

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of the proposed CMS rule change allowing psychologists to supervise psychometricians or other technicians in the administration of diagnostic psychological and neuropsychological tests. Psychologists have the greatest level of expertise in this type of testing, and thus, they are the best qualified to supervise others administering and scoring such tests.

I strongly urge you to enact the proposed rule change.
Thank You

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am writing in support of the proposed CMS rule change allowing psychologists to supervise psychometricians or other technicians in the administration of diagnostic psychological and neuropsychological tests. As the doctor level clinician with the greatest level of expertise in this type of testing, psychologists are the best qualified provider to supervise others administering and scoring such tests.

I urge your favorable consideration of this rule change.

Thank You,

John Howell, Psy.D.
Chairman, Psychiatry and Behavioral Health
Citizens Memorial Hospital

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I strongly support the proposed personnel standards for physical therapy services that are provided 'incident to' physician services in the physician's office. I believe that interventions should be represented and reimbursed as physical therapy only when performed by a physical therapist or by a physical therapist assistant under the supervision of a physical therapist. I strongly oppose the use of unqualified personnel to provide services described and billed as physical therapy services.

Physical Therapy services should only be furnished by an individual who is a graduate of an accredited professional physical therapist education program or must meet certain grandfathering clauses or educational requirements for foreign trained physical therapists.

Personally, I feel that the use of unqualified personnel poses a risk to public safety. They do not have the same understanding of anatomy and physiology, pathology, or contraindications.

Furthermore, patients expect that when they pay for physical therapy services they actually get to see a physical therapist or physical therapist assistant and not an unqualified substitute.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

Marilyn J Hintz, ATC/L, CSCS
1121 N. 44th Street #1123
Phoenix, AZ 85008

September 2, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide

“incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,
Marilyn J Hintz, ATC/L, CSCS
1121 N. 44th St. #1123
Phoenix, AZ 85008

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Dear Sir or Madam:

I am writing to support the proposed new rule allowing clinical psychologists in the Medicare program to be able to supervise technicians and other ancillary staff who perform psychological and neuropsychological testing.

The administration of these tests needs to be technically sound and therefore needs to be under the general supervision of a psychologist, but the administration itself does not require the skills of a doctoral psychologist. Therefore the new rule will allow patients to be tested more economically and free up doctoral psychologists to do the interpretation and integration of the test data, which is the doctoral psychologist's province.

Thank you for your attention to my comments.

Sincerely,

Brian E. Primeau, Ph.D.
Clinical Psychologist

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 1-9

SECTION 613

Comments to
Centers for Medicare and Medicaid Services
Practicing Physician Advisory Council
September 24, 2004

On CMS-1429-P - Medicare Program; Revisions to Payment Policies
Under the Physician Fee Schedule for Calendar Year 2005
As Implemented in the Notice of Proposed Rulemaking Governing
MMA Section 613 Provisions for Diabetes Screening Tests

by Kelly L. Close
On behalf of
Close Concerns, Inc.

I am submitting these comments on behalf of Close Concerns, Inc, an independent consulting firm focused on diabetes and obesity. In this capacity, I have the opportunity to interface with a large number of patients, health care providers and manufacturers in the diabetes field on a daily basis. I have personally lived with diabetes since 1986 and am personally committed to supporting efforts to detect diabetes in the millions of individuals who are at risk.

I am submitting these comments related to the recently issued proposed rules related to section 613 of the Medicare Modernization Act (MMA). Although, I am pleased to see that Medicare has taken steps to provide access to diabetes screening for existing test methods, I am concerned that there are certain provisions within the proposed rule, which may delay access to future tests. Specifically, I want to comment on the proposed rule to impose a National Coverage Decision process on new tests that are developed and approved for use by the FDA for diabetes screening.

Section 613 of the MMA requires CMS to cover fasting plasma glucose tests, post-glucose challenge tests and other such tests that the Secretary of Health and Human Services deems appropriate. I interpret this to mean that as future diabetes screening tests are cleared by the Food and Drug Administration (FDA), they will have automatically been deemed appropriate for their intended use by the Secretary of HHS after review of the relevant regulatory filings and consultation with appropriate organizations such as the ADA and AACE. When you consider that Congress has already legislated coverage for diabetes screening, it seems unnecessary for CMS to impose future FDA-cleared diabetes screening tests to another NCD process. This is especially true when you consider that the FDA typically consults these same organizations prior to granting market clearance. I believe that requiring an NCD process for new diabetes screening tests will add inefficiency to the Medicare coverage process at a time when CMS is taking other measures to improve its internal efficiencies. Furthermore, doing so would unnecessarily delay access to innovative screening technologies in the future.

In summary, it seems logical that if new tests have been cleared by the FDA for the expressed purpose of diabetes screening then they have also been deemed appropriate by the Secretary of HHS. Therefore, I am recommending that CMS rewrite the regulations by removing the -subject to NCD process- provision and instead allow for new diabetes screening tests that have been approved by the FDA to be also covered without subjecting the new test to a new NCD process.

Thank you very much for your consideration

Kelly L. Close

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists must be able to supervise diagnostic testing. Physicians simply do not have the training to supervise this area of expertise. They have never been trained in psychological testing. That would be like having a psychologist supervise a physician's assistant with regard to ear, nose, and throat problems. Psychologists do not have that expertise.

This is an area of consumer protection. People trained in an area should supervise, not people who have never been trained in that area.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I wish to support the proposal that a psychologist be the designated professional approved to supervise psychological testing. To become a psychologist in Maryland, I was required to complete several courses in psychological testing, including intellectual and personality assessment, for the purpose of diagnosis. In addition, I was required to complete a minimum of eight full psychological test batteries, which included administering, scoring and interpreting tests that measure intellectual function, memory, reasoning ability and personality. During my internship at a psychiatric hospital, I was frequently required to administer and interpret psychological test batteries to be used as part of the decision making information for forensic decisions, adolescent and adult diagnosis, and discharge arrangements. My experience is not unusual. Therefore, the requirement that a physician, who generally has no training in diagnostic testing, be present during diagnostic psychological testing, makes no sense. A psychologist is the most qualified professional from all aspects, education, training and experience, to supervise diagnostic psychological testing.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Compared to other professionals, psychologists have 5 to 6 years pre and postdoctoral training in giving and interpreting psychological tests in the context of psychopathology and treatment, and therefore should be allowed to supervise others performing psychological tests.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists receive intensive and extensive training in the use and interpretation of diagnostic psychological tests. As such, psychologists are in the best position to provide supervision of such tests by non-licensed psychologists or other professionals.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I have been conducting psychological and psycho-educational evaluations for close to 20 years and have supervised many interns in this process. I believe it is crucial for licensed psychologists to supervise diagnostic psychological testing. We have doctoral level coursework, rigorous training and years of experience in assessment, statistics, research design and the integration of medical information with all of these areas. Moreover, we are also aware of the emotional/personality disorders which can impact psychological testing issues. I urge you to consider our expertise when making this decision.

Thank you for your time and consideration.

Sincerely,

Diane Toby, Ph.D.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

The supervision of psychological testing is certainly best done by those trained and experienced in the administration of psychological tests. Psychologists are the only professionals who receive advanced graduate school training and supervised experience in diagnostics using psychological testing. The proposed rule change to allow psychologists to supervise others who provide this service addresses the needs of patients and payors to obtain the standard of care with oversight by those who can ensure that the service is being delivered effectively. I fully support this change, which will bring the rule into line with accepted best practices.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

When considering who is qualified to administer and interpret psychological tests, why would a psychiatrist or other physician be more qualified than a psychologist to administer and interpret test results? Having a psychologist administer and interpret psychological test is clearly within the scope of practice, training and expertise, and psychologists are the developers of the tests. It would seem that it is reasonable to recognize that Psychology is an independent profession and able to function independently within its scope of practice and expertise.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Psychologists should be allowed to supervise diagnostic testing without physician supervision. In almost all cases, physicians are not "trained" in psychological assessment. It is not part of their medical training. On the other hand, psychologists have the greatest level of expertise in testing and therefore are the best qualified to supervise others performing such tests. This decision should be a "no brainer" and is in the best interest in the welfare of patients.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists have the greatest level of expertise in testing and therefore are the best qualified to supervise others performing such tests. Psychologists are licenced at the doctoral level and undergo extensive training an quality assurance of competency.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychological testing should be performed only by psychologists or by trained individual supervised by psychologists. Psychologists are required to take classes and have supervised training in giving psychological tests. Others may take testing classes electively. It stands to reason that only those who hold the greatest education and training in the area should supervise the performance.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I would like to ask that this proposed rule change be supported. Psychologists have the most expertise in both performing and supervising psychological testing. Thank you for allowing commnets.

