Submitter : Dr. Earl Cooper **Date:** 08/28/2007

Organization : Georgia College & State University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Dr. Earl R. Cooper, Program Coordinator of the Athletic Training Education Porgram at Georgia College & State University. I am concerned about this pending legislation and the potential detriment to the profession of athletic training. Currently, 54% of the certified/licensed athletic trainers are employed in a clinical setting. Limitation to their ability to contribute to the health care industry would be a dis-service to the general population. All Certified athletic trainers have a minimum bachelor of Science degree and must pass a rigorous certification and/or license examination. Athletic trainers have and do play a vital role in the well being of our active populations.

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,

Dr. Earl R. Cooper, Jr., ATC, CSCS

Submitter : Dr. GRANT LUNDIE **Date:** 08/28/2007

Organization : CALIFORNIA ANESTHESIA ASSOCIATES

Category : Physician

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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.

GRANT LUNDIE M.D.

Submitter : **Ms. Naoko Aminaka** **Date: 08/28/2007**

Organization : **The University of Toledo**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Naoko Aminaka, and I am the second-year Ph.D. student in Exercise Science at the University of Toledo, Toledo, OH. I am also a NATABOC certified athletic trainer and licensed in the state of Ohio.

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,

Naoko Aminaka, MS, ATC

Submitter : **Dr. C. Alvin Head** **Date: 08/28/2007**

Organization : **Medical College of Georgia**

Category : **Physician**

Issue Areas/Comments

Coding-- Additional Codes From 5-Year Review

Coding-- Additional Codes From 5-Year Review

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

Re: CMS-1385-P
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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.

C. Alvin Head, MD

Submitter : **Laurie Orme** **Date: 08/28/2007**

Organization : **Laurie Orme**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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 : **Ms. Kristen Black** **Date: 08/28/2007**

Organization : **Brenham High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer working in a rural high school in Texas. I hold a Masters of Education and a teaching credential in addition to my NATA and State of Texas athletic training credentials. I have an opportunity to work with students from all walks of life and allow them to participate to the fullest extent in athletic activities. My job description includes assisting injured athletes rehabilitate their athletic injuries.

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,

Kristen M. Black, MEd, ATC, LAT

Submitter : **Bryan Orme** **Date: 08/28/2007**

Organization : **Bryan Orme**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Sample Comment Letter:

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 : Mr. Keith Howell **Date:** 08/28/2007

Organization : Wellington Orthopaedics and Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

My name is Keith N. Howell, MS, ATC/LAT. I work in Cincinnati, Ohio as a clinical/outreach athletic trainer. I have earned my Master's Degree in Athletic Training, I am certified by the National Athletic Trainers' Association Board of Certification and licensed by the Ohio PT, OT, ATC Board. I have been working as a Certified Athletic Trainer in Ohio for 10 years now and have recently moved to Cincinnati due to the "Incident to Physician Charges" ruling that pushed me out of my old job position.

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

While I am concerned that these proposed changes to the hospital Conditions of Practice 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 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 accesss and workforce shortage to fill therapy postions 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 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,

Keith N. Howell, MS, ATC/LAT

Submitter : Mr. Aaron Wanish **Date:** 08/28/2007

Organization : Memorial Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am against the CMS issue number: CMS-1385-P

CMS-1385-P-9915-Attach-1.DOC

#9915

Dear Sir or Madam:

My name is Aaron Wanish, and I work as a Licensed Athletic Trainer and Certified Strength and Conditioning Specialist. I graduated from the University of Wisconsin-Eau Claire with a Bachelor of Science Degree in Athletic Training in 2005. As an athletic trainer at Memorial Medical Center in Neillsville, WI I am providing outreach services to Neillsville High School for student-athletes during practices as well as event coverage.

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,

Aaron C. Wanish, LAT, CSCS

Submitter : Dr. Thomas McGinnis **Date:** 08/28/2007

Organization : Johnson City Urological Clinic, PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a urologist in private practice in Johnson City, TN, I would like to comment as to the negative effect the proposed rule changes will have on my ability to serve Medicare patients, which make up 50% of my practice. I have been in practice for over thirty years and it has been the ability to participate in joint ventures in lithotripsy and laser services that have allowed our group to offer these procedures, which are state of the art, to our patients.

Specifically, Under Arrangement contracting allows us to buy the latest advancements in equipment at risk to us. It has been my experience that hospitals will often put off purchasing equipment for new procedures due to the finances involved. Our joint venture has allowed us to transport this equipment to rural hospials in our area which otherwise would not be served. By sharing this equipment among several hospitals, we actually lower costs. As a result of the case of American Lithotripsy vs Thompson, lithotripsy has not been deemed a DHS and thus our partnership cannot be deemed a DHS or causing a claim to be submitted for a DHS. When performed outside the hospital laser and lithotripsy likewise cannot be DHS services when performed by our group. Both lithotripsy and laser procedures are therapeutic and not diagnostic so there should be little risk of over-utilization. Stark legistation clearly indicates Congress intended under arrangement contracting to only require a compensation exception and not an ownership exception.

Per Procedure Fee Prohibiton. I believe Congress clearly wished to preserve per procedure fees in the Stark legistation. Again, since hospitals are adverse to risks, they often will not consider purchasing new and better technolgy. As physicians, we can understand the benefits of such technology in providing better care and as such are willing to accept such risks. I would hope that CMS will confirm that per procedure payment prohibition would not apply to the Stark indirect compensation arrangement exemption relied upon by our partnership.

In summary, I believe the proposed changes potentially affect my ability to provide continued up-to-date services in urology to my Medicare patients. The end result would possibly result to those patients going without treatment, having to travel considerable distance to obtain such treatments with the increased risks of becoming sicker and requiring more extensive and expensive care.

I appreciate the opportunity to express my views. Thank you to CMS for this. Thomas B McGinnis, MD 300 West Watauga Ave, Johnson City, TN 37604.

Submitter : **Dr. Sara Lozano** **Date: 08/28/2007**

Organization : **Cleveland Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

Dear Ms. Norwalk:

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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.

Submitter : **Mrs. Laura Dennis** **Date: 08/28/2007**

Organization : **Missouri Delta Medical Center**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Laura Dennis and I am a Certified Athletic Trainer in Sikeston, Mo. I am currently employed by Missouri Delta Medical Center and provide athletic training services for the Sikeston Public School District. I split my time between the school and clinical setting and find it frustrating that, even though I have earned a Bachelor s of Science degree in Health Management and a Master s of Science degree in Kinesiology, I am still deemed unqualified to provide therapeutic treatment and rehabilitation services for patients with orthopedic pathologies. All certified athletic trainers must past a national exam regulated by a governing board, the Board of Certification (BOC).

