

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

In the proposed fee schedule the Non-Facility RVUs for code 36870 has been significantly reduced for dialysis declotting of AV grafts and fistulas. The facilities that use this code are among the most dedicated, cost effective, and efficient in caring for dialysis patients with access problems. The change in reimbursement will greatly impact the care that we are able to deliver to our patients for vascular access management. The cost of these procedures are significant due the level of accuity which is required to care for these chronically ill patients. An angiographic lab requires advanced diagnostic equipment, routine supplies, and highly trained staff to deliver quality care to the renal community. Please review the input files for this CPT code for possible adjustment.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

Attachment # 2301

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P, P.O. Box 80122
Baltimore, MD 21244-8012

CMS:

We write as a staff of Certified Athletic Trainers in a collegiate setting to react to, and comment on, your recently issued document concerning proposed policy changes, most specifically those relating to “incident to” billing of outpatient therapy service. We as certified athletic training professionals, deeply committed to our profession and respectful of those many individuals who have placed their trust in our competence and in our care, would like to take this opportunity to once again defend our position in the health care system, a position which we deem necessary, vital, and beneficial. And, as you are undoubtedly aware, this most positive of congregate opinions is shared by the myriad athletes and patients who we have treated over the years and who we are now treating and will continue to treat, not to mention the generations of patients yet to come.

We in the Rhode Island athletic training community, as well as the collegiate community are deeply distressed by the potential implications for our profession of the policy changes you propose. We are most particularly concerned about the impact, under the proposal you have promulgated, on certified athletic trainers providing on-site rehabilitation services, home program instruction, or lifestyle/fitness routines.

Let me cite some specific examples of the benefit brought to the people of Rhode Island, to the professional athletes who play here, and to the students and student-athletes who attend universities and colleges within Rhode Island. As athletic trainers we are able to implement the health care process quickly, allowing for care to begin immediately. As such, our athletes are able to return to activity quickly and in good form. Also, we have prevented unnecessary emergency room visits by evaluating injuries and referring people for follow-up and testing accordingly. This saves not only time and money but assists with the visit load many hospitals and physicians are currently burdened by.

Having cited these specifics, let me say that our more general concerns include our contention that the changes you are proposing would create a monopoly in the nation’s clinics and this monopoly would not include athletic trainers, but rather physical therapists, occupational therapists, and speech and language pathologists. Further, we contend that the changes would substantially constrict

athletic training career opportunities and thus, in the near-term, cause our profession to be detrimentally impacted by a slowing-down of new talent into the profession.

You should also be aware that the Providence College athletic training staff endorses the argumentation put forth regarding your proposed policy changes by NATA, the membership body representing certified athletic trainers [ATCs] worldwide.

To reiterate the NATA position points:

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.] 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.

3.] 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.

4.] The United States 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.

5.] 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 also, 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.

6.] 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.

7.] 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).

8.] 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.

9.] Centers for Medicare & Medicaid Services, 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.

10.] Centers for Medicare & Medicaid Services 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.

11.] 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.

12.] 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 accompanied 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.

We can understand the need for you at CMS to ensure that your payment systems are updated to reflect changes in medical practice and the relative value of services. In fact we collectively applaud this updating. But not to the detriment of a respected and beneficial profession [athletic training] and not to the potential diminution of health care for the many, many individuals which that profession serves.

We may be small in geographic stature here in Rhode Island but we are large when it comes to athletic training competence and we are capable of roaring rather loudly and making our communal voice heard. Nothing like a leaflet or an infocard on the seat of every fan attending every athletic event in all the athletic venues throughout the State to underline our message and make it heard via the e-mails and in the postal boxes in Washington.

I thank you for listening to our advocacy and I look forward to a fair hearing and a just outcome.