Eileen Buese, PhD

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

TECHNICAL REVISION

It is entirely appropriate to permit supervised technicians to assist psychologists in incident to billing for psychological and neuropsychological testing for several reasons. First, several organizations within organized psychology have long endorsed this policy, including Division 40 of the American Psychological Association and the National Academy of Neuropsychology. Second, current problems with RVU's for psychological testing severely limit the reimbursement for this service. Currently the Medicare allowance for one hour of psychological/neuropsychological testing is about \$65. The allowance for an hour of psychotherapy from the same provider is considerably higher. Yet, psychological/neuropsychological testing, unlike psychotherapy, requires the practitioner to have purchased testing materials and consumable protocols and to spend additional hours in scoring, interpreting, and preparing written reports of test findings. These problems demand all manner of correction, as psychological/neuropsychological testing is becoming such a loss leader for clinicians to provide that this important mental health service, lending critical objectivity to the diagnostic process as countless studies have shown, is beginning to disappear from the American health care landscape.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

"Please see attached file"

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Alabama Athletic Trainers' Association
PO Box 55565
Birmingham, AL 35255
Phone: 205-540-4760

September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who they can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may

provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Brad Montgomery, MAT, ATC
President, Alabama Athletic Trainers Association
Head Athletic Trainer, The University of West Alabama

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

My name is Labinot Avdiu and I am a pharmacist at The Medicine Shoppe Pharmacy in Two Rivers, Wisconsin.

My response to "Medicare Prescription Drug Benefit" [CMS-4068-P] is as follows:

1. MTMP are direct proactive interventions designed to enhance patients' ability to take medicine correctly and increase patient medication compliance.
2. MTMP is a direct patient care service performed by a pharmacist interacting with a patient and their medications.
3. MTMP include case management and patient counseling, customized packaging and refill management, and specialized patient medication reminders. Customized packaging must conform to United States Pharmacopoeia (USP) standards.
4. MTMP are generally of an ongoing nature, involving and initial patient in-take assessment, followed by routine patient monitoring at regular intervals.
5. MTMP must be reimbursed as a management fee, NOT as a dispensing fee. Costs associated with MTMP are separate and distinct from those costs associated with dispensing.
 - In-take assessment: 30-45 minutes of pharmacists' time per occurrence;
 - Monitoring and following up: 15-25 minutes of pharmacists' time per occurrence.

Thank you,
Labinot Avdiu, PharmD.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

please see attached

August 29, 2004

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Mr. McClellan:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system. During my 15 years as a certified athletic trainer, I have treated many types of patients including professional athletes and senior citizens. The largest segment of the population (55 and over) has current and future Medicare beneficiaries who require musculoskeletal rehabilitation as prescribed by their physician in order to remain active and healthy. **To propose a rule that would only allow these patients to be treated by one or two professionals takes the plan of care and treatment out of the physician’s hands, not to mention the patient’s right to choose their provider.**

During the decision-making process, please consider the following:

- “Incident to” has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers, physician assistants and nurses) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient. There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY “incident to” service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. **It is imperative that physicians continue to make decisions in the best interests of the patients.**
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the

patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays in accessing treatment. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare. **As a country in a healthcare crisis, we should be creating strategies to streamline health care delivery and make it more cost-effective.**
- Athletic trainers are highly educated. ALL certified or licensed athletic trainers **must have a bachelor’s or master’s degree** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology, biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees are comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services. **It is interesting to note that state physical therapy associations are attempting to gain direct access to patients and deny all physical therapists from providing incident to services in a physician’s office by way of attorney general opinions and state**

practice act revision.

- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. **In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.**
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

Many physicians, including professors at major teaching institutions in Chicago from Northwestern Memorial Hospital, Rush University Medical Center and the University of Chicago Hospitals, refer multi-million dollar athletes to me. These same physicians also refer Medicare beneficiaries for the same or similar treatments because they are confident in my educational background, specialized training and the quality care I provide.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

James Allivato, LAT, ATC
Principal

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a practicing psychologist and believe that the training and experience I have recieved to administer and interpret psychological/neuropsychological evaluations is far superior to that of other health care professionals. I have been involved for 15 years in the training of psychological associates in the state of Maryland. I would strongly urge you to make it mandatory that psychologist supervise the administration and interpretation of psychological/neuropsychological testing. Allowing psychologist to supervisor technicians delivery of testing would allow a larger number of patients to receive quality care in a timely manner. Thank you for your consideration of this important patient care issue.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

This is in regard to SectionII,D Coding Issues,6, Venous mapping.

It is my opinion that vein mapping is in antegral part of the care of patients being considered for placement of an AV fistula. However, this mapping is only as good as the facility performing it. Therefore I suggest that only ICAVL accredited laboratories be reimbursed for this study.

Thank you,

Ronald L. Blumoff, M.D.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 1-9

PRACTICE EXPENSE

I want to oppose the reduction in the practice expense RVU for EECF (G0166). EECF is an important therapy for patients who have no other options and are very symptomatic. Its use should be encouraged and facilitated. Cutting the practice expense RVU will make it more difficult for patients to access this important therapy. Our practice expenses are actually increasing at a rather rapid rate. It is difficult to figure out why you think that practice expense for this therapy is decreasing!!

Thanks for listening.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists are the people most qualified to administer, interpret, and report the findings of diagnostic psychological tests. Physicians are not required to have training with these tests, while psychologists are. Therefore, psychologists and not physicians, should be given the responsibility to supervise others' performing these tests.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I would like to express my strong support for the proposal that would allow doctoral level (Ph.D., Psy.D.) psychologists to independently supervise psychometricians who carry out psychological and neuropsychological testing. I believe that the training the doctoral level psychologist completes is necessary and sufficient to allow them to competently supervise diagnostic psychological testing done by an appropriately trained psychometrician. The primary justification for allowing Ph.D. psychologists to supervise diagnostic psychological testing is that it will improve access to needed and underutilized services that will ultimately benefit healthcare consumers and patients. Diagnostic psychological testing is one of the primary areas of focus for many psychologists. There is a distinction in psychological testing between 'testing' and 'assessment.' Testing can be carried out by anyone with proper training in psychometrics, clinical skills, and statistics. Assessment requires more advanced skills, such as that provided by doctoral level training in psychology. Personally, I have undergone 6 years of graduate training, a 1 year internship, and am currently completing a 2-year postdoctoral residency in neuropsychology. Such specialized training is more intensive and advanced than any other profession with respect to psychological testing. The distinction between 'physical' and 'psychological' needs to be discarded and it is not only those who complete medical school who are able to provide competent clinical diagnostic services to patients who really do need our help. Thank you for your consideration. Sincerely, Lisle R. Kingery, Ph.D.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see the following attachment.

CMS-1429-P-727-Attach-1.doc



American Kinesiotherapy Association

P.O. Box 1390 , Hines Ill. 60141-1390

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Dave Hunsaker
6263 Trinidad Ave.
Cypress, CA 90630

September 15, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service, placing an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including registered kinesiotherapists) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY “incident to” service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Dave Hunsaker, RKT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Physicians have been treated as the source of the problems with health care too long.

The number one cost of healthcare is prescription medication.

We are not the culprits for a system that is out of control: it is the insurance industry and the pharmaceutical industry.

Focus on creating a single payer system for the United States and stop criminalizing physicians.

You will, unfortunately, find that American physicians are going to start leaving the profession earlier and earlier. Fewer top students from American colleges are willing to study and train for the years necessary to become physicians if they perceive that they are not going to be able to make a good living. Americans will find more and more of their care delivered by second-rate "practioners" and foreign medical graduates.

Please reconsider these changes.

Submitter : Date & Time:
Organization :
Category :

Issue Areas/Comments**Issues 20-29**

DIAGNOSTIC PSYCHOLOGICAL TESTS

As a clinical neuropsychologist, I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients. My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision. The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients by improving their access to psychological and neuropsychological assessment services.

Thank you for the opportunity to comment on this very important matter.

Robin C. Hilsabeck, Ph.D., ABPP

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 1-9

PRACTICE EXPENSE

As a small business owner, it is difficult to adapt so quickly to such large payment cuts. This comes on top of a 53% increase in my malpractice premium this year. I will have to make drastic changes in my practice when payments are based on average sales price (ASP) in 2005. These changes include closing satellite offices, laying off employees, discontinuing or limiting the types of treatment I am able to offer to Medicare patients, or sending patients to the hospital for drug administration (where they will pay a higher co-pay).

No other business in the United States functions with a 6% markup on the products they "sell". Why are physicians held to a different standard?