That is why 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,
Laura N. Dennis, MS, ATC, LAT

Submitter : **Date: 08/28/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Regarding Physician Self-Referral Provisions and the physician's ability to own and operate a Physical Therapy practice:

Physical Therapy practices should not be owned by any other entity other than by Physical Therapists. PTs cannot own MDs, DOs, DPMs, NPs, Attorneys, Psychologists, etc. We are licensed professionals who are held accountable to ourselves to high standards. Another professional does not have a personal or professional responsibility directly to those that perform or receive physical therapy services. The only person that has the greatest moral, ethical, and professional responsibility to the appropriate practice and provision of physical therapy services is that of a Physical Therapist. I firmly believe there can be little argument with this.

In my experience, a physician owned PT practice located one hour from where the patient lived tried to coerce the patient to commute 2 hours per day to their facility. We are located 5 minutes from the patient, had worked with the referring physicians on a number of occasions with excellent results, yet were not given mention as a choice for the patients PT services. This is a specific case where concern for the patient's best economic interest was intentionally ignored.

While some physicians may be well- intended, POPTS in every way have the opportunity to refer to themselves for profit. This relationship is and of itself is dangerous. Physicians should not be allowed to compete directly with or employ Physical Therapists. This will ultimately take opportunities away from excellent independent PTs and drive the competition for higher qualities of services down. If patients are quite simply not given a choice, the patient will select what there physician tells them is best for them. Patients always have, and some always will continue this behavior. PTs, unfortunately, will have little recourse in these matters. We rely on physician referrals, period. For this reason, the loop-hole needs to be closed so that physicians cannot self-refer.

Submitter : Dr. Paul Yocom **Date:** 08/28/2007

Organization : Dr. Paul J. Yocom

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

I am a retired Chiropractic Physician, and Thank God retired. I spent close to three decades taking very good care of people who were ill, injured, and in pain. Omitting the politically correct bovine feces, it is clear that the Medicare and Medicaid systems have done nothing but pander to a turf war between organized medicine per-se; and organized alternative medicine practitioners. A chiropractic physician by training is just as qualified to order diagnostic tests including x-rays as is his/her medical counterpart. The Medicare and Medicaid systems historically have done absolutely nothing to help these patients receive a higher level of care, in fact the systems try to drive the patients into a posture of receiving sub optimal care by financially limiting the practitioner's scope beyond any statutory limitations, and creating an enviornment where it is difficult to obtain necessary clinical tests and data. This is nothing more than an immoral turf war (which was initiated by organized medicine) that is supported by the Medicare and Medicaid systems. As a practitioner, I will pit my diagnostic ability and knowledge against any family or internal medicine practitioner in my area, and in so doing have actually protected several of my MD acquaintences from mal practice law suits not to mention have protected their patients. Talk to me some time about the Pancost tumors, Ewings Sarcomas, Ovarian Cancers, Breast Cancers, Cardiac disorders, Hot gall bladders, etc. etc. etc. that I have caught that slipped right through the diagnostic hands of some of the MDs that saw the same patients within the same 48 hour period !! And along comes Medicare and Medicaid who notwithstanding the statutory authority of my license, considers me (and those like me) to be some kind of cultist and inferior practitioner. I practiced for almost 30 years, and did it well. My patients were well served. I cared where others did not. I sought answers where others did not. I have saved lives with diagnostics. I am the type of practitioner that you yourself may wish to have available for yourself or a loved one -- why ?? because I give a damn, and I am very good at what I do; and there are thousands of alternative practitioners just like me. The bottom line in this matter concerning x-rays is that the system is broken as it is - rather than fix it in the interest of all - you seek ways to break it further. This country is in trouble, and the Medicare and Medicaid system as it is constitutes a big part of the problem. You probably do not have the power to fix it, but at least have the wisdom to leave it the hell alone at a status that can at least partially function to provide clinical safety for patients who seek our services of their own volition. Dr. Paul J. Yocom, Chiropractic Physician (retired) Titusville, Florida.

Submitter : Dr. Frank Suatoni **Date:** 08/28/2007

Organization : amer Soc Of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms Nowalk

Dear Ms. Norwalk:
I have been practicing Anesthesia for 40 Years our payment for Medicare Services has always been too low .It is not based on Relative Value but almost all other medical srevices are.Now that I am a Medicare Subscriber the issue is even more pressing.

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
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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 : Jodi Waltenberg **Date:** 08/28/2007

Organization : St. Michael's Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

Hello. My name is Jodi Waltenberg. I currently work for St. Michael s Hospital in the sports medicine department with opportunities to provide services as a physician extender as well as rehabilitation. I am concerned about the limitations 1385-P will create to my position as a licensed 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.
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Sincerely,
Jodi L. Waltenberg, LAT, ATC, MS

Submitter : Dr. Steven Johnson **Date:** 08/28/2007

Organization : Associated Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This comment is directed at the current Medicare reimbursement schedule for anesthesia. CMS has for many years under reimbursed anesthesia for their services. It has resulted in a situation where Medicare payments to anesthesia are less than 25% of commercial insurance rates. This results in a situation where it becomes impossible to recruit and retain anesthesiologists in any facility where Medicare makes up a significant portion of the case volume. Current medicare rates do not even cover the cost of a nurse anesthetist, much less an anesthesiologist. Medicare rates are at approximately $18 per unit which translates to $72 per hour. A plumber will not come to your house for that rate. Your mechanic at the local Honda dealership earns more. When you subtract out overhead, billing and other expenses, the true rate is pathetically less. If your long term goal is to destroy the practice of anesthesia in the US then continue on the current course, you are doing an excellent job of crippling the specialty. Any increase in rates is long overdue and without a doubt far short of what is actually needed.

Submitter : **Mrs. kathleen pike** **Date: 08/28/2007**

Organization : **anesthesia medical consultants**

Category : **Other Health Care Professional**

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 : **Mr. Shepard Stone** **Date: 08/28/2007**

Organization : **Yale University School of Medicine**

Category : **Physician Assistant**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Harold Lee** **Date: 08/28/2007**

Organization : **Alliance Anesthesia Assoc**

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.