Cordially,

John Rock, Med, L/ATC
L/ATC
Assistant Athletic Director for Sports Medicine

Kevin Mahoney, MEd,
Assistant Athletic Trainer

Jennifer L. Brodeur, MS, L/ATC
Assistant Athletic Trainer

Quinn Harper, MS, L/ATC
Assistant Athletic Trainer

Kristen Duhamel, MEd, L/ATC
Assistant Athletic Trainer

cc:
U.S. Senator Jack Reed
U.S. Senator Lincoln D. Chafee
U.S. Representative Patrick J. Kennedy
U.S. Representative James R. Langevin

Governor Donald L. Carcieri
R.I. Commissioner of Education Peter McWalters
R.I. Commissioner of Higher Education Jack R. Weaver
R.I. Director of Human Services Jane A. Hayward
R.I. Director of Health Dr. Patricia A. Nolan
Presidents, all Rhode Island colleges and universities
Athletic Directors, all Rhode Island colleges and universities

Submitter :

Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am writing to express my opposition to the proposed revisions to the CMS 1429 as it would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals such as fellow Certified Athletic Trainers to provide these important services.

As a Certified Athletic Trainer we provide a qualified and cost effective option to the physician in rehabilitation services. I believe the CMS would be doing a disservice to our patients if they limit the patient's access to rehabilitation service options. It seems clear to me that we should allow physicians to continue to make the decisions that are in the best interest of their patients.

I feel this proposal is unnecessary and unjustified. I urge you to strongly consider the impact this will have on our patients. I feel that the physician should not be limited as to which provider is best suited to meet an individual patient's needs. Limiting a patient's access to qualified health care providers and care options would be ill advised.

Furthermore, I feel that limiting a physician's ability to direct care is a dangerous step. If this option is restricted, where will the restrictions end? Currently the public is challenged by insurance programs which often deny the appropriate services necessary based on cost. Now the physician's decision making process is further threatened by additional restrictions.

We have granted our physicians with the authority to direct our individual care. Why should we allow others to take away or limit that authority based on narrowly focused and selfish aims. Healthcare is in a state of crisis as it is. Millions of Americans are faced with critical decisions based on a multitude of access restrictions already. Now, once again, a proposal to further restrict the care givers is before you. In view of an ever expanding aging population of "baby-boomers", why can we even give serious consideration to a proposal that would further bottle-neck access to quality health care?

Currently there is a shortage of physicians and related health care services in many areas. This proposal will only further stymie the abilities of those practitioners to maximize the available services. Any attempt to restrict those services will only exaserbate the problem-and especially in underserved regions of the country where the problem is already out of control.

Therefore, I once again strongly urge your consideration of the negative impact that the proposed regulation will have if "incident to" decisions by the physicians are further restricted. I look forward to a favorable decision on this matter.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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. 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.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

Attachment # 2304

Marge Taylor, PT, ATC, JSCC

2076 E. Mitchell, Apt 6

Petoskey, Michigan 49770

September 21, 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,

Marge Taylor PT, ATC, JSCC
2076 E. Mitchell, Apt 6
Petoskey, Michigan 49770

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Thank you for this chance to comment on this very important issue. I wish to strongly support the "incident to" language in the fee schedule. Physical Therapists should be the ONLY people to provide physical therapy services. It seems evident that this would be the law, as licensure is the measure of competence in any given discipline. Physicians while highly competent in their given field have no training or expertise in Physical Therapy. They should no more supervise Physical Therapists than we should supervise them. A close look at the education standards of accredited Physical Therapy programs show a unique body of knowledge being taught. Graduates are achieving a doctoral degree. Ongoing educational requirements are mandatory in 38 states. Clinical research is being produced at a all time high. All of these things point to a profession that stands on it's own body of knowledge, unique and progressive.

I urge you to not cave in to special interests that's main concern is financial, and keep this very good piece of policy intact.

Thank You

Terry C. Brown PT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attached file

Attachment # 2306
Robert E. Williams ATC/LAT
Premier Rehabilitation
2154 Cousteau Dr.
West Lafayette, IN 47906

September 20, 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 show my concern on the recent proposal that would limit providers of “incident to” services in physician offices and clinics. If adopted, this will take away the ability of qualified health care professionals to provide these needed services. This would reduce the quality of care for Medicare patients and increase the costs associated with this service and place more burdens on the health care system.