Issues 20-29

IMPACT

The impact of proposed in-office drug pricing will be devastating to patients being treated for prostate cancer and bladder cancer. If the urologist treating such patients cannot afford to stock, administer, bill, and collect for these drugs, the patients will be unduly burdened.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I have grave concerns about the impacts the drug payment changes will have on urology patients-particularly cancer patients. According to the proposed rule published on August 5, urologists receive 37 percent of their total Medicare revenue from drugs and their Medicare drug revenue will decrease by 36 percent between 2004 and 2005. Such a short transition time for these massive payment reductions has the potential to greatly disrupt or hinder treatment for urology patients who currently receive drug therapy in the office for prostate cancer, bladder cancer, interstitial cystitis and other urological diseases.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I think this is an outrage. The Athletic Training profession is qualified to treat the medicare population as well as the younger. In my years as a health care professional and higher education faculty it has been my experience that it is the person not the profession that makes the difference in treating the individual. I know athletic trainers who I would choose to treat my grandparents over some physical therapists I know. I would strongly urge everyone to reconsider this and stop this proposal from going forward.

David Diers PT,EdD,MHS,SCS,ATC
Profesor
Department of Physical Therapy
Governors State University

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I, along with the other three urologists in my group would like to express our concern about the changes in drug reimbursement by Medicare. There are a number of problems with dropping the reimbursement so rapidly and drastically which I would like to make you aware of. We see a lot of underprivileged and underserved patients in the inner city of Chicago. There is a large African American population which has a high rate of aggressive prostate cancer. We use a lot of Lh-Rh agonists to treat this cancer, and we feel we may no longer be able to provide this service, and patients may suffer from this. In the past when the patients have had no co-insurance, we would attempt to bill the patients for the 20% they could not afford, and they were not able to pay. In order to prevent a reoccurrence of the prostate cancer, we would "eat the cost" and continue to treat the patient. There have been times when a patient in an HMO would be required to pay a pharmacy the 20% cost upfront, and the patient, unable to afford this, would not be treated. I fear that with almost all of the profit margin gone from the drug, patients will suffer if we can't supply this service. I will not be able to give this drug without getting some guarantee of the 20% cost up front.

Also, please consider the drastic way you have changed the payment structure. In Illinois, we already have a difficult time making ends meet because of the exorbitant cost of malpractice insurance. Imagine if you had to take a sudden decrease in salary to the tune of 25 % 30%, I'm sure that wouldn't be acceptable to you, and you might start looking for a new job. Surely, there would be a better way to phase in the payment changes so we can adapt.

I also fear that the treatment of all cancer with chemotherapy will suffer with these changes, I have already spoken to oncologists who say they will not be able to afford to give patients chemotherapy.

There are enormous financial pressures facing physicians everyday. Yes, physicians make good money, but there are enormous costs for us to be educated and to provide good care for our patients. It is really not fair to try and fix the whole Medicare financial crisis by cutting physician reimbursement further, while at the same time passing a Medicare drug bill that protects the financial interests of the big pharmaceutical companies, and hurting physicians and patients in the process.

Thank you for your consideration in this matter.

Sincerely,

John J. Cudecki, MD

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support the CMS rule & the efforts to have psychologists perform the outpatient supervision of technicians. Psychologists have the greatest level of expertise in testing and therefore are the best qualified to supervise others performing such tests.

Thank You.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see the following attachment.



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

Please note: The attachment cited in this document is not included for one of the following reasons:

1. Improper format.
2. The submitter did not follow through when attaching the document.
3. The submitter had intended to attach more than one, but not all attachments were received.
4. The type of document provided was a password-protected file. CMS was given read-only access to the document.

We cannot provide this electronic attachment to you at this time, but you would like to view any of those that are not posted on this web site, you may call CMS and schedule an appointment at **1-800-743-3951**. Those comments along with its attachment(s), that could not be posted, will be available for your viewing at that time.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam:

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During the decision-making process, please consider the following:

Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient. There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

In many cases, the change to 'incident to' services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working 'incident to' the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

Curtailing to whom the physician can delegate 'incident to' procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.

Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

It is inappropriate and unsafe for someone other than a trained physical therapist to offer PT services. The risk to patients is great and the quality of care is compromised. There is a great risk of overutilization of services if a physical therapist is not offering these services (especially if it financially benefits the physician offering PT)

I am married to a physician and it is clear that they receive little to no education in physical therapy during medical school. (He received a one hour lecture on the subject). Physical therapy programs are educating students to a master's and doctorate degree level. It is illogical to think that someone could offer the same quality of service and have similar intellectual "know how" if they did not receive this level of education.

I urge your support of CMS 1429-P. The safety of our patients is at stake.

Sincerely,

Amy Rhuland, PT
914 Ridgecliff Drive
Florence, AL 35634
256-272-0214

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see the following attachment.



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

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Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am writing in support of the proposed CMS rule change allowing psychologists to supervise psychometricians or other technicians in the administration of diagnostic psychological and neuropsychological tests. Psychologists have the greatest level of expertise in this type of testing, and thus, they are the best qualified to supervise others administering and scoring such tests.

I strongly urge you to enact the proposed rule change.
Thank You,

Dr. C.J.Davis, Director of Psychological Services, Royal Oaks Hospital

Submitter : Mrs. Joy Beveridge-Snoke Date & Time: 09/03/2004 04:09:00

Organization : NATA

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

Joy E. Beveridge-Snoke, ATC
21598 Syler Road
Butler, OH 44822

November 22, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Joy E. Beveridge-Snoke, ATC

21598 Syler Road

Butler, OH 44822

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I am writing in support of the proposed CMS rule change allowing psychologists to supervise psychometricians or other technicians in the administration of diagnostic psychological and neuropsychological tests.

Psychologists have the greatest level of expertise in this type of testing, and thus, they are the best qualified to supervise others administering and scoring such tests.

I strongly urge you to enact the proposed rule change.

Thank you..

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Reimbursement for Urology

Sir:

Being a young urologist (less than 5 years in practice) and watching my revenues go down as my expenses go up and the fact that I have more pt then I can see, as well as the fact that Urologists as a whole are in huge demand, I view the 13% decrease in Urology reimbursement predicted for next year as another nail in the coffin as far as my ability to see medicare pt. Already in town (Richland, WA)it is difficult if not impossible for a medicare pt to see a primary care physician as a new pt and this will roll over to urology as the reimbursement continues to decline. I also have seen statistics gathered by our national organization that the number of physician considering retirement has grown exponentially as reimbursement continues to decrease, thus decreasing the availabilty of Specialists. I believe your policy is short sighted and could be the primary motivator to physicians like myself restricting the number of medicare pt see to emergency and f/u pt with chronic life threatening illness.

John Medica MD

Mid Columbia Urology
Richland WA
jfmedica@cwhealth.net

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I urge enactment of proposed CMS rule change to allow psychologists to supervise other trained personnel to administer psychological and neurological tests.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Tim Laurent EDD ATC CSCS
1501 Lakeside Drive
Lynchburg College
Lynchburg VA 24501

September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

One of the main complaints about medicine in the US is lack of control. This complaint comes from both patients and physicians. Limiting providers of ?incident to? services furthers this concern. Patients should have the right to choose their health care provider. Physicians should have the right to delegate health care to the professional of their choice.

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working ?incident to? the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

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Sincerely,

Tim Laurent EDD ATC CSCS
1501 Lakeside Drive
Lynchburg College
Lynchburg VA 24501

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attachment



American Kinesiotherapy Association

P.O. Box 1390 , Hines Ill. 60141-1390

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

Ben Chancey, RKT
227 SW Huntington GLN
Lake City, FL 32024

September 15, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

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In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Ben Chancey, RKT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 1-9

CODING-GLOBAL PERIOD

The proposal to reimburse pre-operative 'mapping' of vessels in preparation for creation of access for hemodialysis is long overdue. This proposal should be implemented expeditiously. It is an essential tool in our efforts to provide better patient care at a lower cost by creating durable arteriovenous fistulas. Thank you for getting this far. Please don't lose your momentum.

Jim Alexander, MD, FACS, RVT
Associate Professor of Surgery
Robert Wood Johnson Medical School / UMDNJ
Head, Division of Vascular Surgery
Cooper Hospital / University Medical Center
Camden, New Jersey

Submitter : Mrs. Amy Schlachter Date & Time: 09/03/2004 05:09:55

Organization : Mrs. Amy Schlachter

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please accept the attached document as my comment regarding this issue.

Amy L. Schlachter
155 Gilgen Ave NE
New Philadelphia, OH 44663

September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

RE: Therapy-Incident To

Dear Sir/Madam:

I am writing to express my concern regarding the proposal to limit providers of "incident to" services in physician's offices and clinics. If adopted, this would eliminate the ability of many qualified health care professionals to provide services that they are fully qualified to perform. In addition, this would create many problems for the Medicare patient; including, a reduction in the quality of care they would receive, an increase in the cost of care for these patients, and an unnecessary burden on the health care system as a whole.

