Submitter : Mr. Christopher Coker **Date:** 08/27/2007

Organization : Missouri State Univ. - Athletic Training Services

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Christopher L. Coker. I am currently an Assistant Athletic Trainer working for Missouri State University - Athletic Training Services. I received my bachelors degree from the Accredited Athletic Training Education Program at William Woods University. I received my Athletic Training Certification in 2006. I am currently studying to join the ranks of other healthcare administrators in our public and private healthcare systems.

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

Christopher Coker, ATC

CMS-1385-P-8981-Attach-1.DOC

Submitter : **Dr. Rickard Hawkins** **Date: 08/27/2007**

Organization : **Ambulatory Anesthesia of Atlanta**

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. My group covers an Eye Surgery Center with a high percentage of Medicare patients. For the first 7 months of 2006, the payor mix was 96% Medicare. It cost my group over $3000 per month to provide care to our Medicare patients--YOUR PATIENTS.

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.

Rickard S. Hawkins, MD

Submitter : **Dr. Yasser Alhaj Hussein** **Date: 08/27/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

CMS-1385-P-8984-Attach-1.DOC

8984

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : Dr. Mark Clark **Date:** 08/27/2007

Organization : Dr. Mark Clark

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I support the increase in anesthesia conversion factor rates.
In my area of Michigan with a high Medicare population we are unable to recruit new physicians to the area because of low reimbursement. Thank you Mark D. Clark MD

Submitter : **Ms. Jennifer Kesler** **Date: 08/27/2007**

Organization : **ValleyCare Health System**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jennifer Kesler and I work for ValleyCare Health System at ValleyCare Medical Center in Pleasanton, California, in the Physical and Sports Medicine Department. I have completing a Masters degree in Kinesiology and I am a Certified Athletic Trainer.

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

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

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

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

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

Sincerely,

Jennifer Kesler, ATC

Submitter : **Date: 08/27/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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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. olawale fadugba **Date:** 08/27/2007

Organization : atlanticare medical center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I support medicare payment increase

Submitter : **Dr. Jennifer Layman** **Date: 08/27/2007**

Organization : **Millcreek Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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Thank you for your consideration of this serious matter.

Jennifer Layman MD

Submitter : **Ms. Allison Moyes** **Date: 08/27/2007**

Organization : **Boston University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

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

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

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

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

Sincerely,

Allison Moyes

Submitter : Dr. Sivasenthil Arumugam **Date:** 08/27/2007

Organization : Woodland Anesthesiology Associates P.C

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Ignacio Rodriguez** **Date: 08/27/2007**

Organization : **South Florida Surgical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Mrs. Agata Vollers** **Date: 08/27/2007**

Organization : **ASA-American Society of Anesthesiologist**

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
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Thank you for your consideration of this serious matter.

Agata Vollers,MD
Assistant Professor
Arkansas Children Hospital

Submitter : Mrs. Kariel Hoagland **Date:** 08/27/2007

Organization : Lafayette Rehabilitation Services

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Kariel Hoagland and I work as a clinical outreach athletic trainer. I work in the clinic in the mornings and provide athletic training services to a local JR./Sr. High School for the past four years. I attended college and received a Bachelors of Science and studied athletic training. My athletic training certification is nationally recognized by the NATABOC and Indiana requires a license as well.

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

Submitter : **Dr. William Hatton** **Date: 08/27/2007**

Organization : **Dr. William Hatton**

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
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Re: CMS-1385-P

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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.

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Thank you for your consideration of this serious matter.

William Hatton, MD
St Vincent's Medical Center
Bridgeport, CT

Submitter : **Dr. Attilio Pensavalle** **Date: 08/27/2007**

Organization : **Dr. Attilio Pensavalle**

Category : **Physical Therapist**

Issue Areas/Comments

Background

Background

It is my understanding that CMS is concerned that the in-office ancillary services exception to the Stark II physician self-referral law, including physical therapy, is being misconstrued and is providing a thriving environment for fraud and abuse . I am informed that CMS is very interested in reading submitted comments on this matter and understanding the physical therapists position.

The in-office ancillary service exception should NOT include physical therapy. The reasons for its exclusion are numerous. The consequences of its inclusion are twofold 1) primarily, it is not in the public interest at this time and 2) consequently it will degrade and weaken the profession of physical therapy, eventually reducing even further, the therapeutic and rehabilitation resources for patients in need of our care.

Though physicians vigorously disagree, self-referral enterprises create abuse of and hardship for the public at large that is in need of proper direction to quality healthcare. Doctors (physicians, chiropractors and podiatrists) involved in POPTS (Physician Owned Physical Therapy Services) engage in self-referral more now than ever, placing the public at greater disadvantage.

Medical doctors, chiropractors and podiatrists are neither educated nor trained in physical therapy, therefore they are neither qualified nor capable of neither establishing, supervising or operating quality P.T. services; they typically run inferior P.T. practices and offer sub standard services to an unknowing public that is relying on their unbiased judgment for thoughtful direction with regard to healthcare management unclouded or swayed by a direct or indirect financial interest. Now that the healthcare market has been changed by Managed Care, they have skewed more toward self referral than ever.

So misguided, they (the doctors) feel all that is necessary to justify in-office ancillary PT as a valid service is to hire one or two P.T. s with bare bones credentials, retain the simple and straightforward cases in house and offer a list of alternative PT services in the area to those patients that are not preferred by them, for various reasons that reason usually being their clinical complexity or the extent of therapeutic work required. The cases are selectively retained by the physician and the remainder (a small percentage, I assure you) are offered choice a very unfair situation and certainly a conflict of interest from a medico legal viewpoint as well as from a purely ethical and altruistic point.

I am a perfect example; I am the sole physical therapist owner of a full service P.T. practice that has earned one of the finest reputations for quality clinical care and patient service in the Greater Metropolitan New York area. Our facility is state-of-the-art and comprehensive; our clinical staff is well credentialed and highly skilled. I am a credentialed Doctor of Physical Therapy (soon all graduating PT s will be doctors) and I provide program development and direction, direct clinical supervision and render physical therapy treatment according to contemporary medical standards. I am bound by and tethered to the ethical and professional responsibility for the administration of physical therapy care, entrusted to me by the State of New York and expected by my professional association. That s a tough enough job to handle in normal circumstances. Can principles in POPTS situations, whether in-office ancillary services or free standing centers really offer the same degree of commitment and face time on task?? Their focus is and should be on the administration of their own clinical specialty to which they are similarly bound. Are they so flawless in their own expertise that they can direct and supervise clinical management of others in a field in which they neither practice nor specialize? Who are these super persons?? Sarcastic, maybe but a valid question nonetheless.
Attilio S. Pensavalle, PT DPT

Physician Self-Referral Provisions

Physician Self-Referral Provisions

In-office ancillary services consist of testing such as blood work and laboratory procedures, imaging and other designated health services (DHS). These services usually consist of a brief clinical interface, administered by technicians through specific medical prescription, requiring minimal decision opportunities and in no way containing the multiple components typical of physical therapy care, such as taking and interpreting a patient history (considering relevant medical and surgical history, current medications, etc), performing a detailed physical therapy examination, treatment design, planning and execution. Physical therapy treatment is rendered by licensed professionals, over a variable period of time, requiring constant evaluation and treatment modification as patient condition changes. Physical therapy treatment is exactly that treatment; its administration and responsibility should be left to independently practicing, duly licensed physical therapists, whose paramount responsibility is to the patients they serve, not the supplemental financial interests of their physician employer as an ancillary service.