I ask that during the review process the you would take a minute and 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 (Certified Athletic Trainers are) 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 not qualified to provide a particular service. Physicians see and care for several patients daily, it is imperative that they continue to make decisions in the best interests of the patients.

- In most cases, it would render many physicians unable to provide quality care quickly to their patients, if “incident to” was changed. The patient would have to find therapy elsewhere, causing more expense and inconvenience.
- With decreased numbers going into allied healthcare, and the physician unable to utilize “incident to” patients will suffer delays in quality care. Patients would also encounter more delays in getting care, due to the increased numbers patients seeking care.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these things themselves. This would increase their workload and the time that patients would wait for 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. Core courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy percent of all athletic trainers have a master’s degree or higher. The great majority of practitioners who hold advanced degrees is comparable to other health care professional, 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 exclude athletic trainers from “incident to” would keep them from getting Medicare reimbursement. These would allow only physical therapist and other therapist to receive this. That would basically take away the rights of states to license allied health care professions who are deemed qualified, safe and appropriate to provide health care services.
- Certain groups are proposing this change, and are offering no evidence that there is problem with the current system. I feel this is being done to make this groups the sole providers of this service.
- CMS does not have the statutory authority to restrict this privilege from certain professionals in 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 provider of therapy services.
- In many studies in the health care field it has been shown that certified athletic trainers provide equal quality care to that of physical therapists.
- Athletic trainers are employed in various settings throughout the U.S.. They include post-secondary educational institution, outpatient clinics, industrial

facilities, physician offices, medical supply companies, and professional sports teams, Olympic Teams. What are they doing? They are preventing, assessing, treating and rehabilitating injuries. For CMS to say that athletic trainers are not qualified to give this care to a Medicare beneficiary who becomes injured as a result of walking 5 miles a day and goes to their local physician for treatment is outrageous and unjustified.

- These could lead to decreased numbers of Medicare patients accepted by physicians.

In conclusion, it is unnecessary or beneficial for CMS to institute the changes proposed. This CMS recommendation is a health care deterrent.

Sincerely,

Robert E. Williams ATC/LAT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am opposed to PT's being the only health care professionals allowed to provide medically related care to physician's patients. If Medicare approves this policy it won't be long before Commercial Insurance Carriers will follow the same route, just as they did in eliminating payment for hot/cold packs in most incidents.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

It would be a discriminatory practice to allow ONLY physical therapists to provide massage therapy. It would also discriminate AGAINST senior citizens - AND WOULD NOT BE IN THEIR BEST INTERESTS.

If this bill is passed it will also have serious ramifications throughout the complimentary health care industry and create a monopoly for physical therapists. This would be contrary to freedom of choice for senior citizens and limiting to all complementary health care professions THROUGHOUT THE COUNTRY.

We beg you to NOT pass this policy whereby a physician can only refer 'incident to' services to physical therapists. All QUALIFIED health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Mrs. Kelly Harkins Date & Time: 09/21/2004 03:09:11

Organization : Erskine College

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

Attachment # 2309
Kelly Harkins, MS,ATC
Two Washington Street
Due West, SC 29639

September 21, 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:

As the Curriculum Director of a CAAHEP accredited athletic training education program, I have grave concerns regarding the recent proposal that would limit providers of "incident to" services in physician clinics. Athletic trainers are not only capable, but extremely qualified to provide specific services included in this proposal, under the supervision of a physician. Since 1965, physicians have had the authority to use their best judgement in the selection of health care providers to provide services to their patients. The fact that this proposal is being made by a non-physician professional group should lead CMS to question the validity of the proposal. CMS, in proposing this change, offers no evidence that there is a problem in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who seek to establish themselves as the sole provider of therapy services.

The scope of a certified athletic trainer (ATC) is much broader than that of a physical or occupational therapist. This in no way deems an ATC of being unqualified to provide services that a physician believes we are qualified for. It is completely irrational for CMS to give such consideration to a proposal created entirely by a group with their own professional interest in mind regarding the quality of care provided by other allied health care professionals. If problems existed in the care being provided by ATC's, it seems that physicians across the nation would have brought this to the attention of CMS long before now. There is no logic behind taking the decision of who is qualified to provide therapy services out of the hands of a physician and granting that privilege to physical and occupational therapists.

