needest beneficiaries. This must be overturned.

TRHCA--Section 101(d): PAQI

TRHCA--Section 101(d): PAQI

CMS must do whatever possible to assure that the physician payment rates do not get cut by the proposed 9.9%.
We feel strongly that the dollars allocated for PAQI should not be used as proposed to fund the 2008 PQRI but rather should be distributed to all with inclusion in the conversion factor. If Congress takes action to protect physician payments at current or increased levels, we can support the money being used for the 2008 PQRI but only if Congressional action erases the 9.9% proposed reduction.

TRHCS--Section 101(b): PQRI

TRHCS--Section 101(b): PQRI

We appreciate that CMS is investigating the relationships that could exist between the registries and submission of PQRI data. We support the elimination of redundant effort in reporting. We would consider submitting our data through a registry only if it totally eliminates the need to code quality activities on the claim. We are concerned about the proprietary nature of the registries and would not support the competition or potential monopoly that could result. Registry options must be available for all to access in the public domain.

With the complexity of the data systems on a national level as well as at a large physician group level, it is concerning that CMS and the registries could actually effectively manage the data integrity. We have issues currently with this on the hospital reporting side and know the challenges that will come in working with numerous third party database vendors. Taking data elements from different databases and trying to accurately match up patient identitifers will be extremely challenging and lead to numerous errors. We have experienced this in the past.

We do not support any efforts for CMS to have direct access to the electronic patient record. We would not support this breach of patient confidentiality with any payer.

Submitter : David **Date:** 08/24/2007

Organization : David

Category : Health Care Professional or Association

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a privatc practicc Physical Therapist. I belicvc Physical therapy services should not be allowed undcr the in-office ancillary services cxception. 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.

Thank you
Sincerly
Davc PT

Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1385-P
RE: Physician Self-referral issues

CMS-1385-P-7599-Attach-1.DOC

#7599

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

FREEDOM
PHYSICAL THERAPY SERVICES, S.C.

Dear Mr. Weems:

I am a physical therapist who has worked in private practice in Milwaukee, Wisconsin for **13 years**. I would like to comment on the July 12th proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception.

The company for which I work takes pride in seeking out and hiring very well-educated, experienced therapists who provide exceptional care. With declining reimbursement and limited visits with both Medicare and other insurers it has become increasingly difficult financially, for us to provide the high level of patient care our patients are used to. To compound the problem, we have physician groups reaping the financial rewards of referring patients to therapy practices they own instead of therapy practices that may provide superior and more cost-effective care. This is possible due to the "in-office ancillary services exception" to the Stark Law, as physical therapy is currently considered a "designated health service (DHS)". In some cases, these patients are not even being seen by PT's, but instead by PTA's and ATC's under the physician's direction. This needs to stop.

Generally speaking, physical therapy services are provided on a repetitive basis. That said, it is no more convenient for the patient to receive PT services 2-3 times per week in the physician's office than to attend an independent physical therapy location. Furthermore, physician-direct supervision is not necessary 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 for your consideration of my comments. I hope these comments have helped to highlight the abusive-nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

Sincerely,

A Concerned Physical Therapist in zip code **53213**

Submitter : **Dr. Mark Sonnenberg** **Date: 08/24/2007**

Organization : **Harmonic Confluence**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: TECHNICAL CORRECTIONS

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

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

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

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

Sincerely,
Dr. Mark Sonnenberg, D.C.

Submitter : Kelly **Date:** 08/24/2007

Organization : Kelly

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Please reconsider the decision to allow physian owned PT clinics. I have seen too many patients who were "forced" to attend PT at these clincs when it truely was not in the best interest of the patient. I have had patients with surgeries, low back problems, and general pain in which the seated position increases the pain and were told that these clinics were the only ones in which they could attend. This concerns me, and also shows that the patients are not getting the best possible care given to them. The patients are not getting the option to chose where they want to go.