Once a magnet for superior clinical care, from doctors involved in POPTS or providing physical therapy under the in-office ancillary services exclusion, now I only see VIP s (family, friends, office staff, the doctors themselves) or patients whose clinical case does not interest them from a rehabilitation point of view, for whatever reasons, financial and otherwise. Believe it; this is from a grass roots practitioner, living in a real world with his ear to the ground. Only a micro percentage of their patients are referred out to non connected P.T. offices; in many instances, through means subtle and otherwise, patients are actually discouraged from seeking P.T. services provided elsewhere. The financial incentive for physicians to keep these patients in-house is too great.

The POPTS situation has worsened over the last 10-15 years and shows no sign of stopping; in fact, with the softening of the Stark II regulations, it appears to be regaining impetus over the past 5 years. POPTS, by their very nature, must be creative, elusive and somewhat deft at circumventing the conflict of interest dilemma created by any referral for profit situation or healthcare regulation situation for that matter. Their existence, while degrading the public awareness and regard for physical therapy services and the entire profession of physical therapy have also created a marked reduction in the number of patients freely available within the marketplace (being horded by POPTS physicians), creating a very uneven playing field and an enormously unfair disadvantage for the independently practicing physical therapist.

A matter that has received little attention within this issue is the long term impact on the public at large stemming from the potential (and probable) negative growth and development impact on the PT professionals working in these situations. Their clinical skills are at risk and their professional/peer status is certainly vulnerable. Why? From my perspective as a supervisor, an employer and as an educator I have the unique opportunity of interacting with, supervising and counseling physical therapists at various stages of their careers. Through the benefit of this experience I have arrived at the conclusion that, over a period of time, employment in and operation within a POPTS situation (differentiated from a hospital based/institutional medical environment) creates a significant developmental detriment to the practicing physical therapist; eventually to the profession in general and ultimately to the public at large.

Attilio S. Pensavalle, PT DPT

Therapy Standards and Requirements

Therapy Standards and Requirements

In many instances, PT s employed in POPTS, for the benefit of profitability, are discouraged from operating according to their professional training; through the dictates of their physician employer, the evaluation encounter is frequently abbreviated or even eliminated to serve the patient flow and production requirements of the POPTS. The facility is frequently limited in scope and design so as to offer streamlined and bare bones service capability resulting in substandard care, based on today s contemporary standards. The longer their employment in these types of situations, the less employable these PT s become to potential employers or supervisors; their overall value to the public at large will decline, hence reducing the aggregate level of care available to the physical therapy consumer. A horrible prospect that would have been fostered by one professions desire to profit outside their domain at the expense of an allied profession and most of all, the public.

Being a realist, I acknowledge that all POPTS situations are not laden with the abuse and exploitation outlined herein, and that there is probably a segment of POPTS offices that operate reasonably and without the intention of abuse. That notwithstanding, the potential for and existence of abuse in all its forms is enormous. Patients are the first victims, unknowingly caught in the mesh of nebulous intentions and conflict of interest; US taxpayers and physical therapy are the second victims, for the reasons outlined; medicine in general is the fourth victim, since this type of abuse, exploitation and misrepresentation is beneath and unbecoming the honorable medical professional.

Aiding and abetting this condition, the American Academy of Orthopaedic Surgeons, through pressure from its physician membership, has conveniently reversed its long standing position against physician ownership of physical therapy practices, that position previously based on conflict of interest principles it now is in full and shameless support of these MD/PT ownership arrangements, whether in office/ancillary or free standing, justifying the referral for profit conflict as actually benefiting patient care and service. This rationalization by their own representative body only worsens the situation described herein and places the public at large as an unknowing pawn in the quest for the medical dollar. It is shameful and reprehensible.

I truly believe it is time to stop this referral-for-profit situation; deter the conflict of interest POPTS promotes and put an end to the abuse and manipulation of the public and the exploitation of the Medicare dollar. Physical therapy should be removed and excluded from the list of exceptions to the in-office ancillary services rule in the Stark II law. It is in the interest of all parties concerned and in the greater interest of the public, to which we have our greatest responsibility.

Thank you for your time and attention in this very serious matter.

Attilio S. Pensavalle, PT DPT

CMS-1385-P-8996-Attach-1.DOC

#8996.

August 27, 2007 *Centers for Medicare and Medicaid Services*

It is my understanding that CMS is concerned that the in-office ancillary services exception to the Stark II physician self-referral law, including physical therapy, is being "misconstrued" and is providing "a thriving environment for fraud and abuse". I am informed that CMS is very interested in reading submitted comments on this matter and understanding the physical therapists' position.

The in-office ancillary service exception should NOT include physical therapy. The reasons for its exclusion are numerous. The consequences of its inclusion are twofold – 1) primarily, it is not in the public interest at this time and 2) consequently it will degrade and weaken the profession of physical therapy, eventually reducing even further, the therapeutic and rehabilitation resources for patients in need of our care.

Though physicians vigorously disagree, self-referral enterprises create abuse ***of*** and hardship ***for*** the public at large that is in need of proper direction to quality healthcare. Doctors (physicians, chiropractors and podiatrists) involved in POPTS (Physician Owned Physical Therapy Services) ***engage in self-referral more now than ever, placing the public at greater disadvantage.***

Medical doctors, chiropractors and podiatrists are neither educated nor trained in physical therapy, therefore they are neither qualified nor capable of neither establishing, supervising or operating quality P.T. services; they typically run inferior P.T. practices and offer sub standard services to an unknowing public that is relying on their unbiased judgment for thoughtful direction with regard to healthcare management - unclouded or swayed by a direct or indirect financial interest. Now that the healthcare market has been changed by Managed Care, they have skewed more toward self referral than ever.

So misguided, they (the doctors') feel all that is necessary to justify in-office ancillary PT as a valid service is to hire one or two P.T.'s with bare bones credentials, retain the simple and straightforward cases in house and offer a ***list*** of alternative PT services in the area to those patients that are not preferred by them, for various reasons - that reason usually being their clinical complexity or the extent of therapeutic work required. The cases are selectively retained by the physician and the remainder (a small percentage, I assure you) are offered choice - a very unfair situation and certainly a conflict of interest - from a medico legal viewpoint as well as from a purely ethical and altruistic point.