The quality of an ATC's education is entirely comparable to that of a PT or OT in both the didactic and clinical aspects. In fact, it is undeniable that the education of an ATC is far superior to that of a PTA or OTA. Since the ability and education of athletic trainers seems to be in question, why isn't careful attention being paid in a comparison of the curriculums of each of these professions?

I sincerely hope that the misrepresentation of the quality of care provided by an ATC has been demonstrated by the above comments. It is vitally important that careful consideration be given to this proposal, as it seems to be completely unfounded.

Sincerely,
Kelly Harkins, MS, ATC
Athletic Training Curriculum Director
Erskine College
Two Washington Street
Due West, SC 29639

Submitter : Mrs. Erin Rippee Date & Time: 09/21/2004 03:09:21

Organization : Mrs. Erin Rippee

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I feel that Massage Therapist are very important in the health field. They should be able to work with physicians and be able to be billed by medicare. Massage is a VERY effective, natural treatment to many disorders/ailments and options should be open when it comes to healthcare. I oppose this measure.
Erin Rippee, L.M.T.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a Massage Therapist that works with insurances to bring down the cost of care to thier members , including Medicare which I do not have to do. Research has been done that proves masage is a viable and useful tool in the managment of pain, stress, and other problems that people are confronted with in todays society. It has also been proven that massage helps in the elderly with thier needs as well as in cancer victims, AIDS, and many other areas. I am not in this business to get rich, but to try to help people. I do not need to give the discounts I do but choose to. Please, do not let Medicare dictate what goes on or what happens with the insurance industry. They can come in and check therapists and not deal with the ones that are not legitamate but don't hold all MT's accoutable for the actions of a few.

Thank you.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Mary T. Keehn, PT, MHPE
24 W. Robertson St.
Palatine, IL 60067

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

Dear Dr. McClellan,

I am a Physical Therapist, licensed in the State of Illinois, who has been practicing for over 24 years. I am writing to strongly support the proposed rule that would require that physical therapy services provided in a physician's office incident to a physician's professional services must be furnished by personnel who meet clear standards.

When I find out that a patient, personal acquaintance or family member has received 'physical therapy' services in their doctor's offices I always inquire further as to whether or not they believe the therapeutic service was provided by a physical therapist. It is typically easy to determine the answer to that question based on the person's description of the interaction. Physical Therapists, because of their extensive education and ongoing professional development are able to evaluate the patient's problem, work with the individual to determine treatment goals and a realistic intervention plan and implement that plan. Without the necessary education in evaluation and plan of care development, the non-physical therapist provider is unable to respond adequately to the patient's needs - implementing modalities or supervising exercise that are fragmented and are not likely to efficiently and effectively progress the patient toward their goals. Physicians do not receive training in providing physical therapy and therefore are not able to adequately complete the patient/client management model that is necessary. It follows that they are not in the position to supervise the implementation a physical therapy plan of care, evaluate the outcome of care and modify the plan efficiently and effectively. It is the patient who is left to determine if the care they are receiving is appropriate. If it is ineffective the person may not be well enough informed to realize that the outcome would have been different if the physical therapy services were provided by a licensed physical therapist.

I am well aware that a fairly significant portion of Medicare resources are utilized to pay for physical therapy services. I think it is outrageous that these dollars are being used to pay for services that do not meet professional standards that have been developed to ensure the best care possible for the public.

Thank you for your consideration of these comments.