I urge you to consider the following points during the decision-making process:

-Athletic trainers are highly educated health care providers. While the name could be deceiving, leading you to believe we are only capable of dealing with athletes, we are educated in and qualified to treat many populations. ALL certified or licensed athletic trainers MUST HAVE A BACHELOR'S OR MASTER'S DEGREE from an accredited college or university. At the very least, we are required to have a foundation of knowledge including: human anatomy, human physiology, kinesiology, biomechanics, nutrition, acute care of injury and illness, statistics and research design, rehabilitation, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This is comparable with other professions, such as, physical therapists, occupational therapists, registered nurses, and speech therapists.

-To allow only physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. By mandating that only these groups may provide "incident to" services, you would improperly remove the state's right to license and regulate the allied health care professions deemed qualified, and safe to provide health care services.

-Athletic Trainers are employed by almost every US post-secondary educational institution with an athletic program, and every professional sports team in America to work with athletes to prevent, assess, treat, and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers accompany the US National and Olympic teams to every competition in which they compete. For CMS to suggest that athletic trainers are unqualified to provide the same services to these same athletes once they become Medicare beneficiaries, or to the average population who may become injured walking in a local 5K race is outrageous and unjustified.

-Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

-CMS has offered no evidence that there is a problem needing to be fixed. It appears as though this change has been suggested in an attempt to appease the interests of a single professional group who would like to establish themselves as the sole provider for therapy services in order to eliminate the competition.

-This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and lack of local and immediate treatment.

-These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. By doing so, you are only limiting the qualified professionals available to aid in the care of your patients, and creating a problem where there was not initially one to be found.

Sincerely,

Amy L. Schlachter, A.T.C./L.
Assistant Athletic Trainer
Malone College
515 25th Street Northwest
Canton, OH 44709
O: (330) 471-8297
Fax: (330) 471-8298
aschlach@hotmail.com

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I want to support authorizing psychologists to supervise psychological testing by other personnel. Psychologists are the ones most well trained to do such supervision.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

"Please see attached file."

CMS-1429-P-749-Attach-1.doc

CMS-1429-P-749-Attach-2.doc

Curtis Lauterbach, LAT, ATC
2442 N. Shefford St.
Wichita, Ks 67204

September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Curtis Lauterbach, LAT, ATC
2442 N. Shefford St.
Wichita, Ks 67204

Curtis Lauterbach, LAT, ATC
2442 N. Shefford St.
Wichita, Ks 67204

September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

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During the decision-making process, please consider the following:

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- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
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- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Curtis Lauterbach, LAT, ATC
2442 N. Shefford St.
Wichita, Ks 67204

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments**GENERAL**

GENERAL

09/03/04

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified providers is inherent in the type of practice, medical subspecialty and individual patient.

There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

In many cases, the change to ?incident to? services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and added expense to the patient.

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working ?incident to? the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

Patients who would now be referred outside of the physician?s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, cost the patient in time and travel expense. Delays would hinder the patient?s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

Curtailling to whom the physician can delegate ?incident to? procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician?s ability to provide the best possible patient care.

To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide ?incident to? services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide ?incident to? care in physicians? offices would improperly remove the states? right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing.

Sincerely
Lori M. Pettit
323 Sierra Vista Lane
Valley Cottage, NY 10989



Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam: The proposed 13%+ cut which will occur for urological services effective January 1, 2005 is going to have a devastating impact on patient care.

Already, urology is an underserved speciality, with the demands for services far outstripping the resources available.

In our practice, a cut of this magnitude will likely result in a net loss of between \$400,000 and \$500,000 net dollars.

We no longer have any fat in our budget. Our board certified urologists have not had a base pay raise in 14 years! Except for occasional annual bonuses - and we will not have one in the foreseeable future if these types of cuts are enacted.

Accordingly, if this reduction in reimbursement occurs (which all private payers will follow), we will be forced to resort to measures which we have avoided:

- (1) Closing offices
- (2) Laying off staff
- (3) Limiting ourselves to the most cost effective services
- (4) Requiring payment for customer services (such as telephone access or on line prescription refills etc).
- (5) Elimination of value added services that are marginally cost effective but patient friendly (newsletters, internet access, web site info, clinical research trial participation, CME provision to name but a few).

There is no way that we can continue to provide services in a climate such as this. Since 1988 legal fees paid to attorneys for malpractice actions (successful or not, and only 0.5% are successful) have increased 2000%! (Source: Physician Insurance Institute)

I am sure you are aware that physician reimbursement has not increased in this manner and in fact has decreased.

If cuts of this type continue, the future of access to quality, state of the art medical care is going to continue to decline.

Changes must be made and these cuts must not go forward.

Respectfully,

Joseph N. Macaluso, Jr., M.D., F.A.C.S.
Managing Director, Urologic Institute of New Orleans
Chairman, Board of Directors, LSU Health Science Center Foundation
Chairman, Medical Advisory Board, Urology Domain
Past President, American Lithotripsy Society
Past President, Urology Society of America

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

CMS Code 1429-P RE: GCPI

CMS-1429-P-752-Attach-1.doc

September 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P RE: GCPI

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

I object to the Proposed Geographic Practice Cost Indices for 2005 because they fail to correct proven inadequacies in reimbursements to localities currently categorized as "Locality 99" that exceed the 5 percent threshold (the "105% rule") over the national 1.000 average. Specifically, the new GPCIs exacerbate reimbursement deficiencies for the California counties of Santa Cruz, Sonoma, Monterey, San Diego, Sacramento, Santa Barbara and El Dorado.

In particular, the county of Santa Cruz, when broken out from Locality 99, would otherwise reflect a 1.125 percent GAF - higher than the California Localities 17 (Ventura), 18 (Los Angeles) and 26 (Orange). The boundary payment difference between Santa Cruz County and its neighboring county of Santa Clara (Locality 9) is a whopping 25.1 percent. Such statistics demonstrate the fallacy of the GCPI formula and demand CMS develop either exceptions to the current rules that would correct for the Santa Cruz situation or refine the formula to more accurately reflect the true cost of medical practitioners. Not to do so perpetuates an inherently unfair and discriminatory formula.

In its August 5 notice, CMS states that on the issue of payment localities "[a]ny policy that we would propose would have to apply to all States and payment localities." Such an effort is commendable and bespeaks a desire to be fair to all physicians across the nation. However, the reality is that the governing statute does not prohibit individual State fixes or individual county or locality fixes. The CMS is not constrained by law from developing a strategy - with or without the concurrence of the state medical association - to correct the discrepancies in the reimbursement levels to California counties and I request that it do so as part of this rulemaking process.

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
September 2004
Page 2

CMS cannot postpone a solution this year as it did last year. Failure to address the GPCI/locality issue in California only grows the problems and will make fixing it all the more difficult in the future. Further, it threatens to undermine medical care to Medicare beneficiaries. Evidence from the local medical society shows an increasing trend toward doctors refusing to accept new Medicare patients. Many doctors are simply leaving the county to practice elsewhere, depleting the county of its medical resources. To implement the August 5 proposed rules would be counterproductive to CMS' mission to make Medicare benefits affordable and accessible to America's seniors.

I object to the Proposed Geographic Practice Cost Indices for 2005 as printed in the Federal Register of August 5, 2004. I request that CMS define a method in which it can revise the GPICs for those California counties - especially Santa Cruz - that exceed 5 percent of the national average and begin reimbursing doctors in those counties more appropriate to their true costs.