I am a perfect example; I am the sole physical therapist owner of a full service P.T. practice that has earned one of the finest reputations for quality clinical care and patient service in the Greater Metropolitan New York area. Our facility is state-of-the-art and comprehensive; our clinical staff is well credentialed and highly skilled. I am a credentialed Doctor of Physical Therapy (soon all graduating PT's will be doctors) and I provide program development and direction, direct clinical supervision and render physical therapy treatment according to contemporary medical standards. I am bound by and tethered to the ethical and professional responsibility for the administration of physical therapy care, entrusted to me by the State of New York - and expected by my professional association. That's a tough enough job to handle in normal circumstances. Can principles in POPTS situations, whether in-office ancillary services or free standing centers really offer the same degree of commitment and face time on task?? Their focus is - and should be on the administration of their own clinical specialty - to which they are similarly bound. Are they so flawless in their own expertise that they can direct and supervise clinical management of others in a field in which they neither practice nor specialize? Who are these super persons?? Sarcastic, maybe - but a valid question nonetheless.

In-office ancillary services consist of testing such as blood work and laboratory procedures, imaging and other designated health services (DHS). These services usually consist of a brief clinical interface, administered by technicians through specific medical prescription, requiring minimal decision opportunities and in no way containing the multiple components typical of physical therapy care, such as taking and interpreting a patient history (considering relevant medical and surgical history, current medications, etc), performing a detailed physical therapy examination, treatment design, planning and execution. Physical therapy treatment is rendered by licensed professionals, over a variable period of time, requiring constant evaluation and treatment modification as patient condition changes. Physical therapy treatment is exactly that - treatment; its administration and responsibility should be left to independently practicing, duly licensed physical therapists, whose paramount responsibility is to the patients they serve, not the supplemental financial interests of their physician employer as an ancillary service.

Once a magnet for superior clinical care, from doctors involved in POPTS or providing physical therapy under the in-office ancillary services exclusion, now I only see VIP's (family, friends, office staff, the doctors themselves) or patients whose clinical case does not interest them from a rehabilitation point of view, for whatever reasons, financial and otherwise. Believe it; this is from a grass roots practitioner, living in a real world with his ear to the ground. ***Only a micro percentage of their patients are referred out to "non connected" P.T. offices; in many instances, through means subtle and otherwise, patients are actually discouraged from seeking P.T. services provided elsewhere. The financial incentive for physicians to keep these patients "in-house" is too great.***

The POPTS situation has worsened over the last 10-15 years and shows **no** sign of stopping; in fact, with the softening of the Stark II regulations, it appears to be regaining impetus over the past 5 years. POPTS, by their very nature, must be creative, elusive and somewhat deft at circumventing the conflict of interest dilemma created by any referral for profit situation - or healthcare regulation situation for that matter. Their existence, while degrading the public awareness and regard for physical therapy services and the entire profession of physical therapy have also created a marked reduction in the number of patients freely available within the marketplace (being horded by POPTS physicians), creating a very uneven playing field and an enormously unfair disadvantage for the independently practicing physical therapist.

A matter that has received little attention within this issue is the long term impact on the public at large stemming from the potential (and probable) negative growth and development impact on the PT professionals working in these situations. Their clinical skills are at risk and their professional/peer status is certainly vulnerable. Why? From my perspective as a supervisor, an employer and as an educator I have the unique opportunity of interacting with, supervising and counseling physical therapists at various stages of their careers. Through the benefit of this experience I have arrived at the conclusion that, over a period of time, employment in and operation within a POPTS situation (differentiated from a hospital based/institutional medical environment) creates a significant developmental detriment to the practicing physical therapist; eventually to the profession in general and ultimately to the public at large.

Submitter : Dr. gilbert chin **Date:** 08/27/2007

Organization : harris county anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Louis Pau** **Date: 08/27/2007**

Organization : **The Pain Center of Kansas**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Louis Pau, M.D.
921 SW 37th St.
Topeka, KS 66611

Submitter : **Dr. Stephen Ellis** **Date: 08/27/2007**

Organization : **Metropolitan Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Submitter : **Angela Duplessis** **Date: 08/27/2007**

Organization : **Maine General Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Angela Duplessis. I am an athletic trainer employed full time by Maine General Medical Center in Waterville, Maine. I provide athletic training services to an area high school through a contract between the hospital and the high school. I received my graduate degree at the University of Maine and have been certified as an athletic trainer for twelve years.

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

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

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

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

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

Sincerely,

Angela Duplessis, ATC, AT/L, M.Ed.

Submitter : **Dr. Michael Zagnoev** **Date: 08/27/2007**

Organization : **Dr. Michael Zagnoev**

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.

Submitter : Mrs. Lisa Gray **Date:** 08/27/2007

Organization : Mrs. Lisa Gray

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Lisa Gray and I am a Certified Athletic Trainer. I am currently working on my Masters in Medicine for Physician Assistant, and I have previously worked in the clinic and hospital setting, directly assisting surgeons with every aspect of patient care.

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

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

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

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

Sincerely,

Lisa Gray, ATC

Submitter : **Date: 08/27/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Submitter : **Ms. Kathleen Martino** **Date: 08/27/2007**

Organization : **Ms. Kathleen Martino**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Let me introduce myself Kathleen Martino MEd, ATC, LAT. I am a Certified Athletic Trainer who works in a high school setting. I have worked in the clinical setting so I do see the impact of Staffing has in regards to the hospital or clinical setting. I basically lot a clinical position due to lack of ability to pay for staff. At that time I had 6 years of clinical experience.

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

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

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

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Sincerely,

Kathleen Martino MEd ATC,LAT

Submitter : **Dr. Brent Silver** **Date: 08/27/2007**

Organization : **Valley Anesthesiology Consultants, Ltd.**

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 yours,

Brent D. Silver, M.D.
13002 E. Turquoise Ave.
Scottsdale, AZ 85259

Submitter : **Date: 08/27/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk

I am writing to you to express support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I appreciate CMS recognizing the undervaluation of anesthesia services. I am grateful the Agency is taking steps to address this issue.

Initially the RBRVS undervalued anesthesia work when compared to other physician services. This created a huge payment disparity for anesthesia care. This has continued and now effects Medicare's patients access to anesthesia care. Anesthesiologist are leaving areas with high Medicare populations.

The RUC recently recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation. This increase would help correct the undervaluation of anesthesia services. I am happy that the Agency accepted this recommendation in its proposed rule. I also support full implementation of the RUC's recommendation.

By following through with the proposal in the Federal Register, CMS can help ensure that Medicare patients have access to high quality anesthesia care. I thank you for your consideration of this serious matter.

Sincerely,

Jeffrey S. Balser

Submitter : **Dr. Alexander Nelken** **Date: 08/27/2007**

Organization : **ASA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Thank you for your consideration of this serious matter.