Sincerely,

Mary T. Keehn, PT, MHPE

Submitter : Mrs. Jacqueline Keenan-Kincaid Date & Time: 09/21/2004 03:09:25

Organization : American Massage Therapy Association

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

All qualified health care providers including massage therapists should be allowed to provide services to patients with a physicians prescription or under their supervision. I urge you NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Re:Medicare and Insurance coverage. Massage therapy is many times more effective than Physical Therapy or drug threapy. The benefits of increased blood flow, and release of muscle tension will reduce pain and the need to be spending a lot of money on drugs. Don't take this away from our older citizens or any person requiring pain relief. Thank you Jeannine Findley, LMT,CNMT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical psychologist and I am opposed to the use of unlicensed, unregulated technicians administering or scoring diagnostic psychological tests. There is too much variability in personnel, vague training of personnel, and lack of identification or accountability in the field of psychology to permit this practice. Before approving such a rule change, the field of psychology needs to take additional steps to protect the public.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 10-19

DEFINING THERAPY SERVICES

I am a Certified Athletic Trainer in Washington State. We are getting close to having state legislation that would give ATC's licensure. Passing this Medicare act would be a major step backwards for the rehabilitation industry. As an ATC, I am certified to work on injury prevention, rehabilitation on this nations best athletes and servicemen and women.

In the scope of practice for a Certified Athletic Trainer we are under orders from physicians, and the supervision of Physical/Occupational Therapist. We are qualified to treat medicare patients, and you not allowing us to do so would dampen the ATC's ability to make a living for a credential that is difficult to obtain. We are required to complete 80 hours of continuing education by the NATA every 3 years.

I just want to encourage you to defeat this bill on the principle that the ATC is qualified to perform treatment on the patients involved, and passing this will reduce an entire group of allied health professionals to over qualified aides.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 1-9

GPCI

See attached file

CMS-1429-P-2318-Attach-1.doc

Attachment # 2318

September 21, 2004

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

RE: FILE CODE CMS-1429-P - GEOGRAPHIC PRACTICE COST INDICES

To Whom It May Concern:

I am writing on behalf of the Santa Cruz County Board of Supervisors 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.

Our Board objects to the Proposed Geographic Practice Cost Indices (GPCIs) for 2005 because they fail to correct proven inadequacies in reimbursements to localities currently categorized as "Locality 99" that exceed the 5% 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% 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%. Such statistics demonstrate the fallacy of the GPCI 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. To not 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 indicates 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. 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. Our Board requests that CMS do so as part of this rulemaking process.

CMS cannot postpone a solution this year, as it did last year. Failure to address the GPCI/locality issue in California only increases the problems and will make fixing them 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. It is difficult to recruit new physicians, and many who do come leave after 1-2 years, moving away to areas where they can afford to live and work. When patients do not have primary care physicians, their health suffers and they have to use our overcrowded emergency rooms for primary care. Many more patients are admitted to the hospital for acute and severe medical diseases that might have been prevented or managed as outpatients. Furthermore, sometimes patients need to be transported out of our county altogether because the hospitals do not have necessary medical specialists on staff for emergencies. To implement the August 5 proposed rules would be counterproductive to CMS's mission to make Medicare benefits affordable and accessible to America's seniors.

Again, we object to the proposed Geographic Practice Cost Indices for 2005 as printed in the Federal Register of August 5, 2004. We request that CMS define a method in which it can revise the GPCIs for those California counties--especially Santa Cruz--that exceed 5% of the national average and begin reimbursing doctors in those counties more in line with their true costs. We suggest removing Santa Cruz County from Locality 99 and placing Santa Cruz County in a separate locality.

If CMS cannot remove our county from Locality 99 based on the above, then we request that you do so based on your language in the 1996 rule. At that time, CMS (then HCFA) stated "While we do not routinely revise payment areas in multiple locality states as we implement the new GPCIs, we will review the areas in multiple locality states if the newer GPCI data indicates dramatic relative cost changes along areas." The new GPCI data result in a gap between our county's GAF and our reimbursement of **greater than 10%**. We believe that is dramatic! Again, we request to have Santa Cruz County removed from Locality 99 and placed in a separate locality.

Thank you for your consideration of this issue and for your efforts to rectify this significant concern.

Sincerely,

MARDI WORMHOUDT, Chair
Board of Supervisors

MW:ted

cc: Clerk of the Board
Health Services Agency Director

Submitter : Mrs. DENISE WILLIAMS Date & Time: 09/21/2004 04:09:41

Organization : SUGAR DUNES CHAPTER MASSAGE THERAPIST

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

ASSIGNMENT

OPPOSED

MASSAGE THERAPISTS WORK HARD AND WORK THE ENTIRE BODY AND HELP THE PATIENTS HAVE A BETTER QUALITY OF LIFE AND REHAB AND ARE FOR THE GOOD AND HEALTH OF THE PATIENT.