Submitter : **Mr. Jeffrey Andres** **Date: 08/24/2007**

Organization : **Mr. Jeffrey Andres**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a physical therapist and I find the self-referral of patient's to physical therapy clinics owned or run by physicians to be a hard pill to swallow. In the state of Michigan, a physical therapy can only see a patient if they recievc "permission" from a doctor with a script. The treatment is coordinated through a plan of care and consistent progress notes being exchanged between myself and the physician. The phsician's role is to "oversee" the patient's treatment and progress which is done in the patient's best interest for recovery. When the physician is given a financial interest in the patient's treatment (plan of care which they approve), then what/who prevents the physician from providing services that he/she may typically not approve or recommend in order to increase the profits.

I have seen abuses of this first hand with physician's I have worked with/around. One physician had said that he does not send patient's to PT because he doesn't believe it is beneficial (contrary to evidence presented hime), but he would use it if the patient requested. ~1-2 years after this conversation, the physician began his own clinic and has been rumored to have a large client base.

Self-Referrals to PT have also created much anger and resentment in the physical therapy community with many overheard to describe it as unethical, a conflict of interest, or even criminal. Due to this belief system, many physician owned physical therapists are thought of poorly amongst this community.

Another example of poor self referral came when I was working in Lapeer, MI. We had an elderly patient who had back problems. She came to the clinic (only 1-2 miles from her home) after 1-2 months of treatment at a second clinic (owned by her physician in Grand Blanc, MI; 25 miles from her home) due to a lack of progress. She reported poor treatment with minimal one on one time at the physician's clinic and noted that one of her largest complaints was "riding in cars". (The patient was discharged meeting all goals in 2 weeks).

I don't know if any of this helps, but I've got it off my chest and onto someone who can make a difference now. Good Luck!

Submitter : **Dr. Omar Ross** **Date: 08/24/2007**

Organization : **North Hills Orthopedic and Sports Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Sincerely,

Omar Ross, PT, ATC

OR/fah

CMS-1385-P-7603-Attach-1.DOC

#7603

August 16, 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 21244-8018

Re: Medicare Program: Proposed Revisions to Payment Policies Under the Physicians Fee Schedule, and Other Part B Payment Policies for CY 2008: Proposed Rule.

Dear Mr. Weems:

My name is Omar Ross and I am currently employed as a physical therapist at North Hills Orthopedic and Sports Physical Therapy in Sewickley, Pennsylvania. I have been in practice as a physical therapist for 3 years and in the profession of physical therapy for 11 years. Please accept this letter as a proposal to comment on the proposed July 12, 2008 physician fee schedule rule specifically the area regarding Physicians Self Referral and the "in office ancillary services" exception.

In my brief and new career as a physical therapy with prior experience in the profession for an additional 8 years I have seen some significant changes take place regarding health care. During this time I have been able to note a progressive increase in the cost of health care services. With these cost increases, we have begun to note decreased access and appropriate utilization of services. This serves as a direct detriment to my current employment in a physical therapist owned practice, as well as a professional commitment towards competent care. The current laws which allow for physical therapy to be used and potentially abused by physicians in a self referral practice continues to drive health care costs into an upward spiral and continue to place a stress on the services we provide.

As a clinical practice we have experienced what physician self referral practices can do to physical therapist owned practices. A local, well known and large orthopaedic practice in our area has recently begun the practice of physical owned physical therapy practices in our area. We have noted a decline in patient visits and potential for abuse. The American Physical Therapy Association has designated by the year 2020 that all graduating and entry level physical therapists will receive The Doctor of Physical Therapy designation. This not only allows for higher level of entry level of practice but also prepares the student for autonomous, profession, and competent physical therapy practice. The continued practice of physical self referral is a direct threat to what many physical therapists aspire to achieve, not only in personal professional growth but also in providing skilled patient care. This also removes the onus on therapists and physicians to build and develop professional relationships, across clinical site distances, to better serve our purpose for choosing this profession–the patient.