Sincerely,

Michelle Nicole Nation
Mother of three, full-time employee,
Part-time student, Former welfare recipient

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

These cuts are coming on top of cuts that already went into place in January 2004, and I have only had one year to reevaluate and restructure my business plan, budget and patient care plans in light of these drastic payment changes. I can't recall any other major change in the Medicare program that was implemented in such a short time without some sort of transition time built in to mitigate impacts.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

Brandy Mailer, ATC/L
6745 E Superstition Springs #2033
Mesa, AZ 85206

September 1, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide

“incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
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- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,
Brandy Mailer, ATC/L
6745 E Superstition Springs #2033
Mesa, AZ 85206

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 1-9

PRACTICE EXPENSE

I have grave concerns re: drug payment plans, their effect on my cancer Patients. These are difficult times w/ rising practice expenses, and an unfavorable malpractice climate. We as physicians provide vital care 24/7; help us to maintain this level of care.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Please See the Attached File About Docket: CMS-1429-P. Thank you

CMS-1429-P-756-Attach-1.doc

D. Grace Tessier, MEd, ATC
James Madison University
MSC 2301, Godwin 128
Harrisonburg VA 22807

September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012
Re: Therapy – Incident To

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- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and

separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

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- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor’s or master’s degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. *In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.*
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,
D. Grace Tessier, ATC, MEd
James Madison University

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Physical Rehabilitation Center Wailuku
1063 Lower Main, Suite C213
Wailuku, HI 96793
Phone: 808-243-7870 Fax: 808-243-7871
Website: www.physicalrehabcenter.com

9-3-04
RE: ?Incident to? rules for Physical Therapists in Physician Offices
Attn: CMS

Dear CMS,
I write today to support the incident to rules for provision of physical therapy by Physical Therapists or Physical Therapist Assistants under the direct supervision of a Physical Therapist proposed by CMS.
Physical Therapists who graduate from accredited programs receive extensive medical training at the graduate school level with an increasing number graduating with Doctorate level degrees. Under the old rules Physician?s could have employees who did not even graduate or achieve GED level education administer physical therapy to patients. There exists many pathologies that could be aggravated or even turned deadly by the untrained practitioner. To not respect the condition of the patient by having unskilled people performing them would mean endangerment to the public good without question. The protection of the public good is served by the actions proposed by CMS and I support these actions as being pure in their commitment to the medical well being of Medicare recipients everywhere.

Sincerely,

Korre Pieper, PT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

Via Electronic Mail -- <http://www.cms.hhs.gov/regulations/ecomments>

420 Arnell Lane
Auburn, AL 36830
(334) 821-9060

September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who they can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license

and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Jamie S. Gamber, MEd, ATC
Secretary Elect, Alabama Athletic Trainers Association
Head Athletic Trainer, Smiths Station High School

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

My name is Dr Justin Parkinson I am a Urology resident who is very concerned about the current environment for administration of medications in our clinics. As I travel the country looking at different practices for jobs I have a unique perspective of evaluating many practices and the topic that has been brought up in every interview has been the uncertainty of reimbursment for administration of medications in the office. The majority of medications that are given in a urology office are for bladder cancer and prostate cancer. I have grave concerns with regaurd to patients losing access to care based upon these new rules. I fear that many patients that are faced with a co pay to recieve their medications will choose to not have the drugs given. I have seen patients with end stage prostate cancer and the bone pain associated with it. I am concerned that new rules that make access more difficult may make this presentation more common.

From a buisness perspective I can tell you that this is the number one concern in every office of every urology practice that I have visited. Is it not better to have your doctor worry about the patient. I went into medicine to take care of patients.

I fell that a slower transition would be much more effective at allowing the medical community to adapt and adjust to allow patient care to go uninterrupted.

Thank You for you time,

Justin Parkinson, MD

Submitter : **Mr. Brandon Sawyer** Date & Time: **09/03/2004 08:09:59**

Organization : **National Athletic Trainer's Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Brandon Sawyer
1110B River Court
Charlottesville, VA 22901
September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient. There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

In many cases, the change to ?incident to? services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working ?incident to? the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

Patients who would now be referred outside of the physician?s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient?s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

Curtailing to whom the physician can delegate ?incident to? procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician?s ability to provide the best possible patient care.

To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide ?incident to? services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners

may provide ?incident to? care in physicians? offices would improperly remove the states? right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

THERAPY STANDARDS AND REQUIREMENTS

(Continued)

CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

CMS does not have the statutory authority to restrict who can and cannot provide services ?incident to? a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Brandon Sawyer, ATC
1110B River Court
Charlottesville, VA 22901

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Attached is my response to this issue.

CMS-1429-P-761-Attach-1.txt

Attention: CMS-1429-P

Jackie Brown
Graduate Assistant-Indiana University
100 E. Miller Drive #54
Bloomington, IN 47401

September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To:

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To allow only physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

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unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,
Jackie Brown ATC/L

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

201 S. Pine St.
Lamoni, IA 50140
September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services thus reducing the quality of health care and ultimately increase the costs associated with this service.

During the decision-making process, please consider the following:

1. “Incident to” has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
2. In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible healthcare. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient. Because this country is already experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas, if physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
3. Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have at least a bachelor’s degree from an accredited college or university. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

4. To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
5. CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.

Certainly before making such a monumental decision, the larger picture should be viewed. In summary, it is not necessary or advantageous for CMS to institute the changes proposed; the CMS recommendation may actually become a deterrent to health care access and appropriate care.

Sincerely,
Dr. Diane Bartholomew, ATC

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

My name is Dan Swanner. I am a physical therapist practicing in Ventura County, CA. I have been a licensed physical therapist for 11 years and have owned my own clinic for six years. I graduated with a Master of Arts degree in physical therapy from Touro College in 1993.

I would like to comment on the rule proposed August 5 regarding physical therapy services provided in a physician's office. I would like to express my strong support for legislation requiring individuals practicing physical therapy in a physician's office, or any office, meet personnel qualifications for physical therapy.

While it is true a physician can diagnose an injury or disease process that is appropriate for physical therapy, nobody except a physical therapist is trained adequately to provide those physical therapy services.

I worked, needless to say for only a short while, in an office that billed for physical therapy when the individual providing the "therapy" was a sixteen-year-old high school student that didn't know there was such a thing as physical therapy schooling or licensure. This is a frightening indictment on physician's billing for a service using completely untrained and unqualified personnel that not only results in increased costs, but could also result in injury to the patient. This sixteen-year-old "therapist" had no idea what to do for each different patient with different diagnoses. He could not recognize any "red flags" or danger signs of a patient in distress. He didn't even realize the electrical modality he was using wasn't plugged in. The patient (and Medicare) was still billed for the treatment as "physical therapy!"

An appropriately trained physical therapist is educated at the college/university level and is then required to pass a national licensing exam. As licensed health care professionals, physical therapists are fully accountable for their professional actions. The schooling and training that is required to obtain a physical therapy degree (and license) includes an in-depth study of anatomy, physiology, kinesiology, neurology, and each of the body's systems including, but not limited to, the neuromuscular and musculoskeletal systems. This training then affords the physical therapist the ability to make informed decisions and take appropriate actions for that specific patient once a thorough evaluation is completed.

Lastly, the Social Security Act clearly requires that in order for a physician to bill "incident to" for physical therapy services, those services must meet the same requirements for outpatient therapy services in all settings. Thus, the services must be performed by individuals who are graduates of an accredited educational program and properly licensed as physical therapists.

Physicians must play by the same rules that each of us does. Physical therapy must be provided by a qualified physical therapist only!

THERAPY STANDARDS AND REQUIREMENTS

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Medicare drug reimbursement fees for urologist are planned to decrease by 13% on January 2005. This drop will significantly change the way urologists including myself will be able to practice and offer patient care. Already, our office loses money when we treat patient's with medications for bladder cancer. At this time, I have a patient with aggressive bladder cancer that I am treating with a medication called BCG. Currently, Medicare pays us 15% less in reimbursement than we have to pay just to buy the medication. This does not include the time of care to the patient, a \$25 catheter that we must use to instill the medication. In all, we lose \$45 a visit. This make no economic sense for me except for GIVING out of my own wallet proper patient care. Now how can you decrease our reimbursement another 13%??? It is not a fair proposition. What will happen in the future is I will have to prescribe these patient medications and when they can't afford them with money out of their own pocket they will not be able to be treated for their cancer.

Changes to your proposed drop in reimbursement must be halted. Insteade, please review what you are doing and make sure that physicians will be at least reimbursed evenly for the medications we must purchase.

sincerely,
Steven W. Sukin, M.D.
Tomball Urology Associates
919 Graham
Tomball, TX 77375

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

See Attachment on next page

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

Please note: The attachment cited in this document is not included for one of the following reasons:

1. Improper format.
2. The submitter did not follow through when attaching the document.
3. The submitter had intended to attach more than one, but not all attachments were received.
4. The type of document provided was a password-protected file. CMS was given read-only access to the document.