It is universally accepted that Medicare rates for anesthesiology services are grossly undervalued. The cost shift from Medicare to the private sector has become untenable. Soon, we may have to outsource these jobs overseas? If you want high quality anesthesiologists to continue to care for you, your loved ones, and all American citizens, I urge you to take immediate action to correct this gross undervaluation.

Thank you for your consideration of this serious matter.

Sincerely,
Harold S. Lee, MD
Chairman, Department of Anesthesiology
St. Mary's Hospital
25500 Point Lookout Road
Leonardtown, MD 20650
301-475-6204

Submitter : **Ms. Heather Golly** **Date: 08/28/2007**

Organization : **Minot State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an Assistant Professor at Minot State University. I am concerned about the proposed rule changes by the Centers for Medicare and Medicaid Services regarding outpatient clinics and rehabilitation departments.

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,

Heather L. Golly, M.A., ATC, CSCS

Submitter : Dr. Jay Schwartz **Date:** 08/28/2007

Organization : Dr. Jay Schwartz

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

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. First, you don't permit patients to get reimbursed for xrays when taken by a chiropractor although chiropractors are just as qualified as radiologists. This increases overall medicare expenditures since xrays are usually cheaper in a chiropractic office. Now by eliminating patient reimbursement when they are referred to radiologists results in a hardship for the patient who will now have to be referred to his primary doctor for a referral and again increases patient expenditures for another copay as well as medicare expenditure for the extra pcp visit. This "correction" makes absolutely no sense whatsoever and should be eliminated immediately.

Submitter : Mr. William Robbins **Date:** 08/28/2007

Organization : Huntington County Community School Corporation

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1385-P-9929-Attach-1.DOC

CMS-1385-P-9929-Attach-2.DOC

9929

Home of the Vikings

Huntington North High School

Dear Sir or Madam:

I am a school administrator at Huntington North High School and a Certified Athletic Trainer. I have had the opportunity to work with student athletes in secondary schools for nearly 15 years. It has been a rewarding job that allows me to serve my community and my 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.

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Sincerely,

William S. Robbins, EdS, ATC

450 MacGahan Street ♦ Huntington, IN 46750 ♦ 260-356-6104 ♦ 260-358-2208 FAX

Submitter : **Jessica Bungard** **Date: 08/28/2007**

Organization : **CORA Rehabilitation and Sports Medicine**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an Athletic Trainer who currently works at an outpatient rehabilitation clinic. I also provide outreach to a local private high school. I have a bachelors degree in science in health and I am certified and licensed as an Athletic trainer. I provide rehabilitation and treatment services at an outpatient clinic and I also provide evaluation, prevention, and treatment of injuries at the local 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.

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Sincerely,

Jessica Bungard, ATC, LAT

Submitter : Dr. Jay Schwartz **Date:** 08/28/2007

Organization : Dr. Jay Schwartz

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Attention: CMS-1385-P 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. First, you don't permit patients to get reimbursed for xrays when taken by a chiropractor although chiropractors are just as qualified as radiologists. This increases overall medicare expenditures since xrays are usually cheaper in a chiropractic office. Now by eliminating patient reimbursement when they are referred to radiologists results in a hardship for the patient who will now have to be referred to his primary doctor for a referral and again increases patient expenditures for another copay as well as medicare expenditure for the extra pcp visit. This "correction" makes absolutely no sense whatsoever and should be eliminated immediately.

Submitter : **Dr. DeWitt McCarter** **Date: 08/28/2007**

Organization : **Texas Anesthesia Group**

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. Paul Higgs** **Date: 08/28/2007**

Organization : **Georgia College**

Category : **Other Health Care Professional**

Issue Areas/Comments

Therapy Standards and Requirements

Therapy Standards and Requirements

Dear Sir or Madam:

I am the Head Athletic Trainer at Georgia College & State University in Milledgeville, GA. I am certified and licensed to practice my profession. My undergraduate degree is in Sports Medicine and my Master's degree is in education. In my particular setting, I oversee the healthcare needs, including rehabilitiation for musculoskeletal injuries of collegiate athletes, but also treat other students and employees under the direction of a physician for their outpatient rehabilitation needs.

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,
Paul Higgs MEd, ATC, LAT, CSCS

Submitter : **Dr. Kevin Anderson** **Date: 08/28/2007**

Organization : **Dr. Kevin Anderson**

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.

Kevin J. Anderson, M.D.

Submitter : Dr. Parvinder Singh **Date:** 08/28/2007

Organization : ASA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1385-P-9935-Attach-1.TXT

9935

Parvinder Singh, M.D., F.R.C.A.
Anesthesia Practice Associates ICMC
210 W San Bernardino Rd
COVINA, CA 91723
Phone: 626-915-6286

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.

Parvinder Singh, M.D., F.R.C.A, Diplomate American Board Of Anesthesiology

Submitter : **Date: 08/28/2007**

Organization :

Category : **Occupational Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

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

CMS-1385-P-9936-Attach-1.DOC

9936

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

FREEDOM
PHYSICAL THERAPY
SERVICES, S.C.

Dear Mr. Weems:

I am an Occupational therapist who has worked in private practice in Milwaukee, Wisconsin for the past 5 years. I own my own practice and am active within the occupational therapy community. I would like to comment on the July 12th proposed 2008 physician fee schedule rule, specifically the issue surrounding physician self-referral and the "in-office ancillary services" exception.

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

Occupational therapy services are generally provided on a repetitive basis. That said, it is no more convenient for the patient to receive OT services 2-3 times per week in the physician's office than to attend an independent occupational therapy location. Furthermore, physician-direct supervision is not necessary to administer occupational therapy services. In fact, an increasing number of physician-owned occupational therapy clinics are using the reassignment of benefits laws to collect payment in order to circumvent "incident-to" requirements.

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

Sincerely,

A concerned Occupational Therapist in zip code 53217

Submitter : **Dr. Leonid Gorelik** **Date: 08/28/2007**

Organization : **Physician Anesthesia Service, P.C.**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

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Thank you for your consideration of this serious matter.

Submitter : **Dr. Kenneth Lee** **Date: 08/28/2007**

Organization : **Pacific Anesthesia, 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

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Thank you for your consideration of this serious matter.