The desire is to level the playing field and create opportunities for therapists to practice in a setting and environment conducive to fair practice, appropriate checks and balances and a high level of patient care.

Sincerely,

Omar Ross, PT, ATC

OR/fah

Submitter : Ms. **Date:** 08/24/2007

Organization : Ms.

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Several physicians in the area have hired their own PT staff. I have numerous patients tell me that their doctor told them to go see their PT, but they wanted to go to another place. Many patients do not realize they have a choice of where to go for PT. Several private practice PT offices have shut down because since the physicians have their own PT offices, they no longer send them any patients. Please address this situation. The potential for abuse is omnipresent.

Submitter : **Dr. Beth Ann Traylor** **Date: 08/24/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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,

Beth Ann Traylor M.D.

Submitter : Mrs. Tracy Hodge **Date:** 08/24/2007

Organization : American Association of Nurse Anesthetists

Category : Other Health Care Professional

Issue Areas/Comments

Background

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Dear Administrator:
As a member of the American Association of Nurse Anesthetists (AANA), I write to support the Centers for Medicare & Medicaid Services (CMS) proposal to boost the value of anesthesia work by 32%. Under CMS' proposed rule Medicare would increase the anesthesia conversion factor (CF) by 15% in 2008 compared with current levels. (72 FR 38122, 7/12/2007) If adopted, CMS' proposal would help to ensure that Certified Registered Nurse Anesthetists (CRNAs) as Medicare Part B providers can continue to provide Medicare beneficiaries with access to anesthesia services.
This increase in Medicare payment is important for several reasons.
- First, as the AANA has previously stated to CMS, Medicare currently under-reimburses for anesthesia services, putting at risk the availability of anesthesia and other healthcare services for Medicare beneficiaries. Studies by the Medicare Payment Advisory Commission (MedPAC) and others have demonstrated that Medicare Part B reimburses for most services at approximately 80% of private market rates, but reimburses for anesthesia services at approximately 40% of private market rates.
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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).
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Sincerely,
Tracy Hodge, SRNA

Submitter : **Dr. Steven Hugenberg** **Date: 08/24/2007**

Organization : **Indiana School of Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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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,

Dr.Steven Hugenberg

Submitter : **Dr. Janet Wendeln** **Date: 08/24/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Sincerely,

Dr. Janet Wendeln

Submitter : **Ms. Christy Baginski** **Date: 08/24/2007**

Organization : **Oakland University School of Nurse Anesthesia**

Category : **Other Health Care Professional**

Issue Areas/Comments

Background

Background

Dear Administrator:

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

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? 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.
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? 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. Beth Ann Traylor** **Date: 08/24/2007**

Organization : **Anesthesia Consultants of Indianapolis**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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,

Beth Ann Traylor M.D.

Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
U.S. Dept of Health and Human Services
Attention: CMS 1385-P
RE: Physician Self-referral Issues

CMS-1385-P-7611-Attach-1.DOC

#7611

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

FREEDOM
PHYSICAL THERAPY SERVICES, S.C.

Dear Mr. Weems:

I am a physical therapist who has worked in private practice in Milwaukee, Wisconsin for 7 years. I would like to comment on the July 12th proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception.

The company for which I work takes pride in seeking out and hiring very well-educated, experienced therapists who provide exceptional care. With declining reimbursement and limited visits with both Medicare and other insurers it has become increasingly difficult financially, for us to provide the high level of patient care our patients are used to. To compound the problem, we have physician groups reaping the financial rewards of referring patients to therapy practices they own instead of therapy practices that may provide superior and more cost-effective care. This is possible due to the "in-office ancillary services exception" to the Stark Law, as physical therapy is currently considered a "designated health service (DHS)". In some cases, these patients are not even being seen by PT's, but instead by PTA's and ATC's under the physician's direction. This is illegal under Physical Therapy laws and needs to stop.