Submitter : **Dr. Pard Pryor** **Date: 08/27/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Pard H. Pryor, MD

Submitter : Mr. David Edell **Date:** 08/27/2007

Organization : Stafford Municipal School District

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Nationally Certified and State of Texas Licensed Athletic Trainer. I have also been certified by the National Strength and Conditioning Association as a Certified Strength and Conditioning Specialist. I have over 30 years of professional experience in the evaluation, treatment and rehabilitation of musculoskeletal injuries to active individuals. I earned a Bachelor's Degree in Human Biology and a Master's of Education.

My career path has placed me in the collegiate setting, the clinical setting and the secondary school setting. So, as you can see, I have experiences in a variety of settings within an AMA recognized Allied Health Professional field of practice.

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

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

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Sincerely,

David Edell LAT, ATC, CSCS
d_edell@comcast.net
713.858.3802

Submitter : Mr. Rusty Sullivan **Date:** 08/27/2007

Organization : Nampa School District

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I am an athletic trainer in southern Idaho at a high school. I work with about 600 athletes through out the school year on 16 different sports teams. In working with these athletes I treat hundreds of injuries each year. I have a BS degree for the University of Montana in Health and Human Perform with an emphasis in Athletic Training. I am currently finishing my Masters in Education from the University of Idaho. I have a certification in Personal Training from the National Academy of Sports Medicine. I also teach high school students sports medicine classes that are concurrent credited through the Idaho university system. In the summer I work with professional cowboys traveling the rodeo circuit.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.
The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.
Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.
Sincerely,
Rusty Sullivan L,ATC
Nampa, ID 83686

Submitter : **Dr. Craig Nordhues** **Date: 08/27/2007**

Organization : **Dr. Craig Nordhues**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Dr. Andrea Waingold** **Date: 08/27/2007**

Organization : **Anesthesia Medical Group of Santa Barbara, Inc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
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Submitter : **Date: 08/27/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Steven Wang, M.D.

Submitter : Dr. R. Keith Beamer **Date:** 08/27/2007

Organization : Michigan Association of Chiropractors

Category : Chiropractor

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

Abolish the recommendation that Medicare patients, under the care of a chiropractic physician, can not be sent directly to a radiologist for x-rays when deemed necessary.

Submitter : Dr. Dharmesh Mehta **Date:** 08/27/2007

Organization : Dr. Dharmesh Mehta

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

anesthesia

Submitter : Dr. Todd Cooperider **Date:** 08/27/2007

Organization : Anesthesiology Consultants of Toledo, Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Valerie Herzog** **Date: 08/27/2007**

Organization : **Weber State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am both a practicing Certified Athletic Trainer and a Professor of Athletic Training at Weber State University in Ogden, Utah. I have both an undergraduate degree and a masters degree in Athletic Training. I am both Certified and Licensed to practice Athletic Training in Utah.

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

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

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

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Sincerely,

Valerie Herzog, EdD, LAT, ATC
5205 Shawnee Avenue
Ogden, UT 84403
valerieherzog@weber.edu

Submitter : **Dr. Brian Schreiber** **Date: 08/27/2007**

Organization : **Summit Anesthesiology, LTD**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Andrew Gill** **Date: 08/27/2007**

Organization : **California Rehab and Sports Therapy**

Category : **Comprehensive Outpatient Rehabilitation Facility**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am a veteran Certified Athletic Trainer of 13 years currently working in a outpatient orthopaedic physical therapy clinic as well as a high school setting. I am responsible for the prevention, care rehabilitation and reconditioning of musculoskeletal injuries due to physical activity. I am a graduate of an accredited university and certified by a nationally accredited organization to perform as such. I have worked previously in the professional, university, clinic, industrial and high school settings.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

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Sincerely,

Andrew Gill ATC

Submitter : Dr. Muhammad B KHAN **Date:** 08/27/2007

Organization : Dr. Muhammad B KHAN

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I STRONGLY SUPPORT CMS-1385-P,TO INCREASE MEDICARE PAYMENT TO ANESTHESIOLOGISTS,LIKE ME,WHO ARE GIVING HIGH QUALITY CARE,TWENTYFOUR HOURS A DAY & SEVEN DAYS A WEEK, TO THE EVER INCREASING ELDERLY PATIENTS!!
I HOPE AND PRAY THAT THIS PROPOSAL WILL BE PASSED AS SOON AS POSSIBLE.
THANKYOU AND GOD BLESS AMERICA!
SINCERELY
MUHAMMAD B KHAN,MD

Submitter : **Ms. Rebecca Johnson** **Date: 08/27/2007**

Organization : **The Evergreen State College**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am the Head Athletic Trainer at The Evergreen State College in Olympia Washington. In addition to being a Certified Athletic Trainer, I am also a Clinical Education Instructor, Adjunct Faculty, Certified Strength and Conditioning Specialist, and a credentialed Physical Eduction Teacher.

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

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

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Sincerely,

Rebecca Johnson MA, ATC, CSCS

Submitter : **Miss. Karen Eagley** **Date: 08/27/2007**

Organization : **East Valley Diagnostic Imaging**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

I hope the legislation can do a revision of payment policies...We are a private imaging center and we diagnosis osteoporosis and wish to continue doing so

Submitter : **Dr. Bruce Bainton** **Date: 08/27/2007**

Organization : **ACAMG**

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.

Bruce Bainton, M.D.

CMS-1385-P-9024-Attach-1.TXT

9024

ANESTHESIA CART	QTY
ARTIFICIAL TEARS	1
ATRACURIUM 10MG/ML 10 ML	2
ATROPINE 0.4MG/ML 1 ML	4
BETADINE OINTMENT 1 OZ	1
CEFAZOLIN 1 GRAM	6
CEFOTETAN 2 G	2
DEXAMETHASONE 4MG/ML 1ML	12
DIPHENHYDRAMINE 50MG/ML	4
DROPERIDOL 5MG/2ML	4
ENLON 15ML	1
ENLON PLUS 15ML	1
EPHEDRINE 50MG/ML 1ML	4
ESMOLOL 100MG/ML	1
FLUMAZENIL 0.5MG/5ML	1
FUROSEMIDE 20MG/2ML	6
GENTAMICIN 80MG/2ML	4
GLYCOPYROLATE 0.2MG/ML 20ML	1
HEPARIN 1000 U/ML 10ML(4)	4
HYDRALAZINE 20MG/ML	2
HYDROCORTISONE 100MG	2
INDIGO CARMINE	1
KETOROLAC 30MG/ML 1 ML	2
KETOROLAC 30MG/ML 2ML	2
LABETALOL 100MG/20ML	1
LACRILUBE	1
LIDOCAINE 2% 20ML	2
LIDOCAINE JELLY 2% 30ML	1
LUBRICATING JELLY - FROM CPD	1
METHYLPREDNISOLONE 40MG	2
METOCLOPRAMIDE 10MG/2ML	2
NALOXONE 0.4MG/ML 1ML	2
NEOSTIGMINE 1MG/ML 10ML	2
NORMAL SALINE 10ML	4
ONDANSETRON 2MG/ML 2ML	8
OXYTOCIN 10U/ML 1ML	6
PANCURONIUM 1MG/ML 10ML	2
PHENYLEPHRINE 1% 10MG/ML 1ML	4
PROPRANOLOL 1MG/ML	3
ROCURONIUM 10MG/ML 5ML	4
STERILE WATER FOR INJ. 10ML	4
SUCCINYLCHOLINE 1MG/ML 10ML	3
TRIPLE ANTIBIOTIC OINTMENT 1 OZ.	1
TUBOCURARINE 3MG/ML 10ML	2
VECURONIUM 10MG	4
VERAPAMIL 5MG/ML 2ML	2

Submitter : **Dr. Francine Moring** **Date: 08/27/2007**

Organization : **CHS,S.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

Francine K. Moring M.D.