WE NEED MORE INSURANCE COMPANIES TO WORK WITH US AND THERE PATIENTS SO THEY CAN GET WELL AND NOT COST INSURANCE AND TAX PAYERS MONEY.

ALOT OF THESE PATIENTS ARE ELDERLY AND NEED THIS HELP PLEASE HELP MASSAGE THERAPISTS TO BILL THESE TREATMENTS AND HELP PEOPLE TO GET WELL.

IMPACT

THE IMPACT IF PASSED WILL BE STRAIN ON THE PATIENTS AND ALSO MASSAGE THERAPISTS ARE HEALERS WE WANT THE BEST FOR OUR PATIENTS PT DO NOT HAVE TIME TO TREAT THESE PEOPLE I WORK IN A HOSPITAL AND A PHYSICAL THERAPY DEPARTMENT AND PT DO NOT WANT TO DO THIS.

MASSAGE THERAPY NEEDS TO BE ALSO TREATED AS A MEDICAL CARE AS WE PUT OUR HEART AND CARE INTO HELPING PEOPLE AND ALOT OF WHAT WE DO IS NOT AT THE SAME COSTS TO THE INSURANCE COMPANY AS PT. AS WE DO NOT HAVE ALOT OF THE OVERHEAD. AND AS WE KNOW COST IS AN IMPACTED PLAN FOR THE INSURANCE COMPANY AND PATIENT THUS SAVEING A HUGE COST TO EVERYONE.

LOW OSMOLAR CONTRAST MEDIA

opposed

THERAPY - INCIDENT TO

opposed

MASSAGE THERAPISTS WORK HARD AND WORK THE ENTIRE BODY AND HELP THE PATIENTS HAVE A BETTER QUALITY OF LIFE AND REHAB AND ARE FOR THE GOOD AND HEALTH OF THE PATIENT.

WE NEED MORE INSURANCE COMPANIES TO WORK WITH US AND THERE PATIENTS SO THEY CAN GET WELL AND NOT COST INSURANCE AND TAX PAYERS MONEY.

ALOT OF THESE PATIENTS ARE ELDERLY AND NEED THIS HELP PLEASE HELP MASSAGE THERAPISTS TO BILL THESE TREATMENTS AND HELP PEOPLE TO GET WELL.

THERAPY STANDARDS AND REQUIREMENTS

opposed

MASSAGE THERAPISTS WORK HARD AND WORK THE ENTIRE BODY AND HELP THE PATIENTS HAVE A BETTER QUALITY OF LIFE AND REHAB AND ARE FOR THE GOOD AND HEALTH OF THE PATIENT.

WE NEED MORE INSURANCE COMPANIES TO WORK WITH US AND THERE PATIENTS SO THEY CAN GET WELL AND NOT COST INSURANCE AND TAX PAYERS MONEY.

ALOT OF THESE PATIENTS ARE ELDERLY AND NEED THIS HELP PLEASE HELP MASSAGE THERAPISTS TO BILL THESE

TREATMENTS AND HELP PEOPLE TO GET WELL.

THERAPY TECHNICAL REVISIONS

opposed MASSAGE THERAPISTS WORK HARD AND WORK THE ENTIRE BODY AND HELP THE PATIENTS HAVE A BETTER QUALITY OF LIFE AND REHAB AND ARE FOR THE GOOD AND HEALTH OF THE PATIENT. WE NEED MORE INSURANCE COMPANIES TO WORK WITH US AND THERE PATIENTS SO THEY CAN GET WELL AND NOT COST INSURANCE AND TAX PAYERS MONEY.