Generally speaking, physical therapy services are provided on a repetitive basis. That said, it is no more convenient for the patient to receive PT services 2-3 times per week in the physician's office than to attend an independent physical therapy location. Furthermore, physician-direct supervision is not necessary 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 for your consideration of my comments. I hope these comments have helped to highlight the abusive-nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

Sincerely,

A Concerned Physical Therapist in zip code 53209

Submitter : **Brian Harrington** **Date: 08/24/2007**

Organization : **Brian Harrington**

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.

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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.

Brian Harrington
501 Chancery Lane
Billings, MT 59102

Submitter : **Dr. Matthew Grabowski** **Date: 08/24/2007**

Organization : **Georgia Anesthesiologists, PC**

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 : **Dr. Thomas Patnoe** **Date: 08/24/2007**

Organization : **St. Mary's Duluth Clinic Health System**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1385-P-7614-Attach-1.DOC

#7614

SMDC
HEALTH SYSTEM

August 25, 2007

Dear Sirs,

St. Mary's Duluth Clinic Health System is the largest healthcare organization in the northern Minnesota/northeastern Wisconsin region, with over 400 physicians entering 1.5 million electronic medication orders into our Epic ambulatory electronic health record annually, most of which are auto-faxed to the patient's pharmacy of choice. Medication order entry by physicians into our ambulatory care settings is a goal we highly value as one element contributing to safe care for our rural, elderly, and geographically dispersed patient population. We welcome the opportunity to comment on the proposed rule that would eliminate the exemption for computer generated-faxes from the Medicare Part D e-prescribing requirements.

We believe that the e-prescribing standard as defined in the proposed rule will be the safest and most secure method for communicating prescriptions to pharmacies, and we support this ideal. However, the proposal to eliminate our ability to fax prescriptions by January 2009 is too soon. That timeline gives us inadequate time to plan for a project of this magnitude. We intend to pursue standard electronic prescription writing as part of our electronic health record implementation, but we recognize that full implementation of the technology is not a trivial undertaking. We have been working to implement components of electronic health record in order to meet our strategic objectives for safe, efficient, effective, timely, equitable, and patient-centered care. For example, we had been planning to implement physician order entry in our hospitals over the next two years. These critical projects compete for the same scarce capital and human resources. Planning and implementing an electronic prescription solution takes months of time and assumes we are using the appropriate software versions to take advantage of the technology. Upgrading versions can often take as much or more time than the implementation of those new features--we have to devote a minimum of four months to upgrade just our Epic system.

While January of 2010 would still be a challenge for us in terms of delaying other critical initiatives, it would certainly be more feasible for us than the proposed January 2009 deadline. If we cannot meet the timeline, we face bleak alternatives because we will lose the efficiency of automatically faxing the prescriptions our physicians are entering into Epic. Our physicians would have to perform double work. Prescriptions must be entered into our electronic health record so that our patients benefit from the safety alerts and reminders for drug interactions, important follow-up care, drug recalls and so on. In addition to entering the prescriptions into Epic, our physicians would have to revert to paper prescriptions for the patient to take to their pharmacy. We exist in an environment that must focus on productivity to survive. Double work would be an untenable burden on physicians, and without a

SMDC
HEALTH SYSTEM

reasonable option to reduce workload, prescriptions would end up on paper only. Even computer-generated faxes are more legible than a hand-written prescription, and they support the safe care alerts and reminders. Our patients would lose a convenience that they have come to expect, since their prescriptions would not be ready to pick up when they arrive at their pharmacy. As you can begin to appreciate, the negative consequences of the current proposal are significant.