Submitter : **Dr. Andrea Fuller** **Date: 08/27/2007**

Organization : **University of Colorado**

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
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Submitter : Scott Harley **Date:** 08/27/2007

Organization : Maryville University

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Scott Harley, I am the Head Athletic Trainer and Assistant Director of Athletics at Maryville University of St. Louis.

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

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

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Sincerely,

Scott Harley, ATC

Submitter : Dr. Scott Garber **Date:** 08/27/2007

Organization : American Society of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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Acting Administrator
Centers for Medicare and Medicaid Services
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Thank you for your consideration of this serious matter.

Submitter : **Miss. Brittany Lane** **Date: 08/27/2007**

Organization : **University of Georgia, North Oconee High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer through the National Athletic Trainers' Association Board of Certification. I am currently working as a graduate assistant athletic trainer at the University of Georgia. Through a partnership with a local orthopedic clinic, I work at North Oconee High School in Bogart, GA. These proposed changes could affect athletic trainers, including myself, working in the hospital, clinical, or secondary school setting. A lot of athletic trainers working in high schools are employed through hospitals and clinics.

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

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

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Sincerely,

Brittany C. Lane, ATC

Submitter : Mrs. Erin Long **Date:** 08/27/2007

Organization : Mtn. Valley Therapy

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Erin Long and I have been a Certified Athletic Trainer for 10 years. I hold a Masters degree in Education and currently work in the outpatient Physical Therapy setting. I also teach Exercise science courses for Eastern Oregon University.

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

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

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

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

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

Sincerely,

Erin Long, M.Ed, ATC

Submitter : **Dr. Debra Kimless-Garber** **Date: 08/27/2007**

Organization : **American Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

Submitter : Dr. Julius Boakye **Date:** 08/27/2007

Organization : Aneathesia Associates of Northern Ohio

Category : Physician

Issue Areas/Comments

Coding-- Payment For IVIG Add-On Code

Coding-- Payment For IVIG Add-On Code

CMS-1385-P

GENERAL

GENERAL

I am writing to express my strongest support for the proposal to increase anesthesia paymentsunder the 2008 Physician Fee Schedule. Since the introduction of the RBRVS there has been a huge paymcnt disparity for anesthesia care due to a tremendous undervaluation of anesthesia work compared to other physicians. The 32% increase recommended by CMS for anesthesia work will only be a begining to rectify what has been a gross injustice for the last 10years.

Submitter : **Dr. Jeffrey Manning** **Date: 08/27/2007**

Organization : **Texas Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Sincerely,

Dr. Jeffrey T Manning

Submitter : **Mr. Dai Sugimoto** **Date: 08/27/2007**

Organization : **Lakeland College**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

I am Dai Sugimoto, ATC. I am working for a liberal arts college at Wisconsin as a certified athletic trainer.

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

Submitter : Dr. Steven J. Swindle, DC **Date:** 08/27/2007

Organization : Michigan Association of Chiropractors

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 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,

Dr. Steven J. Swindle, DC (CCEP) (FICPA)

Submitter : **Dr. Saurin Shah** **Date: 08/27/2007**

Organization : **UAB**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4 00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Brian McWilliams** **Date: 08/27/2007**

Organization : **Aurora BayCare Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Brian McWilliams and I currently work as a athletic trainer at Aurora BayCare Medical center in Green Bay, WI. I have been a certified athletic trainer for 11 years and licensed in the state of Wisconsin for 5 years.

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

Brian J.P. McWilliams MS, LAT, CSCS

Submitter : **Dr. Michelle Manning** **Date: 08/27/2007**

Organization : **American College of Obstetricians and Gynecologist**

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.

Sincerely,

Dr. Michelle T Manning

Submitter : **Miss. Katherine Bartosik** **Date: 08/27/2007**

Organization : **NovaCare Rehabilitation**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Katie Bartosik and I am a Certified Athletic Trainer working my fourth school year in a high school setting. I have a Master's of Education in Athletic Training and passed the National Athletic Training Certification Examination in February of 2003. During the school year my patients consist of about 800 athletes, as well as teachers, administrators, and even parents. Athletic Training is the best job in the world as far as I'm concerned! There is nothing like the feeling of rehabbing that athlete's injury and seeing them return to their sport pain and injury-free. Being a former athlete - and one who spent of a lot of time rehabbing in an athletic training room myself - this is the kind of work I have always wanted to do. I can only hope that I can continue to work in this setting and that the hard work and dedication that it took to get me here will not have been in vain.

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

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

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

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

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

Sincerely,

Katherine E. Bartosik, MEd, ATC

Submitter : **Dr. Barbara Rosenblatt** **Date: 08/27/2007**

Organization : **North Texas Anesthesia Consultants**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

scc attachmcnt

CMS-1385-P-9041-Attach-1.DOC

CMS-1385-P-9041-Attach-2.DOC

CMS-1385-P-9041-Attach-3.DOC

9041

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.

Barbara Rosenblatt, M.D.
North Texas Anesthesia Consultants

Submitter : Dr. Christopher Teggatz **Date:** 08/27/2007

Organization : American Society of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Rick Bond** **Date: 08/27/2007**

Organization : **Rehab Group of Rutledge**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Rick Bond, I am a certified athletic trainer with a Master's degree from Kent State University. I have been an ATC since 1979 and worked very hard for my degree and am proud of my profession. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans especially those in rural areas, to further restrict their ability to receive those services. I currently work in an outpatient physical therapy center in a rural setting and our clinic provides a valuable service not available for almost 50 miles from the current setting. In addition to this service, I also provide sports medicine coverage for the athletes at the local school system. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available. In this area, many local high schools have athletic trainers provided for them by hospital and clinic based facilities. Without these services, many of the athletes would have to do without any kind of medical coverage, except for that provided by the coach.

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

Sincerely,

Rick Bond, MA, ATC/L, CSCS

Submitter : Dr. Jeffrey Glaser **Date:** 08/27/2007

Organization : Jeffrey B. Glaser, M.D., Inc.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As an anesthesiologist I will be unable to continue providing care to elderly patients on Medicare if the rate reductions keep happening and the value of our work is not increased. I am in favor of a long overdue adjustment in the anesthesia work value.