ALOT OF THESE PATIENTS ARE ELDERLY AND NEED THIS HELP PLEASE HELP MASSAGE THERAPISTS TO BILL THESE TREATMENTS AND HELP PEOPLE TO GET WELL.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Dr. McClellan;

I am a physical therapist with a Masters Degree and have been practicing in the field since 1993. I have also been an instructor of other physical and occupational therapists for 3 years. I have worked in several environments including nursing homes, inpatient acute hospital settings, community adult day-care programs, home health, outpatient clinics, and am currently in private practice.

I was quite pleased to see the language in CMS' proposed requirements that physical therapists working in physicians offices be graduates of accredited professional physical therapist programs.

Though it is not current law, I think licensure should be the standard to most appropriately protect the public from individuals who lack the training and skill level required to provide safe services as a physical therapist.

Physical therapists and physical therapist assistants under the supervision of physical therapists are the only practitioners who have the education and training to furnish physical therapy services. I am quite concerned that unqualified personnel would possibly be considered to provide physical therapy services.

I have a physical therapy aide in my office that assists with cleaning rooms, linen preparation, moving patients to treatment rooms and bringing supplies as needed to the physical therapist. However, she makes it clear to the patient that she is not a therapist and is not involved in their medical care other than to get them scheduled and to the correct place. I am concerned that those individuals or corporations with ethics that are more interested in financial gain rather than the best care for the patient would cause harm to patients who are trusting that the license achieved by the therapist is understood when they enter the treatment room.

Please keep our consumers/patients safe and help us to maintain a profession that can be trusted by the public in healthcare. Thank you very much for your time and consideration in this very important matter.

Very Truly Yours,
Loraine, MPT (Zip code 98324)

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

SANTA CRUZ IS NOT RURAL ANYMORE. Why is the federal government slowly destroying the health-care system in my community? Has no one looked at the changes to Santa Cruz County since 1967? Median house prices \$630,000, young and skilled physicians come to visit this county and turn disappointed elsewhere to establish their careers. There is no county line in the US with a greater difference in physician payments than the line you cross when you reach the Highway 17 summit. Studies show that Santa Cruz County is one of the most expensive areas in the country to live!!Santa Cruz county is not rural anymore. The designation must be changed to URBAN to preserve access to care for our seniors. We lose key physicians monthly heading for urban-designated communities. This MUST be stopped. A map drawn almost 40 years ago? Sound fair? Sound right? We have had the same economic changes in Santa Cruz County as Santa Clara County. Our housing costs now exceed those in Santa Clara County. Something MUST be done to preserve our health care.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapist. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I do believe that massage therapy when done by a qualified licensed massage therapist helps many people with chronic pain and disfunctions caused from soft tissue disfunctions and trigger points. Qualified licensed massage therapists who have further knowlegde in accupressure or accupuncture points have also made a difference in the quality of life for their patients/clients in alleviating disfunctions and discomforts of the patient or client. Our healthful services have been able to help others and we hope to continue to do so. There are many geriatric patients and even those with old injuries who have benefited and hopefully will continue to benefit from our work. I know that there are a lot of PT's who do not know anything about meridians and healing points that we as therapists use to help our patients. Medicare should not discontinue our right to help people who are ailing and have a lot of discomfort.

We provide a service that most medical professionals have not had much training in and I do believe that we make a difference for those people that do seek our services and also for those who want to be reimbursed by their insurance for this important and beneficial healthful service that we as qualified massage practitioners provide. We as qualified massage practitioners do count in our patient's healing processes. Don't take away from the consumer patient the valuable service that we provide. Thank you.

THERAPY STANDARDS AND REQUIREMENTS

Basic Massage therapy training and continuing educational units or specializing in one or more massage modalities to help others that need our trained touch for their healing process.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See Attached File

CMS-1429-P-2324-Attach-1.doc

**Department of Health and Human Services
Centers for Medicare and Medicaid Services (CMS)
Offices of Strategic Operations and Regulatory Affairs**

The attachment to this document is not provided because:

1. The document was improperly formatted.
2. The submitter intended to attach more than one document, but not all attachments were received.
3. The document received was a protected file and can not be released to the public.
4. The document is not available electronically at this time. If you like to view any of the documents that are not posted, please contact CMS at 1-800-743-3951 to schedule an appointment.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