We cannot provide this electronic attachment to you at this time, but you would like to view any of those that are not posted on this web site, you may call CMS and schedule an appointment at **1-800-743-3951**. Those comments along with its attachment(s), that could not be posted, will be available for your viewing at that time.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly urge revision of the regulations in this area so that only licensed psychologists are permitted to supervise diagnostic psychological testing. Psychologists receive extensive training and supervision in the administration and interpretation of psychological tests; physicians and other non-psychologists do not. The public will be much better served if psychological testing and supervision are performed by psychologists, rather than by others with lesser training and knowledge in this area.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Allowing doctoral trained psychologists to supervise testing services is not only necessary but it should have been allowed long ago. Psychologists are trained at the highest level possible and should be treated with the professional respect and courtesy of any other doctor. Please enact this provision to Medicare/CMS ruling to assure that psychologists can independently practice and supervise testing procedures. In addition, the RVU issue with neuropsychological testing needs to be resolved where CPT code 96117 and 96100 are no longer treated as "lab tests" that do not require the intensive training and experience which are required for both administration and interpretation of such.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

September 3, 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

Please reconsider your proposed rule. CMS committed in 1996 to update the physician payment localities if there has been a significant change in practice costs. Santa Cruz County remains the most disadvantaged county in California. The payment differential for physician services in a county less than 20 miles from our business is over 25% greater than for services performed by local physicians. I understand that this is by far the greatest such differential in the country.

This needs to stop. We are losing doctors and important specialties. Our organization cannot fathom how this is allowed to continue. I believe that Congress has delegated to CMS the responsibility to manage the payment to physicians. Further, I believe that no other county in the U.S. is in greater need of reform than our county. It is your responsibility to correct this problem. Continued postponement of this long-needed reform is ill advised, inappropriate, and unfair!

Health care costs are high in our community. The economy of this county is entirely equivalent to Santa Clara County. Housing costs, wages, and benefits are equivalent. How can you support the payment differential as you propose in your rule? How can you continue to include counties such as Santa Cruz, Sacramento, and San Diego in the rural Locality 99 designation? We understand that Congress is directing to include our county in a federally sponsored redistricting in 2005. This needs to occur now.

Sincerely,
John E Short
Visiting Nurse Association of Santa Cruz County

September 3, 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P

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Sincerely,
John E Short
Visiting Nurse Association of Santa Cruz County

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am strongly in favor of this rule change, which would allow psychologists to supervise diagnostic testing. Psychologists receive specialized training in the development, administration and interpretation of these tests and are uniquely qualified to supervise others who may administer them.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

See Attached letter. Please reconsider your proposed rules governing Physican Fee Schedules for Santa Cruz County, California.

September 3, 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

Please reconsider your proposed rule. CMS committed in 1996 to updated the physician payment localities if there has been a significant change in practice costs. Santa Cruz County remains the most disadvantaged county in California. The payment differential for physician services in a county less than 20 miles from where I live is over 25% greater than for services that I receive from my doctor. I understand that this is by far the greatest such differential in the country.

This needs to stop. We are losing doctors and important specialties. I cannot understand how this is allowed to continue. I believe that Congress has delegated to CMS the responsibility to manage the payment to physicians. I believe that no other county in the U.S. is in greater need of reform than our county. It is your responsibility to correct this problem. Continued postponement of this long-needed reform is ill-advised and inappropriate. Please act now.

Sincerely,

Elizabeth Groves
290 Beach Pines Dr
Aptos, CA 95003

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

- ? Places athletic trainers work, such as physicians' offices and other non-athletic locations
- ? Athletic trainers already provide therapy under the direction of a physician in athletic training rooms, sports medicine clinics, and other venues
- ? The qualifications of a certified athletic trainer
 - o Educational preparation (often the athletic training student sits side by side with the physical therapy student taking the same classes)
 - o Passing the certification exam
 - o Continuing education requirements for ATCs; many states have no continuing education requirements for physical therapists.
- ? According to the federal government, the preparation of an athletic trainer is rated as equivalent to a PT's, and it is more significant than that of an OT, OTA or PTA. O*NET OnLine is a Web site (the web address is onetcenter.org) developed for and funded by the U.S. Department of Labor. It rates jobs according to level of education, preparation required, and duties. Athletic trainers (ATCs are code 29-9091.00) have a Specific Vocational Preparation (SVP) rating of 8+, versus a 7 to <8 for occupational therapists (code 29-1122.00), and a 4 for occupational therapy assistants (code 31-2011.00) and physical therapy assistants (code 31-2021.00).

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I wish to express my support for the rule change allowing psychologists to supervise technicians who do psychological or psychodiagnostic testing. As a profession, psychology is best trained and best suited to supervise this type of activity.
Thank you.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

see attached letter.

Meredith Atwood, ATC, ATL
University of Tennessee Chattanooga
UTC Athletic Training
615 McCallie Ave. Dept. 3503
Chattanooga, TN 37403

September 3, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Service
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing in regards to the recent proposal that would limit providers of “incident to” services. I find it highly disturbing that only physical therapist, physical therapist assistants and occupational therapist will be allowed to provide incident to care. If adopted, the change would eliminate the ability of qualified health care professionals to provide important services. The proposed change will cause only to limit the quality of care for Medicare patients and increase costs associated with services, both for the patient and CMS.

There have never been any limitations or restrictions placed upon the physician for the utilization of “incident to” services. Medicare has always relied on the professional judgment of the physicians. Changes to “incident to” services reimbursement would limit the ability of physicians to provide comprehensive, quality and cost effective care to patients. Patients would be forced to seek only physical therapist causing significant inconvenience and increased travel for hundreds of thousands of patients living in rural areas. The increased travel would not only delay health care for Medicare patients but also ultimately increase medical expenses to the patients, which in turn would increase costs, the Medicare. If a patient is unable to seek appropriate care in a timely fashion conditions will worsen increasing recovery time, therefore increasing recovery expenses. I believe it is imperative that physicians be allowed to continue to make decisions in the best interest of the patient.

To allow only physical therapist, physical therapist assistance, and occupational therapist to provide “incident to” outpatient therapy services would improperly provide these groups with exclusive rights to Medicare reimbursement. Limiting practitioners for “incident to” outpatient therapy would restrict other highly

qualified allied health care professionals, such as certified athletic trainers, from providing excellent health care services. Physical therapists are attempting to influence lawmakers by claiming only they are qualified to provide these services because of the educational background they receive. However they seem to have no problem allowing physical therapist assistants to perform the same services. Under the proposed rule changes physical therapist assistants will be allowed to perform incident to services, yet according to the U.S. Department of Labor physical therapist assistants are merely required to earn a 2-year associates degree with a background in anatomy, physiology, biology and psychology.

ALL certified or licensed athletic trainers ***must have a bachelor's or master's degree*** from an accredited college or university. That is 4 to 6-years of education with foundation courses in human physiology, human anatomy, kinesiology, biomechanics, nutrition, acute care of injury and illness, statistics and research design, exercise physiology, psychology, rehabilitation, and exercise therapy. The U.S. government employs athletic trainers to care for men and women in the armed forces providing advanced medical and rehabilitation services at army training facilities, on Naval ships, and for the elite Navy Seals. Major manufacturers from Appleton Papers in Appleton, WI to GE plants throughout the country employ athletic trainers to treat and return to production workers comp patients, people from age 18 to 65 or older. Athletic trainers are already employed in doctor's offices, physical therapy clinics, rehabilitation facilities, hospitals, and chiropractic offices. Athletic trainers care for musculoskeletal disorders in children, teens, adults and geriatric patients across the country and the world. I find it hard to believe that athletic trainers are unqualified to perform "incident to" services.

Physical therapists are blatantly attempting to dominate a health care practice stating that there are no other professionals who are as qualified. I think it is clear that this is not the case. Athletic trainers are highly qualified to work with Medicare patients and provide "incident to" services. To limit the practice of athletic trainers would be an injustice to the Medicare patients, the doctors who make decisions about care and to the Centers for Medicare and Medicaid Services. I highly recommend that these changes not be made and that athletic trainers be allowed to perform incident to services.

Sincerely,

Meredith Atwood, ATC, ATL
Cc: NATA

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

As a licensed psychologist, I would like to strongly encourage the modification of the Medicare rules to allow psychologists to supervise therapy techs who administer psychological or neuropsychological testing. By virtue of recognized training and expertise, psychologists are the most well-prepared professionals to provide appropriate and ethical supervision of these assessments.

Thank you for your thoughtful consideration of these issues.

Catherine L. Anderson, Ph.D.
6917 Arlington Road, Suite #217
Bethesda, MD 20814
(301) 951-0949

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

This particular issue requires clarification and adoption of the rule allowing licensed and HSPP psychologists to supervise technicians in the administration of psychological testing. This is important for consumer protection, training, and to ensure the delivery of needed services to patients who may not have adequate access to this valuable service. Please support the proposed changes and increase the options for the delivery of services.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I have grave concerns about the impacts the drug payment changes will have on urology patients-particularly cancer patients. According to the proposed rule published on August 5, urologists receive 37 percent of their total Medicare revenue from drugs and their Medicare drug revenue will decrease by 36 percent between 2004 and 2005. Such a short transition time for these massive payment reductions has the potential to greatly disrupt or hinder treatment for urology patients who currently receive drug therapy in the office for prostate cancer, bladder cancer, interstitial cystitis and other urological diseases.