Submitter : **Jim Lonning** **Date: 08/27/2007**

Organization : **Northwest Iowa Bone and Joint**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Jim Lonning and I am a Certified Athletic Trainer that works in the highschool setting evaluating, treating and rehabiltating athletic related injuries. I have a masters degree from Drake University and have been an athletic trainer for 20 years.

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

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

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Sincerely,
Jim Lonning, ATC

Submitter : **Dr. Matthew Andoniadis** **Date: 08/27/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

Medicare Economic Index (MEI)

Medicare Economic Index (MEI)

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter
Sincerely,
Dr. Matthew Andoniadis

Submitter : **Dr. Robert Doty** **Date: 08/27/2007**

Organization : **Dr. Robert Doty**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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Thank you for your consideration of this serious matter.

Robert Doty, Jr., MD

Submitter : Mr. John Zemanek **Date:** 08/27/2007

Organization : AT1 Physical Therapy

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer that currently works in an outpatient phyical therapy setting. I have been practicing athetic training in various settings and working with diverse populations for over seven years.

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

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Sincerely,
John Zemanek, MA,ATC,CSCS

Therapy Standards and Requirements

Therapy Standards and Requirements

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

Submitter : **Dr. Robert Chinn** **Date: 08/27/2007**

Organization : **South County Hospital Depart of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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.

Robert Chinn, MD
Staff Anesthesiologist
South County Hospital
Wakefield, RI

Submitter : Dr. Timothy Tom **Date:** 08/27/2007

Organization : Dr. Timothy Tom

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.

CMS-1385-P-9052

Submitter : **Dr. Dennis Klebba** **Date: 08/27/2007**

Organization : **Independent Anesthesiologist**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

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

Dear Ms. Norwalk:

I believe my letter to you is largely representative of those physicians in the backwater , border and rural communities of this great nation who are, like me, very grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue. Though we care for an equal percentage of this nation s population as do our urban counterparts, we have been doubly penalized in our Medicare reimbursements.

Perhaps with some justification based on urban practice patterns when RBRVS were conceived, a huge nationwide payment disparity for anesthesia care was created, mostly due to significant undervaluation of anesthesia work compared to other physician services but, not insignificantly, with respect to geographical factors also. In no rural location where I have practiced does the regional conversion factor amount cover the cost of caring for our nation s seniors and these compounding nationwide under valuations and reallocations of rural resources to more politically visible, organized urban centers has created an unsustainable system in which anesthesiologists are being forced away from areas, especially those rural areas, which have disproportionately high Medicare populations.

In an effort to rectify this untenable nationwide 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. Further benefit to the silent 50% (the rural) medicare patients would follow from an across the board uniform compensation factor pegged to the practice cost of the most costly urban center (the rural areas need to be raised more than 32%, some, where all medical professionals are emigrating en-masse, need much more than 32 %).

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that at a minimum 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.

Dennis S. Klebba, M.D.
8235 County Road 581
Ishpeming, Michigan 49849
(906) 458 - 0820

Submitter : **Dr. Minh-Chau Dang** **Date: 08/27/2007**

Organization : **Anesthesiology Consultants of Virginia**

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.
Minh-Chau Dang, M.D.

Submitter : **Dr. Daniel Kuo** **Date: 08/27/2007**

Organization : **Dr. Daniel Kuo**

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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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.

Daniel Kuo M.D.

CMS-1385-P-9055

Submitter : **Mr. Nathan Swift** **Date: 08/27/2007**

Organization : **Chino Hills High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

LETTER

Dear Sir or Madam:

My name is Nathan Swift, I am a Certified Athletic Trainer at Chino Hills High School in southern California.

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

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

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

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

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

Sincerely,

Nathan Swift MA, ATC

Submitter : Dr. SHASHI SANGHVI **Date:** 08/27/2007

Organization : Ottumwa 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)

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.

Shashi Sanghvi MD

Submitter : **Dr. Sherif Zaafran** **Date: 08/27/2007**

Organization : **American Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P
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.

Sherif Zaafran MD

CMS-1385-P-9058

Submitter : **Dr. Seol Yang** **Date: 08/27/2007**

Organization : **George Washington University Hospital**

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

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

Thank you for your consideration of this serious matter.

Submitter : **Mr. Michael Galvan** **Date: 08/27/2007**

Organization : **Galvan Training**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:
My name is Michael Galvan and I am a licensed Athletic Trainer in the state of Illinois. I have a Master s degree in Sports Medicine and I currently own a small business providing these types of services in the state of Illinois.

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

Submitter : **Mr. Samuel Richardson** **Date: 08/27/2007**

Organization : **North Alabama Bone & Joint Clinic**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a state licensed, nationally certified athletic trainer working for a group of orthopedic physicians in Northwest Alabama where I work with nine other athletic trainers in helping to provide free sports medicine services to local scholastic and collegiate athletic programs. I have a B.S. in Athletic Training degree from the University of Alabama, and a MAEd. degree in physical education from the University of North Alabama with a teaching certificate from the State of Alabama Department of Education. I have been licensed and certified as an athletic trainer since 1994.

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

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

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. Athletic trainers have also been recognized by the American Medical Association as allied health care professionals since 1990. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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

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

Sincerely,

Samuel W. Richardson, MAEd., LAT, ATC, LEMT-B

Submitter : **Dr. sukhjinder dhother** **Date: 08/27/2007**

Organization : **american society of anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

I 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.
Being paid less to take care of older and sicker patients makes no sense.
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.

Dr SS Dhother

Submitter : **Mr. William Michael Sullivan** **Date: 08/27/2007**

Organization : **Athletico**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Wm. Michael "Sully" Sullivan, and I work as a nationally certified, state licensed athletic trainer in the State of Illinois. Not only do I serve student-athletes in the Chicago suburbs, but I serve a diverse population of individuals that may not receive care otherwise. In addition to my clinical work as an out-reach ATC, I also serve as the Governmental Affairs Director for the Illinois Athletic Trainers Association. Furthermore, I have worked in the states of Ohio, Michigan, and Indiana.

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

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

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

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

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

I have been working in this field of health care professionally for well over 20 years. It is disappointing to me to see our area of practice to suffer such personal attacks as we have seen the past seven years. We have taken the most substantive steps of any similar profession to improve our public regulations, scope of practice standards, as well as our individual educational and performance requirements. Despite these facts and that we are recognized for our leadership in advancing scientific and clinical standards, we continue to be targeted for exclusion to the detriment of our patients.

Again, I ask that you withdraw any and all proposals and regulatory changes that do not protect the PHYSICIAN's and PATIENT's right to determine the appropriate care options and providers. It is sad to think that as a human being, I have more control over the quality of care options for my car or my dog than I have over my own life. Please consider what is occuring to our healthcare system with these exclusionary and subjective regulatory changes.