Submitter : Mr. james morrow **Date:** 08/28/2007

Organization : brazosport regional hospital

Category : Physical Therapist

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I am a Lymphatic Therapist working at a hospital. I have a BS, am a Liscensed Massage Therapy, Certified Vodder Therapist and Certified LANA Therapist. I have seven years of successful treatments for lymphatic patients. I have treated a patient that was bed ridden for 30 years and gotten him walking almost a mile several times a week. I have had patients with numerous hospital visits due to cellulitis who no longer have these infections. I work with a wound center and have had patients who were frequent visitors who no longer have recurring visits because they have learned to control their edema. My training as a Vodder Therapist and passing the LANA exam insure my ability to treat a lymphatic patient. The proposed change would limit my ability to treat these people and put the treatment in the hands of someone who has very little training in this specific condition. This is not only dangerous for the patient, it makes no since in cost effectiveness. This treatment done properly saves countless $$$ on hospital stays, recurrent wound visits, and home health visits not to mention the improvement patients get in pain relief, increased mobility and improved quality of life. I have had patients travel over 150 miles to come for my treatment because there are no therapists near them. There are a number of Physical Therapists where I work and none of them are interested in doing lymphedema treatment and openly admit they received no training in obtaining their liscence that would qualify them to treat these patients. I have found that the therapists that have received Vodder training and are LANA certified are dedicated in helping these patients who are ignored by other medical professions. I urge no I beg you to consider their health and allow people who are properly trained to help these people. It is not only the right thing to do it is the most cost effective for everyone. If you want to make a change, add a billing code for lymphedema treatment to be done by a certified lymphedema therapist that has passed the LANA exam. You will then be getting people treated by people who have received the proper training.
Sincerly,
James Morrow CLT, LANA

Submitter : **Dr. Emily Garmon** **Date: 08/28/2007**

Organization : **Dr. Emily Garmon**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Submitter : Dr. Alden Reine **Date:** 08/28/2007

Organization : Advanced Urology of Central Florida

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

CMS should work with Congress to fix the Sustainable Growth Rate to prevent the upcoming 10% cut to physicians who provide services to Medicare beneficiaries. Drastic cuts will total 40% over the next 8 years. Over that same period, the Medicare Economic Index (MEI) will increase 20%. How long will physicians be forced to ask for a legislative fix from Congress?

Although no specific proposals exist from CMS, any change to the Stark in-office ancillary exception would unduly harm the ability of urologists to provide efficiencies and needed services to patients. Services provided under the exception are important to healthcare delivery. CMS should not further limit this already complex and burdensome regulation.

Under the proposed rule regarding reassignment and diagnostic testing, the only technical or professional services a medical group could mark-up would be those performed by the group s full time employees. This would significantly would hurt the ability of group practices with in-office imaging equipment to utilize independent contractors and part-time employees to perform professional interpretation services. We understand CMS desire to prevent markups and gaming the system but offices with in-office imaging equipment utilize independent contractors and part time employees to perform high-quality professional interpretation services

Prohibition of under arrangements rule will prohibit the provision of that are provided to a hospital through a joint venture in which you have an ownership interest, (such as radiation therapy or lasers). This will be detrimental to patient eare because of access to these services are expensive in our community and across the country. In addition, CMS has taken efforts through a variety of different regulations through the years to eliminate duplication of services. If CMS or Congress were to prevent or further limit the ability to Joint venture with hospitals or other practices it may create an environment that would induce physieians to provide more services in-house under the practice exclusion . Each practice group will buy their own equipment or subject patients to return to the more costly and inefficient hospital providers.

We understand the importance of striking a balanee between eradicating fraud and abuse and promoting efficiency and protecting patient access to care. As a urologist, these regulations, if implemented would have a negative effect on innovation, efficiency and patient access to care. Please consider suggested changes and withdraw these proposals.
CMS should not be considering making significant changes to Stark rules on an annual basis or for inclusion in the Physician Fee Schedule. Too many financial and business arrangements, legal contracts and services are involved to be altered on a yearly basis or through a piecemeal approach. In sum, the proposed rule creates two levels of uncertainty: (1) significant lack of clarity within the specific proposals themselves; and (2) general instability due to the prospect of annual changes to Stark.

Please be cognizant to the level of "abuse" you are laying upon physicians. How mueh more of this will we need to endure before patient care is adversly affected and we leave this profession all together. You are "killing" us for lack of a better word.

Sincerely,
Alden Reine, MD

Submitter : **Dr. Felix Angelov** **Date: 08/28/2007**

Organization : **UIC**

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 : **Phoebe Stapleton** **Date: 08/28/2007**

Organization : **WVU Student - School of Medicine**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a graduate student, currently earning a PhD in exercise physiology. I am also a certified athletic trainer, who put herself through graduate school using said certification. I find it objectionalble that you would consider these changes. I treated and aided MANY NCAA athletes in my tenure at a variety of accredited institutions. I know that without my assistance, some of these athletes would not have been able to afford the care that I provided to them: travel time, in-room treatments while travelling, treatments outside of normal business hours, and the rapid rehabilitation time; these athletes would have been unable to achieve their athletic goals (and for some, without the on the bus counseling and tutoring, their educational goals 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. 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,

Phoebe G Stapleton, MSEd, ATC

Graduate Student
West Virginia University
School of Medicine
Cardiovascular Center
Health Science Center - North
Morgantown, WV 26505

Submitter : **Kathryn Burford** **Date: 08/28/2007**

Organization : **Kathryn Burford**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Kathryn Burford. I am an Athletic Training Student at Missouri Valley College in Marshall. Missouri.

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,

Kathryn Burford

Submitter : **Dr. Daniel Tominello** **Date: 08/28/2007**

Organization : **Dr. Daniel Tominello**

Category : **Chiropractor**

Issue Areas/Comments

GENERAL

GENERAL

Refer to file code CMS-1385-P. Technical Corrections
This change could and would quite frankly jeopardize some ones health and saftey. Medicare clients would feel if Medicare does not pay for it thet do not need it and would refuse the procedure and that would complicate the safety and delivery of chiropractic care.

Submitter : **Mr. Jerry Bean** **Date: 08/28/2007**

Organization : **Neosho County Community College**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

My name is Jerry Bean, the Head Athletic Trainer at Neosho County Community College. I have obtained a Bachelors of Science and Masters of Science in my pursuit of multiple certifieations and licensure. To date, I am a Certified Athletie Trainer for the National Athletie Trainers' Association with licensure in the state of Kansas as well as a Certfied Strength and Conditioning Specialist for the National Strength and Conditioning Association. Subsequent endorsements include first aid, CPR, automated external defibulator and basic life support.

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 coneerned that these proposed rules will create additional lack of aecess to quality health care for my patients.