I will not be able to continue to provide drugs to patients in my office if the payments are lower than my cost of buying and administering a drug. This is especially true for Medicare patients who do not have Medigap policies. With a 6 percent markup, I can not afford to order, stock and cover the bad debt associated with it for patients that do not have supplemental Medicare coverage. Many of my Medicare patients are poor and will not be able to pay the co-pay up front, meaning that they may choose to forego the proper care. Another option would be for me to write a prescription for my patients to have filled and then bring to the office. However, I'm not sure if the Medicare rules will allow me to do that.

As a small business owner, it is difficult to adapt so quickly to such large payment cuts, and I will have to make drastic changes in my practice when payments are based on average sales price (ASP) in 2005. These changes include discontinuing or limiting the types of treatment I am able to offer to Medicare patients, or sending patients to the hospital for drug administration (where they will pay a higher co-pay).

Therefore, I kindly request that a delay in implementation of this change in payment scheduled for January 1, 2005 may be considered.

Thank you,
Kumaresan Ganabathi,M.D.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Unlicensed persons performing psychological tests should be supervised by a psychologist or neuropsychologist. Physicians do not have training in administering or interpreting psychological tests, and do not have the expertise to provide oversight or supervision of such.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

If reimbursement is severely cut for urology meds it will do irreparable damage to the practices providing care. Urologists have between 60 and 90% of their patients in the Medicare age range. Over the past few years, reimbursements have been cut. Either with direct cutting of the reimbursement or by bundling procedures together so that only some are paid for. The reimbursement for drugs (lupron, zoladex, BCG, Viadur) have helped to float overhead expenses. With the loss of this, many will opt to close or close their practices to Medicare patients or no longer accept assignment or participate at all. All other venues for reimbursement have been curtailed or eliminated. Please reconsider this ruling so as to prevent the further deterioration of our current system.

MGG

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly support the rule change that would require psychologists to supervise psychological testing performed by technicians and other non-psychologists. Only psychologists have the training and expertise to do this. The current rule requiring physician supervision is outdated, outside the realm of a physician's expertise, and is potentially harmful to patients.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments**GENERAL**

GENERAL

The August 5 proposed rule lists estimated 2005 payments for only three urology drugs. Although these drugs represent 94 percent of 2003 drug payments for urology, there are still important drugs for which we have no information. For example, bladder cancer drugs, which in some cases are already reimbursed less than they cost, are not on the list. Also, actual 2005 payments will be based on third quarter 2004 data, which won't be available until after October 30. How can I assess the impact of payment changes on my practice and my patients when I don't even have a complete list of estimated 2005 payments? It is unfair to expect anyone to operate a business under such uncertain conditions, especially when that business is caring for cancer patients. Therefore, CMS should release a complete list of estimated ASPs to physicians for review and comment as soon as possible. And, if there are problems validating ASP data, CMS should seriously consider delaying implementation of the ASP payments. At the very least, if CMS does go ahead with January 1 implementation of ASP payments, the payments should be considered interim so that they could be further refined as more data is gathered on the payment changes.

I have grave concerns about the impacts the drug payment changes will have on urology patients-particularly cancer patients. According to the proposed rule published on August 5, urologists receive 37 percent of their total Medicare revenue from drugs and their Medicare drug revenue will decrease by 36 percent between 2004 and 2005. Such a short transition time for these massive payment reductions has the potential to greatly disrupt or hinder treatment for urology patients who currently receive drug therapy in the office for prostate cancer, bladder cancer, interstitial cystitis and other urological diseases.

I will not be able to continue to provide drugs to patients in my office if the payments are lower than my cost of buying and administering a drug. This is especially true for Medicare patients who do not have Medigap policies. With a 6 percent markup, I can not afford to order, stock and cover the bad debt associated with it for patients that do not have supplemental Medicare coverage. Many of my Medicare patients are poor and will not be able to pay the co-pay up front, meaning that they may choose to forego the proper care. Another option would be for me to write a prescription for my patients to have filled and then bring to the office. However, I'm not sure if the Medicare rules will allow me to do that.

As a small business owner, it is difficult to adapt so quickly to such large payment cuts, and I will have to make drastic changes in my practice when payments are based on average sales price (ASP) in 2005. These changes include closing satellite offices, laying off employees, discontinuing or limiting the types of treatment I am able to offer to Medicare patients, or sending patients to the hospital for drug administration (where they will pay a higher co-pay).

These cuts are coming on top of cuts that already went into place in January 2004, and I have only had one year to reevaluate and restructure my business plan, budget and patient care plans in light of these drastic payment changes. I can't recall any other major change in the Medicare program that was implemented in such a short time without some sort of transition time built in to mitigate impacts.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support this rule change.



Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

26 - I am a licensed psychologist and I specialize in psychological assessment. I have worked with many fine physicians/psychiatrists/neurologists to address specific assessment questions. Their knowledge of psychological testing is minimal and they are not qualified to supervise or make decisions regarding an appropriate psychological assessment battery to answer a specific referral question. Psychologists should be given this responsibility as they are specifically trained in psychological assessment.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Therapy-Incident To



Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support this rule change that allows psychologists to supervise others administering diagnostic tests.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I belong to a 10 partner Urology group in Phoenix, AZ. These cancer drugs are very expensive to purchase, store, secure and collect. I will not be able to continue to provide drugs to my patients if the payments are lower than my cost of buying and administering a drug. Please keep in mind that the accounting and billing for these drugs is very difficult. Audits within our group have revealed that somehow we do not bill approximately two injections per month. With a 6 percent markup, I can not afford to order, stock and cover the bad debt associated with these very expensive medications for patients that do not have supplemental Medicare coverage or who are inadvertently not billed. I am a physician, not a businessman. My employees are expert at taking care of patients and providing quality care and empathy, which is there main priority, and not at billing, collecting and accounting. The patient comes first in my office. Many of my Medicare patients are poor and will not be able to pay the co-pay up front, meaning that they may choose to forego the proper care. Another option would be for me to write a prescription for my patients to have filled and then bring to the office. However, I'm not sure if the Medicare rules will allow me to do that. We plan on discontinuing the administration of LHRH agonists in 2005 as the group cannot afford to lose money on its administration. The seventy five patients per month that receive their chemotherapy at our office will need to make other arrangements for their cancer therapy and I am hopeful you will provide instructions to patients so affected in order to decrease their confusion on how to find another location to receive their chemotherapy.

Thank you,

Eric Zeidman MD, FACS

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

The physicians are already under heavy pressure with rising overheads, malpractice costs and staff salaries and benefits. Any further reduction in the reimbursement may drive many to retire or cut down their practice and thereby affect patient access to care and make good doctors inaccessible to deserving patients.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

As a urologist in private practice with a high percentage of medicate patients, I am concerned about the proposed payment reductions that would cut the average urologists reimbursement by 13%. It is becoming more difficult to provide quality care under increasing financial pressure. We are on the front lines of medicine, taking care of ill seniors on a daily and nightly basis. We need support from our government to continue to make quality health care available.

This is a request to delay implementation of the new payments until payment information based on the new methodology can be validated and actually made available to physicians.

Submitter : Mrs. Christine Richardson Date & Time: 09/04/2004 07:09:42

Organization : MeritCare Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Christine Richardson, ATC/R, MED
1621 36 1/2 Ave. S.
Fargo, ND 58104

9/2/2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

*Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered.

The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

*There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

In many cases, the change to ?incident to? services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working ?incident to? the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

Patients who would now be referred outside of the physician?s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient?s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide incident to services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide incident to care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,
Christine Richardson

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments**GENERAL**

GENERAL

I am very concerned about the proposed rules for payments in 2005+ to my Urologic practice.

My patients with prostate cancer, Bladder cancer, Interstitial Cystitis and infections need the best medicines and affordable medical care. My practice cannot take the burden of supplying and stocking these drugs without proper reimbursement. The reimbursement for providing these medicines is now often lower than the cost of purchasing them.

I recently took care of 2 patients, that illustrate the importance of this issue to my practice.

One man developed a prostate infection and was faced with either hospitalization (at a greater cost to him and to Medicare), or injectable antibiotics in my office for 3-5 days. I provided the medications saving him and the system thousands of dollars. THEN I find that my reimbursement for the drugs was > \$20/ injection less than my costs. My losses are further compounded by the reduced allowables for office visits and providing the injection, nursing time, paper work, and my liability cost for undertaking the care in the office, etc.

It is about time we physicians are compensated and rewarded for what we do, and not portrayed as greedy, rich or underserving.