Sincerely,

William Michael "Sully" Sullivan MS, ATC
3114 Hillary Court
Joliet, IL 60435
H: (815) 436-7086
C: (630) 853-0820
sullyatc@comcast.net

Submitter : **Dr. Larry Stevener** **Date: 08/27/2007**

Organization : **American Society of Anesthesiology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Thank you for your consideration of this serious matter.

Submitter : Mrs. Rebecca Saylor **Date:** 08/27/2007

Organization : Creed Medical

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer in the State of Indiana. I have practiced in both the Hospital setting and private practice setting. I feel my education and expertise should be utilized helping patients get better and achieve their goals in therapy.

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

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

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

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

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

Sincerely,

Rebecca L. Saylor ATC

Submitter : **Dr. Donna Lucas** **Date: 08/27/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

Resource-Based PE RVUs

Resource-Based PE RVUs

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your time and consideration of this serious matter.

Sincerely yours,

Donna M. Lucas, M.D.

CMS-1385-P-9066

Submitter : **Mr. Eric Hall** **Date: 08/27/2007**

Organization : **Cary High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Eric C. Hall and I am a Certified Athletic Trainer and Certifed Teacher at Cary High School in Cary, NC. I currently teach sports medicine at the high school level and help provide medical coverage to over 600 athletes in over 35 athletic teams at Cary High School.

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

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

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

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

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

Sincerely,

Eric C. Hall, MAEd, ATC, LAT

Submitter : **Dr. Juan Fernandez** **Date: 08/27/2007**

Organization : **Greensboro Gynecology Assoc. PA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear Mr. Weems:

I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.

As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:

a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;

b. The Direct Practice Expense RVU for 77080 (DXA) should reflect the following adjustments:

* the equipment type for DXA should be changed from pencil beam to fan beam with a corresponding increase in equipment cost from $41,000 to $85,000;

* the utilization rate for preventive health services involving equipment designed to diagnose and treat a single disease or a preventive health service should be calculated in a different manner than other utilization rates so as to reflect the actual utilization of that service. In the case of DXA and VFA, the 50% utilization rate should be changed to reflect the utilization rate for DXA to 12%.

c. The inputs used to derive Indirect Practice Expense for DXA and VFA should be made available to the general public, and

d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,

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As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:

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d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,

Submitter : **Dr. David Hwang** **Date: 08/27/2007**

Organization : **First Colonies Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter.

David Hwang, M.D.
Potomac, Maryland 20854

Submitter : Mr. Ira Hofer **Date:** 08/27/2007

Organization : Mr. Ira Hofer

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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

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

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

Thank you for your consideration of this serious matter.

Submitter : **Allison Suran** **Date: 08/27/2007**

Organization : **Healing Bridge Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

In Addition:
" The in-office ancillary services exception is defined so broadly in the regulations that it facilitates the creation of abusive referral arrangements.

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

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

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

Thank you for your consideration of these comments.
Sincerely,
Allison Suran, PT
Owner, Healing Bridge Physical Therapy
404 NE Penn Ave
Bend OR 97701

Submitter : **Dr. Matthew Treece** **Date: 08/27/2007**

Organization : **Fairfield Anesthesia Associates, Inc.**

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 : **Mrs. Jean Hammill** **Date: 08/27/2007**

Organization : **Marion Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I think we need to strengthen the Stark II provisions. Some physicians who have a financial interest in a physical therapy clinic are cherry picking patients. We have found in some clinics in our state that the percentage of Medicare and Medicaid patients are going up in non physician owned clinics, and newly opened physician owned clinics are getting a higher percentage of privately insured patients. I think that physical therapy needs to be removed from the "in house anxillary services" exception to the physician self referral laws.

Submitter : **Dr. Jack Kan** **Date: 08/27/2007**

Organization : **Dr. Jack Kan**

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.

Submitter : **Stephanie Lopez** **Date: 08/27/2007**

Organization : **Stephanie Lopez**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

To whom it may concern:

As a Certified Athletic Trainer (ATC) and Licensed Athletic Trainer (LAT), I work at Indiana State University as a Graduate Assistant while I am working on obtaining my Masters' in Athletic Training. I care for all of the cross country and track and field athletes. I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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

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

Sincerely,

Stephanie Lopez, LAT, ATC

Submitter : **Sue Reed** **Date: 08/27/2007**

Organization : **Aurora Health Care**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Some basic information on my professional background: I earned a Bachelor of Science and Master of Science in the areas of health and sport science. I am licensed by the state of Wisconsin as an athletic trainer, being certified since 1983. My experience includes college, high school and clinic settings.

I am writing today request that you withdraw the proposed therapy standards and requirement changes related to staffing provisions for rehabilitation in 1385-P. The changes proposed would continue to decrease the access to available and quality health care for mine and other patients.

Athletic trainers are qualified to perform physical medicine and rehabilitation services, similar but different from physical therapy. My education, both BS and MS, clinical experience, in the settings from college, high school and rehabilitation clinics, national certification exam and state licensure ensure that my patients receive quality health care. State law and hospital medical professionals have also deemed me qualified to perform these services, I believe that these are the most qualified to determine who has the knowledge and skill to deliver high quality care. These proposed regulations attempt to circumvent those standards.

I believe it is irresponsible for CMS to continue to implement restrictions that would continue to restrict patients access, especially in rural areas. Is not the responsibility of the CMS to focus on the health of Americans, especially those in rural areas? The current standards of staffing in hospitals and other rehabilitation facilities are key to ensuring patients receive the highest quality, most cost-effective treatment available.

With the proposed changes brought forward by the CMS, not presenting any clinical or financial justification, I respectfully request that the CMS follow the recommendations of those professionals that have the responsibility to assure the quality and aceess of day-to-day health care needs of their patients, and withdraw the changes related to hospitals, rural clinics and any Medicare Part A or B hospital or rehabilitation facility.

Providing quality rehabilitation,

Sue R. Reed MS LAT (ATC)

Submitter : **Dr. Brent Murdock** **Date: 08/27/2007**

Organization : **Dr. Brent Murdock**

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.

Brent J. Murdock, D.O.

Submitter : **Mr. Nicholas Thompson** **Date: 08/27/2007**

Organization : **Mr. Nicholas Thompson**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Nicholas Thompson. I'm a Maine licensed and nationally certified Athletic Trainer (BOC), as well as a Certified Strength and Conditioning Specialist (NSCA). I work for MaineGeneral Medical Center (Waterville, ME) where I'm contracted to provide athletic training services for both a local high school (Messalonskee H.S., Oakland, ME) and a NCAA Div.III college (Thomas College, Waterville, ME).

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

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

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

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

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

Sincerely,

Nicholas J. Thompson, ATC, LAT, CSCS

Submitter : **Dr. Angus Burns** **Date: 08/27/2007**

Organization : **Dr. Angus Burns**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
CMS
Attn: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P

Anesthesia Coding

Dear Ms. Norwalk:

Thank you for considering the increase in anesthesia payments under the 2008 Physeian Fee Schedule. Anesthesia services have been significantly undervalued in the RVRBS as compared to other physcians. This disparity has existed for a decade, and is creating a system that discourages physcians from taking care of our seniors.