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Sincerely,

Jerry Bean, MS, LAT, ATC, CSCS
Head Athletic Trainer
NCCC Panthers

Please feel free to copy and paste the NATA or my website address for more information regarding Athletic Training.

http://www.nata.org

http://www.neosho.edu/athletics/athletic_training/index.asp

Submitter : **Dr. Ramon Matos** **Date: 08/28/2007**

Organization : **American Society Of Anesthesia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

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

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.

Ramon Matos, M.D.
Staff Anesthesiologist
Cartersville Medical Center
960 Joe Frank Harris Pkwy SE
Cartersville, GA 30120
(770) 606-2129

Submitter : **Dr. George Peneff** **Date: 08/28/2007**

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

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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. Shawn Klenk** **Date: 08/28/2007**

Organization : **Sterling Regional School District**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Shawn T. Klenk and I am a Certified Athletic Trainer, who works for the Sterling Regional School District in Somerdale, NJ.

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,

Shawn T. Klenk, ATC.

Submitter : **Dr. Kenneth J. Meyer** **Date: 08/28/2007**

Organization : **Northwest Chiropractic Centre**

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. Kenneth J. Meyer and Dr.Matthew B. Meyer

Submitter : **Mr. Cale Yarbrough** **Date: 08/28/2007**

Organization : **Sumner Regional Health Systems**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Cale Yarbrough I am an ATC @ Westmoreland High School in Westmoreland, TN. I have been an Athletic Trainer for four years and enjoy my job.

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. My job is not to take away from the profession of physical therapy but add to the care of the athletes that they see.

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.

As and athletic trainer who spends 50-60 hours a week with the athletes at my school I fill that this dicision would not benefit the best interest of the youth in High Schools. Again we (ATC's) are not trying to take away from what PT's are capable of doing but I think it is unfair for laws to be passed that allow PT's to take away from what we as Athletic Trainers do.

Sincerely,
Cale Yarbrough ATC, MS

Submitter : **Dr. Leila Reduque** **Date: 08/28/2007**

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. 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. Sunit Jolly **Date:** 08/28/2007

Organization : Milton Chiropractic and Rehabilitation

Category : Chiropractor

Issue Areas/Comments

Technical Corrections

Technical Corrections

Re: Technical Corrections. The proposed rule dated July 12th contained an item under the techincal 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 OPPOSITION OF THIS PROPOSAL. While subluxation does not need to be detected on 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 also to dertermine the need for further diagnostic testing; eg MRI or referral to an appropriate specialist. By limiting a Doctor of Chiropractic from referring for an X-ray study, the COSTS OF PATIENT CARE WILL INCREASE for duplicate evaluation prior to the referral to the radiologist. If treatment is delayed illness that could be life threatening may not be discovered. The patient's care will be compromised. I strongly urge you to table this proposal. These X-rays if needed, are integral to the overal treatment plan of Medicare patients and , again, it is ultimately the patient that will suffer should this proposal become standing regulation.

Sincerely,
Sunit Jolly, D.C

Submitter : Dr. George Vanichsombat **Date:** 08/28/2007

Organization : California Anesthesia Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-9954-Attach-1.DOC

9954

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

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

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Thank you for your consideration of this serious matter.

Submitter : **Mr. Andy Boehnke** **Date: 08/28/2007**

Organization : **Sanford Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Andy Boehnke, and I am a certified athletic trainer in Sioux Falls, SD. I have Bachelor of Science degrees in Athletic Training and Health, Physical Education and Recreation. I also have a Master of Science degree in Sports Management.

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,

Andy Boehnke, MS, ATC, CSCS

Submitter : Dr. Carolyn Serbousek **Date:** 08/28/2007

Organization : Dr. Carolyn Serbousek

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Arkansas is one of the lowest states for Medicare reimbursement yet has one of the highest numbers of Medicare patients to care for. In addition, Medicare patients are usually the most difficult to care for from an anesthetic standpoint. Please pass this bill to make reimbursement more equitable.

Submitter : Dr. Tim Holroyd **Date:** 08/28/2007

Organization : Atlantic Anesthesia

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

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To ensure that our patients have access to expert anesthesiology medical eare, 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.

Tim Holroyd MD

Submitter : Dr. HOLLY HAPPE **Date:** 08/28/2007

Organization : MERIDIAN ANESTHESIA

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

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Thank you for your consideration of this serious matter.

Holly E Happe, DO

Submitter : **Ms. Mattie Kaminskas** **Date: 08/28/2007**

Organization : **Bolingbrook High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Mattie Kaminskas, I have BS in Secondary Education and Athletic Training. I currently work for the public school system in Bolingbrook, IL. In the state of Illinois, not only do Athletic Trainers have to pass the national certification test but we also must be licensed in the state in order to 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.

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,

Mattie M Kaminskas, ATC

Submitter : **Dr. Richard Johnson** **Date: 08/28/2007**

Organization : **Johnson Chiropractic Center**

Category : **Physician**

Issue Areas/Comments

Chiropractic Services Demonstration

Chiropractic Services Demonstration

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

Re: TECHNICAL CORRECTIONS

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

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,

Richard B Johnson D.C.

Submitter : Mr. Christopher Magott **Date:** 08/28/2007

Organization : St. Edward's University

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Christopher Magott and I am currently the Assistant Athletic Trainer at St. Edward's University in Austin, Texas. I have worked in the field of athletic training for over 5 years and am both certified by the nation and licensed by the state of Texas to 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.

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,

Christopher P. Magott, ATC, LAT

Submitter : Dr. Girish Vallabhan **Date:** 08/28/2007

Organization : Dr. Girish Vallabhan

Category : Physician

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

My name is Girish Vallabhan, MD. I practice Urology in Lubbock, TX for over 13 years. I provide comprehensive urological care for my patients including in office ultrasound, labs, urodynamic testing, xray, cystoscopy, etc. In order to provide the very best in patient care, I was involved in organizing a physician owned surgery center and lithotripsy. When physicians are involved in the decision making process in delivery of care, quality and efficiency certainly improve in regards to patient care. Limiting physician ownership will only hamper patient care, NOT enhance it. It will also potentially place some practices in severe jeopardy. I urge you to reconsider the proposals.
Sincerely,
Girish Vallabhan, MD

Submitter : **Date: 08/28/2007**

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)

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. David Pennington **Date:** 08/28/2007

Organization : ortho indy

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1385-P-9964-Attach-1.PDF

#9964

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Strategic Operations & Regulatory Affairs

The attachment cited in this document is not included because of one of the following:

- The submitter made an error when attaching the document. (We note that the commenter must click the yellow "Attach File" button to forward the attachment.)
- The attachment was received but the document attached was improperly formatted or in provided in a format that we are unable to accept. (We are not are not able to receive attachments that have been prepared in excel or zip files).
- The document provided was a password-protected file and CMS was given read-only access.