The second patient has intractable bladder pain. she has received intravesical medications in the past with success., but when I ordered the medicines to give to her, I can't get reimbursed even for my costs again! So add Rimso, BCG, Thiotepa and Mitomycin to the lists of poorly compensated drugs. When I sent this patient to a local pharmacy to pick up the drug, the costs to her were too high and she could not afford her necessary treatments. I was gracious enough to lose money for this patient too, but this will stop. My point among others is that patient access to care is effected by your proposed rules. These conditions will then worsen and more expensive hospital treatments will be necessary. This will drive up the costs of health care and your shortsightedness will come back to hurt us all.

Please immediately publish all reimbursement proposals so we can debate them and establish reasonable allowable levels of reimbursement. Please stop hurting patient care by preventing acceptable reimbursement for outpatient services.

Thanks You,

Sincerely

Philip Butler, MD

SaN Diego Calif

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

IMPACT

Gentlepersons:

As a part time urologist due to ongoing disability I am particularly concerned as to how the pending changes in payment will effect my solo practice. Already I am running a "barebones" operation, yet frequently have not been able to take a paycheck myself. This practice currently supports two families entirely, and two more partially (~1/2). I am fearful that the proposed changes, particularly those that apply to reimbursable chemotherapy drugs administered in my office will force me to either close my doors entirely, or merge into another practice, having a negative impact on my staff, and more importantly on my patients. There is something about a solo practice that allows for more intimate patient contact, and followup, further enhancing the quality of care, and probably also decreasing the cost of it. My patients will lose this should either of the above scenarios be forced upon me.

My practice is 90% Medicare, so the proposed changes that apparently will represent a 13% decrease in payment across the Urology board will not be able to be offset by increased revenue from other patients. I am fortunate that I have had some investigational/research experience, so hopefully I will be able to further supplement my own personal income with this. However in that I am limited in the amount of work I can do in a day, this will impede my patient care activities, and again decrease the opportunities to provide the quality one on one care that I am used to giving.

Can you delay implementation of the new regulations until such time as we, the practicing Urologists, and other physicians - especially the Oncologists - have an opportunity to assess its impact on us. If you could publish the actual payment figures, giving us 6 months lead time then we can attempt to deal with this in an intelligent fashion. Currently I have no idea how much I will be paying for drugs, and how much will be allowed, including the physician and administration components. It is unclear to me how you arrived at some of the figures that I am hearing banded about for some of the injectables, such as Viadur, at \$2287 whereas I am paying more than this if I order individual doses, and \$2200 if I order in quantities of five. I believe the planned percentage above purchase price should be above the quoted figure.

I believe that patient quality of care will be sacrificed if we as Urologists are no longer able to give these medicines due to the losses taken on administering and stocking and the simple cost of money tied up in these medications. How would you like it if you came to me for your care, and diagnosis of a malignancy yet I could not offer you the appropriate treatment in my office, and you had to go elsewhere to a "sterile" institution for the administration of the medications. This will undermine the physician - patient relationship even more.

Sincerely, Mark D. Ziffer, M.D. mdziffer@bellsouth.net

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I have conducted psychological tests for the past ten years in both Maryland and Colorado. I feel more than qualified to supervise master's level clinician's who conduct psychological tests.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

American Psychological Association has long maintained that psychologists have the greatest level of expertise in testing and therefore are the best qualified to supervise others performing such tests. In fact, psychologists have more training in psychological testing than any other profession and are therefore uniquely qualified to supervise others performing tests. Testing is the main area in which psychologists are different from all other healthcare professions.

I support this rule change.

Submitter : **Mr. Jim Mackie**

Date & Time: **09/04/2004 11:09:50**

Organization : **1st Coast Athletic Training Services**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

1st Coast Athletic Training Services
Nationally Certified/State Licensed Sports Medicine Professionals & Services

September 6, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services.

As a licensed certified athletic trainer we have the educational background and clinical skills necessary to provide quality therapy to patients, across the age span. I have worked closely with many certified athletic trainers throughout my career and have personally witnessed their skills and effectiveness. Eliminating access to these professionals would be a severe loss for Medicare patients.

Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor's or master's degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, nutrition, kinesiology/biomechanics, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

I firmly believe that the physical medicine CPT codes are intended for use by qualified health care providers, and that certified athletic trainers are as qualified as physical therapists and more qualified than physical therapy assistants to provide these services.

I strongly oppose the proposed policy change and urge its withdrawal.

Sincerely,

Jim Mackie, M.Ed., ATC/L



Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I am dismayed that medicare plans to cut overall reimbursement to urologists by approximately 14%. I think it is an insult to me as a urologist trained in urologic oncology, that my reimbursement in treating muscle invasive bladder cancer surgically, a 7 hour operation, is approximately three times less than a fellow plastic surgeon charges for the most minor of operations, a blepharoplasty. I was able to make ends meet for this absurdly low reimbursement by higher reimbursements for drug therapies. If you suddenly want to cut the cost of drug delivery, please come up with a more reasonable reimbursement for cancer operations so that I can make ends meet. Otherwise, I will not be able to afford to deliver healthcare to medicare patients.

Yours sincerely,
Farshid Sadeghi, MD.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To whom it may concern:

I am a physical therapist and athletic trainer and I am formally commenting to CMS not acknowledging athletic trainers as providers under the present and proposed fee schedules. Athletic trainers have extensive education in all age categories and have competencies that extend into all disease and pathophysiology conditions. They are more than qualified to give care to the Medicare population. They study all body systems and have competencies that include but not limited to evaluation/assessment of ears, eyes, heart rhythms, auscultory heart beats, pathophysiology of diabetes and cardiovascular diseases, etc. I employ athletic trainers and am forced to limit their practices to payers that acknowledge them as providers. CMS is missing the boat here. Athletic trainers like physical therapists think progressively and seek the best treatments in the shortest period of time for their patients. Studies have been done that report that athletic trainers and physical therapists have the same treatment outcomes. They get patients better in the same amount of time and do not cost any more than does a physical therapist. Allowing them to be providers will allow your patients to have a provider that is equal to a physical therapist and will not cost CMS any more money. The patient wins and the athletic trainer wins and CMS wins! Please don't tie the hands of employers in our state and country. Allow athletic trainers the opportunity to treat CMS patients.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Sir,
I have deep concerns about the implementation of the deep cuts in Medicare reimbursement for in-office drugs to our CANCER patients. The drugs have kept patients out of Hospitals and have thereby reduced the overall cost of care. Drastic reductions would force us to admit patients to hospitals for care which so far has been effectively rendered in the office setting. Historically hospital costs have driven the overall costs sky high. As a small business owner, it is difficult to adapt so quickly to such large payment cuts, and I will have to make drastic changes in my practice when payments are based on average sales price (ASP) in 2005. These changes include closing satellite offices, laying off employees, discontinuing or limiting the types of treatment I am able to offer to Medicare patients, or sending patients to the hospital for drug administration (where they will pay a higher co-pay).

These cuts are coming on top of cuts that already went into place in January 2004, and I have only had one year to reevaluate and restructure my business plan, budget and patient care plans in light of these drastic payment changes. I can't recall any other major change in the Medicare program that was implemented in such a short time without some sort of transition time built in to mitigate impacts.

Sincerely,
Dr. Ashok J Kar

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

This rule is a significant improvement over current policy. The procedure suggested protects Medicare beneficiaries and assures higher quality care.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 1-9

PRACTICE EXPENSE

As a practicing urologist with a large population of oncology patients, we are concerned for our patients on LHRH agonist drugs for prostate cancer. We are in the dark as to the ASP and what to tell our patients as it will no longer be economically feasible to stock the drugs in our office. We have given out patient letters explaining as best we could about what will take place in 2005. We are asking you to delay this decision so that we can at least tell the patients where the drug will be available and what they will be responsible for. While I realize that this will be a burden on our own income, you must realize that this will create a state of utter confusion and financial hardship on our patients as well. As the GAC representative for the state of Georgia I ask you to reconsider this Draconian ruling or at least clarify the confusion that it has created.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

Robert Super
534 River St.
Dickson City, PA, 18519

September 15, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- “Incident to” has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY “incident to” service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

□ This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

□ Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

□ Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.

□ Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor’s or master’s degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

□ To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

□ CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

□ CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.
In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,
Robert Super

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attached Word document.

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

Please note: The attachment cited in this document is not included for one of the following reasons:

1. Improper format.
2. The submitter did not follow through when attaching the document.
3. The submitter had intended to attach more than one, but not all attachments were received.
4. The type of document provided was a password-protected file. CMS was given read-only access to the document.

We cannot provide this electronic attachment to you at this time, but you would like to view any of those that are not posted on this web site, you may call CMS and schedule an appointment at **1-800-743-3951**. Those comments along with its attachment(s), that could not be posted, will be available for your viewing at that time.