In our predominantly rural service area, we know that most of the pharmacies that serve our patients are unprepared for electronic prescribing. Many of these small, locally owned pharmacies did not even have a fax machine until our physicians started to use our Epic electronic health record for prescriptions. Most of those pharmacies are years away from implementing the receiving side of the ePrescribing solution. We understand from our peer organizations that third-party intermediaries required for robust electronic prescription communications, such as SureScripts and RxHub, often have inaccurate or missing data about local pharmacies because they rely on the pharmacies themselves to provide this information. This situation, too, will contribute to failed ePrescribing transactions. If we are not allowed to use faxing even as a back-up mechanism, the result is unnecessarily delayed and missed prescriptions and/or regression to the old prescription pads and the safety issues already described. We think it unlikely that these gaps could be completely eliminated in the short timeframe allowed in the proposal, and we are concerned because our patients, physicians, and nurses will suffer the detrimental consequences.

We strongly recommend that the proposed ePrescribing requirement be delayed until January 2010. We further recommend that, even after the final ePrescribing requirement date, computer-generated faxing should still be allowed as a back-up mechanism for communicating prescriptions, in the event that the fully electronic transmission fails for any reason for a particular transaction. Faxing also needs to be allowed in the equally probable event that our small rural pharmacies are not prepared for some years to receive ePrescription transactions.

Thank you for your consideration of these recommendations. We look forward providing the safety, security, and convenience benefits of fully electronic prescription writing to our patients, as the reliability of the technologies mature and we are able to successfully use them.

Sincerely,

Thomas G. Patnoe, MD
President, Duluth Clinic

Submitter : **Date: 08/24/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Mr. Kerry N. Weems
Administrator-Designate
Centers for Medicare and Medicaid Services
U.S. Dept of Health and Human Services
Attention: CMS-1385-P
RE: Physician Self-referral Issues

CMS-1385-P-7615-Attach-1.DOC

#7615

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

FREEDOM
PHYSICAL THERAPY SERVICES, S.C.

Dear Mr. Weems:

I am a physical therapist who has worked in private practice in Milwaukee, Wisconsin for 12 years. I would like to comment on the July 12th proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception.

The company for which I work takes pride in seeking out and hiring very well-educated, experienced therapists who provide exceptional care. With declining reimbursement and limited visits with both Medicare and other insurers it has become increasingly difficult financially, for us to provide the high level of patient care our patients are used to. To compound the problem, we have physician groups reaping the financial rewards of referring patients to therapy practices they own instead of therapy practices that may provide superior and more cost-effective care. This is possible due to the "in-office ancillary services exception" to the Stark Law, as physical therapy is currently considered a "designated health service (DHS)". In some cases, these patients are not even being seen by PT's, but instead by PTA's and ATC's under the physician's direction. This is illegal under Physical Therapy laws and needs to stop.

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Thank you for your consideration of my comments. I hope these comments have helped to highlight the abusive-nature of physician-owned physical therapy services and support PT services removal from permitted services under the in-office ancillary exception.

Sincerely,

A Concerned Physical Therapist in zip code 53217

Submitter : **Dr. Tim Wilson** **Date: 08/24/2007**

Organization : **Carolina Anesthesia**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

Leslie V. Norwalk, Esq.
Acting Adm. Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
Re: CMS1385-P Anesthesia Coding
Dear Ms.Norwalk,
I am writing you in support for the proposal to increase anesthesis payments under the 2008 Physician Fee Schedule. I am glad to see that CMS is addressing the gross undervaluation of anesthesia services. RBRVS created huge payment disparity for anesthesia services compared to other physician services. Current CMS anesthesia payments do not cover the cost of paying an employee to administer anesthesia. Anesthesiologists are being forced out of areas with high Medicare populations. To correct this untenable situation, the RUC recommended a nearly $4.00 per unit increase to help offset the gross undervaluation in anesthesia. Please fully implement the anesthesia conversion factor increase.
Thank you for your consideration.
Tim Wilson MD

Submitter : **Miss. Chelsea Courtney** **Date: 08/24/2007**

Organization : **Portsmouth Anesthesia Associates**

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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Thank you for your consideration of this serious matter.