Please direct any questions or comments regarding this attachment to (800) 743-3951.

Submitter : **Dr. Paul Ligertwood** **Date: 08/28/2007**

Organization : **Dr. Paul Ligertwood**

Category : **Physician**

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

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

Sincerely,

Submitter : Mr. Scott Cooper **Date:** 08/28/2007

Organization : Certified Athletic Trainer

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Scott Cooper and I am a Certified Athletic Trainer who has been delivering quality health care to patietns for over ten years. I currenly work at Vanderbilt University Medical Center where we employ over 15 Certified Athletic Trainers to assist with patietn care in our physical therapy 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 eare 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,

Scott Cooper,MS, ATC

Submitter : Ms. Kara Werner **Date:** 08/28/2007

Organization : Lakeland College

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
I am Kara Werner, 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.
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Sincerely,
Kara Werner, ATC

Submitter : **Meredith Crenshaw** **Date: 08/28/2007**

Organization : **Meredith Crenshaw**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1385-P

Anesthesia Coding (Part of 5-Year Review)

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross 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 : **Date: 08/28/2007**

Organization :

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

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;
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%.
e. 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.

Submitter : Mrs. Susan Wilson **Date:** 08/28/2007

Organization : Athletic Trainer

Category : Other Health Care Professional

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Dear Sir or Madam:

My name is Sue Wilson and I am a Certified Athletic Trainer with a Masters in Exercise Physiology and a Performance Enhancement Specialist Certification. I have 7 years of education from accredited institutions in the prevention, recognition, treatment and rehabilitation of athletic injuries. I had to complete a thesis specializing in exercise physiology in order to receive my masters. My thesis was then submitted and approved to be presented at the 2006 ACSM (National Academy of Sports Medicine)International Conference held in Denver, Colorado.

I currently work in Indianola, Iowa as an Athletic Trainer for the local high school and spend most my mornings watching Physical Therapist perform exercises with their patients that I was taught during my undergraduate schooling. I have the same knowledge and education as a Physical Therapist. My coworker, a Physical Therapist, and I both attended a 4 year college and graduated, we passed National Certification Exams, and both continued our education in the form of a Masters. I was more interested in the Exercise Physiology route, and my coworker chose Physical Therapy. I am extremely good at what I do and it is heart breaking to find out that uninformed people who probably have not worked with a Certified Athletic Trainer have decided that my education is not good enough for certain healthcare services.

I am not a 'trainer' that received their certification in 6 weeks, I am not a personal 'trainer' of people that want to work out twice a week or lose weight, nor am I a 'trainer' for animals. I am a Certfied Athletic Trainer with a Masters Degree and deserve to make a living and be resepcted in my chosen field.

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,

Susan M. Wilson M.A., L.A.T., A.T.C., P.E.S.

Submitter : Dr. Michael Wiles **Date:** 08/28/2007

Organization : Northwestern College of Chiropractic

Category : Academic

Issue Areas/Comments

Technical Corrections

Technical Corrections

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

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

Sincerely,

Dr. Michael Wiles,
Dean, College of Chiropractic
Northwestern Health Sciences University

Submitter : **Mrs. Teresa Ford** **Date: 08/28/2007**

Organization : **Mrs. Teresa Ford**

Category : **Individual**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

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

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

Dear Ms. Norwalk:

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

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

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

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

Thank you for your consideration of this serious matter

Sincerely,

Teresa D. Ford

Submitter : **Mrs. Amanda Langton** **Date: 08/28/2007**

Organization : **University of Georgia Athletic Association**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

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,

Amanda M. Langton, MEd, ATC, NREMT-I

Submitter : **Mrs. Emily Whiting** **Date: 08/28/2007**

Organization : **Sanford Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified athletic trainer in a collegiate setting in Sioux Falls, South Dakota. I have bachelor of arts degrees in athletic training, exercise science, and fitness management, and a master's of science degree in athletic training from one of the most prestigous Division I athletic training programs in the country.

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,
Emily Whiting, MS, ATC

Submitter : **Miss. Katherine Songer** **Date: 08/28/2007**

Organization : **Spring-Ford Area High School**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Katherine Songer and I am a Certified Athletic Trainer working at Spring-ford Area High School. I received a bachelors degree from Springfield college in 1999 and became a Certified Athletic Trainer from the National Athletic Training Association Board of Certification in April, 1999 and have been practicing in the field of Athletic Training since.

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,

Katherine R Songer, ATC

Submitter : **Date: 08/28/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

I would like to express my opinions strongly against the practice of POPTS. I believe that physical therapy is it's own, autonomous profession and should be treated as such, not as a sub-service of physician offices. There is no reason that physical therapy care cannot be provided in a convenient location, in a timely manner, and be established with good communication between the physical therapists and the referring physician without having the physician own the physical therapy practice. It is well established by CMS that physical therapy is a licensed profession, that clinicians who provide physical therapy be educated by an accredited institution and pass the licensure laws applicable to each state. They must also abide by state and federal rules and regulations in regards to continuing education, ethics, safety and confidentiality. Many safeguards are in place to ensure that physical therapy is provided by quality health care professionals who have demonstrated positive outcomes and quality of care. The practice of physicians owning physical therapy clinics allows physicians to bill for physical therapy that is not necessarily provided by licensed physical therapists or physical therapist assistants. It is based on referral for profit, which serves only to harm the health care consumer, potentially resulting in fraud or abuse by referring more patients than normal, ordering longer duration or higher frequency of care, and restricting the patient's right to select his or her own caregivers. This would not be tolerated if a physician owned a pharmacy and required all his or her patients to fill expensive prescriptions at that pharmacy, resulting in higher profits for the physician. This is the same issue at stake with physical therapy practices. Please consider the rights of the patient and equality to all practioners of physical therapy by ruling to end POPTS. Thank you.

Submitter : **Dr. Michael McGinnis** **Date: 08/28/2007**

Organization : **Dr. Michael McGinnis**

Category : **Physician**

Issue Areas/Comments

Payment For Procedures And Services Provided In ASCs

Payment For Procedures And Services Provided In ASCs

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly $4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC s recommendation.