The RUC has recommended that CMS increase the anesthesia conversion factor to help rectify this long-standing disparity. Please give your full support to this recommendation so we as physcians can continue to care for the seniors-our most complex and challenging patients.

Thank you in advance.

Angus Burns M.D.
The Dalles Oregon 97058

Submitter : **Dr. Pouya Mohajer** **Date: 08/27/2007**

Organization : **Dr. Pouya Mohajer**

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.

Pouya Mohajer, M.D.

Submitter : **Date: 08/27/2007**

Organization :

Category : **Individual**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am an athletic training student at an accredited school in Cincinnati, Ohio. I will be graduating this year with my Bachelors of Science in Athletic Training, and plan on entering the clinical setting once I have passed my certification exam. I am a single mother of a four year old little girl, and I plan on providing for her with my degree.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.
While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.
As an athletic trainer student, I will be qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam will one day ensure that my patients receive quality health care. State law and hospital medical professionals have deemed that I will be qualified to perform these services and these proposed regulations attempt to circumvent those standards.

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

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Sincerely,
Amber O'Shea, ATS

Submitter : **Ms. Ruth Kubitza** **Date: 08/27/2007**

Organization : **Providence Osteoporosis Center**

Category : **Other Technician**

Issue Areas/Comments

GENERAL

GENERAL

Comments:

The Physician Work RVU-CPT 77080 (DXA)

The Direct Practice Expense RVU for 77080 (DXA)

Indirect Practice Expense for DXA and VFA

Deficit Reduction Act

Dear Mr. Weems:

I appreciate the opportunity to offer general comments on the proposed rule regarding changes to the Medicare physician fee schedule CMS-1385-P.

As a provider of DXA and/or VFA services, I request CMS to reevaluate the following:

a. The Physician Work RVU for 77080 (DXA) should be increased from 0.2 to 0.5, consistent with the most comprehensive survey data available;

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d. DXA (77080) should not be considered an imaging service within the meaning of the section 5012 (b) of the Deficit Reduction Act of 2005 because the diagnosis and treatment of osteoporosis is based on a score and not an image.

Sincerely,
Ruth Kubitza, RT, CDT
Providence Osteoporosis Center
7005 Woodway Drive, Ste. 101
Waco, Texas 76712
(254)776-8297

Submitter : crystal mark **Date:** 08/27/2007

Organization : crystal mark

Category : Physician

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

By limiting a Doctor of Chiropractic from referring directly to the radiologist for an X-ray study, the costs for patient care could go updue to the probability of a referral to another provider (family doctor, orthopedist, rheumatologist, etc.). With fixed ineomes and limited resources, seniors may choose to forgo X-rays and thus needed treatmcnt. If treatment is delayed, illnesses that could be life threatening may not be discovered.

Submitter : Dr. R. Lawrence Sullivan, Jr., M.D. **Date:** 08/27/2007

Organization : Coast Anesthesia Medical Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-9085-Attach-1.DOC

9085

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 urge CMS to approve and implement the recommendation of the AMA Relative Value Update Committee (RUC) that would increase payments to anesthesia providers under the Medicare Physician Fee Schedule for 2008.

As an anesthesiologist who has been practicing for over thirty-two years in a hospital with a large Medicare and Medi-Cal patient population, I am keenly aware and sensitive to the continued underpayment for my professional services. Currently, in Santa Clara County, California, Medicare payments for surgical anesthesia care amount to approximately 21% of usual, customary, and reasonable fees ($85.00 per unit), 27-30% of contracted PPO payments ($60-68.00 per unit), and 33-40% of contracted HMO blended rates (under 65 and over 65 year old patient risk pools). This current disparity has made it difficult to recruit and retain qualified anesthesiologists to a hospital-based practice, thus jeopardizing quality care for an aging and medically challenging patient base.

I applaud the RUC and CMS for recognizing the problem that was created for anesthesiologists when the Physician Fee Schedule was implemented in 1992-1994, and their current intent to correct this disparity. In my opinion, the RBRVS methodology never fully recognized the intensity of work that anesthesiologists regularly experience in caring for senior citizens in the peri-operative environment as compared to other physician services. Through a complex analysis using a building block methodology, the RUC has concluded that the work component of the RBRVS for anesthesia services is undervalued by 32%, and that an increase of the Medicare conversion factor for anesthesia providers should be increased by approximately $4.00 should be instituted. I fully support this change.

I urge CMS to adopt the proposed $4.00 increase in the anesthesia conversion factor as reported in the Federal Register.

Respectfully submitted,

R. Lawrence Sullivan, Jr., M.D.
1345 Webster St.
Palo Alto, California 94301

Submitter : **Dr. David Blue** **Date: 08/27/2007**

Organization : **Dr. David Blue**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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.

David M. Blue, MD

Submitter : **Miss. Dawn M. Minton** **Date: 08/27/2007**

Organization : **University of South Carolina**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Dawn, and I am a graduate student at the University of South Carolina. I am in the process of obtaining my masters in athletic training and preparing myself for a doctoral degree in the years to come with interest in athletic training education and research. I currently work as a graduate assistant at the USC Sports Medicine Clinic, specifically orthopedics, with highly educated orthopedic surgeons, family medicine practitioners, medical assistants, and many other healthcare providers. In this setting I play a vital role in evaluation, patient education, treatment, and even rehabilitation. I also work as the athletic trainer at a small inner city high school, CA Johnson, in Columbia. Today I am writing to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

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

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

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

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

Sincerely,

Dawn M. Minton, ATC

Submitter : **Ms. Rebecca Elmshauser** **Date: 08/27/2007**

Organization : **Blankinship Physical Therapy**

Category : **Physical Therapist**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Rebecca Elmshauser and I have been working as a professional in the Athletic Training and Physcial Therapy fields since 1999. I am a nationally certified Athletic Trainer and a licensed Athletic Trainer in the State of Arizona and am currently working in a clinical setting.

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

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

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Sincerely,

Rebecca M. Elmshausr, ATC, ATL

Submitter : **Dr. Robert Parks** **Date: 08/27/2007**

Organization : **American Society of Anesthesiologists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.

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 nations'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 the 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 most serious matter.

Robert I. Parks, Jr., M. D.

Submitter : **Dr. David Heyman** **Date: 08/27/2007**

Organization : **Dr. David Heyman**

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,
David M. Heyman, DO

Submitter : **Dr. William Harrison** **Date: 08/27/2007**

Organization : **NCAP**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Thank you for your consideration of this serious matter.

William Harrison, MD

Submitter : **Date: 08/27/2007**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
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Centers for Medicare and Medicaid Services
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Dr. Marlene Chua
Sellersburg, IN 47172