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

Thank you for your consideration of this serious matter.

Sincerely,

Michael McGinnis,M.D.

Submitter : **Dr. Shailesh Mori** **Date: 08/28/2007**

Organization : **Pinnacle Partners in Medicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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

Rc: CMS-1385-P

Ancsthesia 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 serviccs, and that the Agency is taking steps to address this complicated issue.

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Thank you for your consideration of this serious matter.

Sincerly Yours,

Shailcsh Mori, MD

Submitter : **Miss. Amy Welp (Ingraffia)** **Date: 08/28/2007**

Organization : **AthletiCo, LTD**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a Certified Athletic Trainer that has worked in college athletics for 10 years and just this year have moved into the high school setting through AthletiCo, LTD. I also have a Masters Degree in Education.

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

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

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

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

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

Sincerely,

Amy Welp (Ingraffia) MEd, ATC

Submitter : Dr. Michael Fontes **Date:** 08/28/2007

Organization : Texas Anesthesia Group

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
Baltimorc, MD 21244-8018

Rc: CMS-1385-P
Ancsthesia Coding (Part of 5-Year Review)

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Thank you for your consideration of this serious matter.

Yours truly,

Michael A. Fontes M.D.

Submitter : Dr. Mark Chen **Date:** 08/28/2007

Organization : Dr. Mark Chen

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

This is in regards to CMS-1385-P, pertaining to non-reimbursement for X-ray services requested by chiropractors. I highly recommend that this proposal be abolished. If there is a category of patients whose care would be best determined by radiology studies it would be medicare patients. By eliminating the reimbursement of any xray studies by chiropractors, you either put the burden of payment on the patients or the health care providers to skip this important step as they would not want to bear the expenses of pro bono services. Either way, the people most likely affected by this would be the patients themselves who need the care, and most importantly the correct care that radiology studies would provide insight.

Submitter : **Mr. Edward Evans** **Date: 08/28/2007**

Organization : **Northwestern State University**

Category : **Other Health Care Professional**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

Dear Sir or Madam:

I am Ed Evans, Head Athletic Trainer at Northwesten State University in Natchitoches, LA. I hold certification as an athletic trainer both nationally and in the state of Louisisana.

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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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,

Edward C. Evans MS, LAT, ATC

Submitter : **Dr. Dean Mariano** **Date: 08/28/2007**

Organization : **UPMC**

Category : **Physician**

Issue Areas/Comments

TRHCA--Section 101(d): PAQ1

TRHCA--Section 101(d): PAQ1

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. David J. Bradley **Date:** 08/28/2007

Organization : Univ.of Utah and Primary Children's Medical Center

Category : Physician

Issue Areas/Comments

Coding--Reduction In TC For Imaging Services

Coding--Reduction In TC For Imaging Services

August 28, 2007

Dear CMS:

I am writing regarding the proposed change to eliminate CPT 93325 (Doppler Color Flow Mapping) and bundle this code into other echocardiography CPT codes. As a cardiac specialist caring for patients with congenital heart disease, this is of particular concern to me for a number of reasons.

I do not believe the appropriate process has been followed with respect to this proposed change. After significant interaction and research between the Relative Value Scale Update Committee (RUC) and the appropriate specialty societies (ACC and ASE), the CPT editorial panel has recommended that a new code be established that would bundle the 93325 with the 93307 to be implemented on January 1, 2009. The RUC is scheduled to evaluate the recommended relevant work and practice expense for the new code at its upcoming meeting. The CPT editorial panel did not recommend that other echo codes be bundled as well with the 93325. Because the actions of CMS are contrary to the normal process for such changes and the resultant compressed timeframe, the specialty societies have not been able to effectively work with their membership to evaluate the proposed change in a reasoned, methodical manner (something that is in the interests of all parties).

Importantly, there is no proposed change to the RVUs of the codes with which 93325 will be bundled. The proposal would simply eliminate reimbursement for CPT 93325, yet the amount of work performed and time spent by the physician for this service will remain the same.

Color Doppler is typically performed in conjunction with 2D echo to define structural and dynamic abnormalities as a clue to flow aberrations and to provide internal anatomic landmarks necessary for positioning the Doppler cursor to record cardiovascular blood flow velocities. The performance of echo in patients with congenital anomalies is unique in that it is frequently necessary to use color Doppler (93325) for diagnostic purposes and it forms the basis for subsequent clinical management decisions. CPT Assistant in 1997 references the uniqueness of the 93325 code for the pediatric population stating that color Doppler is "& even more critical in the neonatal period when rapid changes in pressure in the pulmonary circuit can cause significant blood flow changes, reversals of fetal shunts and delayed adaptation to neonatal life." There are many other complex anatomic and physiologic issues that we as cardiac specialists face on a daily basis when performing echos on patients with complex heart disease. Color Doppler imaging is a critically important part of many of these studies, requiring additional time and expertise from both the sonographer and the cardiologist interpreting the study. Bundling 93325 with other echo codes does not take into account this additional time, effort, and expertise. I am concerned that this change would adversely impact access to care for cardiology patients with congenital cardiac malformations. Programs caring for this select patient population do so not only for those with the resources to afford private insurance, but also, to a large extent, to patients covered by Medicaid or with no coverage at all. Because a key impact of this change will be to reduce reimbursement for congenital cardiac services across all payor groups, the resources available today that allow us to support programs that provide this much-needed care to our patients will not be sufficient to continue to do so should the proposed bundling of 93325 with other echo codes be implemented.

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

Sincerely,

David J. Bradley, M.D.
Assistant Professor of Pediatrics
University of Utah School of M

Submitter : **Dr. Mary Feldkircher** **Date: 08/28/2007**

Organization : **Anesthesia Associates**

Category : **Physician**

Issue Areas/Comments

TRHCA--Section 101(d): PAQ1

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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.

Dr. Mary Feldkircher

Submitter : Dr. Mitchell Levine **Date:** 08/28/2007

Organization : Dr. Mitchell Levine

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare and Medicaid Services
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 strongly oppose this proposal.

An X-ray is not always needed to detect the presence of subluxations, however, 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. Eliminating the reimbursement for X-rays requested by Doctors of Chiropractic would open the door for patient treatment with reduced medical knowledge about a patient's underlying condition. This reduction of medical coverage may delay a referral to an appropriate specialist when chiropractic care would not be indicated, or even contra-indicated.

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. Mitchell B. Levine
Chiropractic Orthopedist
NYS #: X19581

Submitter : Dr. nnaneme mgbodille **Date:** 08/28/2007

Organization : American Society Of Anesthesiologists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re:CMS-1385-P (anesthesia coding,part of 5-year review.

Dear mrs Norwalk,

Iam writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 physician fee schedule.
I am grateful that the CMS has recognized the gross undervaluation of anesthesia services, and that the agency is taking steps to address this complicated issue.

When RBRVS was instituted,it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation work compared to other physician services.Today, medicare payment for anesthesia services stands at just 16.19 dollars per unit, this does not cover the cost of caring for our nations seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with high medicare populations.

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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.

Thanks for your consideration of this serious matter.

Submitter : Ms. Samantha Campbell **Date:** 08/28/2007

Organization : Deep Relief

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am recently graduated Athletic Trainer self-employed in the state of Hawaii.

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,

Samantha Campbell, ATC, CSCS

Submitter : Dr. Benjamin Unger **Date:** 08/28/2007

Organization : Columbia University Dept. of Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Ms. Norwalk:

Thank you so much for the CMS considering an increase in anesthesia payments under the 2008 Physician Fee Schedule. No other medical specialty deals with as much stress and terror as anesthesiology and no other speciality has been as proactive in improving patient safety. We hope that we may continue to bring the absolute best care to our nation's seniors. This fee increase will help us do just that. Thank you for your consideration.

Sincerely,

Ben Unger, M.D.

Submitter : Dr. Keri chiappino **Date:** 08/28/2007

Organization : Dr. Keri chiappino

Category : Health Care Professional or Association

Issue Areas/Comments

Technical Corrections

Technical Corrections

This proposal will negatively impact the very patients that we are try to care for. If an X-ray is necessary to determine appropriate treatment, patients should be able to access this benefit.

Submitter : Dr. Ricardo Nieves-Ramos **Date:** 08/28/2007

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
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.

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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. Garrick Edwards** **Date: 08/28/2007**

Organization : **Florida Atlantic University Sports Med Dept.**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am an athletic trainer in the university athletic setting. I work at Florida Atlantic University and work with 17 varsity sports including football and basketball. I have been a certified athletic trainer for more than seven years and hold degrees from the University of Miami and Kansas State 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.

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Sincerely,

Garrick J Edwards, M.S.Ed ATC

Submitter : **Dr. Benjamin Paul, MD, PhD** **Date: 08/28/2007**

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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Thank you for your consideration of this serious matter.

Benjamin Paul, MD, PhD

Submitter : **Date: 08/28/2007**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Physician Self-Referral Provisions

Physician Self-Referral Provisions

August 28th, 2007

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

Dear Mr. Weems:

I would like to take this opportunity to voice my opposition to the practice of physician self-referral for physical therapy. I have been practicing as a physical therapist in the Birmingham area for the past six years. I am currently self-employed and direct an outpatient orthopedic clinic. It has been difficult to obtain referrals over the past year due to the prevalence of physician owned physical therapy clinics. Some of my colleagues have had to close their practices secondary to the lack of referrals. As physical therapists in the state of Alabama, we can only evaluate and treat patients by referral. In other words, we are dependent on physician referrals. The practice of self-referral completely undermines this system.

I have personally had patients who wanted to see me for their therapy, but were forced to go elsewhere by their physician. In some cases, patients are forced to travel up to 60 miles to have therapy. Imagine a patient driving 60 miles to be treated for low back pain because he was not told he could go where he wanted to for physical therapy. Patients should be allowed to receive care in the most convenient location, by the practitioner of their choice. Instead, they are being pressured to go to therapy where their physician has a financial incentive.

CMS should eliminate physical therapy as a designated health service under the in-office ancillary services exception. If the current practice of self-referral is continued, our patients will suffer and the system will most assuredly be abused.

I appreciate your consideration on this very important matter.

Sincerely,

Paul
35080

CMS-1385-P-9994-Attach-1.DOC

9994

August 28th, 2007

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

Dear Mr. Weems:

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Sincerely,

Paul
35080

Submitter : Dr. Jeremy Reading **Date:** 08/28/2007

Organization : Critical Health Systems

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 : **Mr. Jamal Obeid** **Date: 08/28/2007**

Organization : **Mr. Jamal Obeid**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

I am a certified Athletic Trainer, I have a B.S. in Kinesiology from California State University, Fullerton. I have completed the Caahep accredited Athletic Training Education Program, and completed the NATABOC's exam. This is much more training and education than many of the health care professionals that you list as people that can bill or perform duties that are billable. I currently work Part time at Mount San Antonio College in Walnut, CA, and also at Crossroads School of the Arts in Santa Monica, CA. I am one of the people responsible for the well being of the athletes at these facilities. We work as a team with doctors, nurses, PTs, and various other health care professionals to do what we do best, care for our patients.

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,

Jamal Obeid, ATC

Submitter : Dr. Boleslaus Falinski **Date:** 08/28/2007

Organization : Dr. Boleslaus Falinski

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS 1385-P

I am a practicing anesthesiologist who is pleased that the CMS proposed payment policy changes will "transform Medicare into an active purchaser of high quality services." Therefore, I strongly support the increase in anesthesia payments under the 2008 Physieian fee schedule.

When the RBRVS was instituted the work component of anesthesiology services was grossly undervalued compared to other physician services. As a result, the current Medicare payment of $16.19 per anesthesia unit does not even approach my cost of caring for Medicare pateients. The elderly comprise some of the sickest patients I care for and often require the most intensive anesthesiolgy care.

This fact has been tacitly acknowledged by the RUC committee of the American Medical Association. I support CMS's full inmplementation of the Anesthesia conversion factor as recommended by the RUC committee.

Sincerely,

Boleslaus A. Falinski MD

Submitter : **Dr. Charles Venneman II** **Date: 08/28/2007**

Organization : **Dr. Charles Venneman II**

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.

Charles R Venneman II MD

Submitter : Dr. Stuart Weg **Date:** 08/28/2007

Organization : Dr. Stuart Weg

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The payments that we have been getting from medicare for anesthesia care of elderly people is much lower than it ever should have been. Any correction that is done will help us. The medicare fees paid for anesthesia is so low that we are at the point of considering not offering services due to such poor return on our labor. As the population ages, the offset of higher paid private cases gets smaller which brings us closer to considering, just not practicing anesthesia in areas dominated by older medicare patients.

Submitter : Mr. Patick Bendel **Date:** 08/28/2007

Organization : American Association Nurse Anesthetist

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

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