Attachment # 2325
Lourdes D Piojo
15807 Vassar Ave
San Lorenzo, CA 94580

September 21, 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,

Lourdes D Piojo, ATC

15807 Vassar Ave , San Lorenzo, CA 94580

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Attachment # 2326
September 21, 2004

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

Re: CMS Code 1429-P
Physician Fee Schedule/ Calendar Year 2005

Dear Sir or Madam:

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

I urge you to immediately reconsider your proposed rule. In the 1960's, Santa Cruz County was determined to be a rural county for Medicare reimbursement purposes. *It is no longer a rural county – it is in fact a bedroom community to Silicon Valley, and our economy is one and the same with that of San Jose, in terms of the cost of living.* It is perhaps higher, because of the extraordinary price of real estate here. Doctors in San Jose, and Santa Clara County (adjoining Santa Cruz – less than 20 miles distant) receive 25% more reimbursement than our doctors.

This means that local doctors are refusing to accept Medicare patients, and in fact, it is difficult to recruit new physicians to practice here because of the low reimbursement rates. Over the long term, we will lose doctors and important specialists. Already, there has been a local crisis in recruiting a neurosurgeon for the local hospital – for some months, they were without access to one and had to helicopter all head and spinal injuries to Stanford for treatment. Such compensations cost CMS needless expense; the situation could be remedied by reclassifying Santa Cruz County as an urban county. I hope you will do this.

I believe that no other county in the U.S. is in greater need of reclassification than Santa Cruz. Congress has given you the power to correct this problem. I implore you to do so. Continuation of the status quo is deleterious to the local health care system.

Sincerely,

Clarke Dixon-Moses

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I am writing to protest Medicare's proposed plan to eliminate all healthcare professionals except physical therapists from providing "incident to" therapies to patients in physicians and chiropractors offices. Massage therapy has been extremely valuable to many patients, including diabetics and stroke victims, and should not be eliminated. A physical therapist is not trained to do what a massage therapist does and should not be considered a replacement for such. Both are valuable forms of therapy and both should be available for patients. The growing popularity of massage therapy has proven the above statements, and I would implore you not to turn back the clock on this issue and cause needless hardship on those individuals who would receive genuine help and relief from a massage professional.

Thank you.

Dawn Dominick, LMT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please review the attached word document. Thank you.

Attachment # 2328
Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Subject: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

Dear Dr. McClellan,

My name is Steve Messineo, P.T., M.S. and I am a licensed physical therapist practicing in Massachusetts. I have been in practice since December of 1998 with the majority of my experience taking place in outpatient private practices. I currently own two clinics, and my staff and I see approximately 2-3 new patients a week who are Medicare beneficiaries.

I am writing to comment on the August 5th proposed "Therapy-Incident To" rule in the "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005". I agree with the CMS in that the only qualified personnel who should be allowed to provide physical therapy services incident to a physician's services, are those that have graduated from an accredited physical therapy or physical therapy assistant program.

I want to express strong support for making licensure to practice physical therapy as a requirement for the same personnel as well. Licensure is the standard that all health care professionals need to obtain in order to practice in their respective professions. Allowing non-licensed physical therapists to provide services incident to a physician's visit would be a disservice to the patient and place that patient at risk. Licensure qualifies all physical therapists and makes them accountable for the services they provide. Those who do not have license to practice have not met the minimum requirements recognized by each state to provide quality physical therapy care. Licensure defines a physical therapist as is does for medical doctors, chiropractors, and other health care professionals. We have all heard of the harm

non-licensed clinicians have caused their patients in different settings. The risks to patients are the same if they are being treated by non-licensed physical therapists.

Additionally, a financial limitation on the provision of therapy services (referred to as the therapy cap) is scheduled to become effective January 1, 2006. Under the current Medicare policy, a patient could exceed his/her cap on therapy without ever receiving services from a physical therapist. This will negatively impact patient's outcomes as they will not receive the proper care and/or instruction needed to help them obtain their functional goals and return to normal activity without restriction within the financial guidelines established by the therapy cap. Medicare beneficiaries also do not generally have the financial resources to pay for PT services out of their own pocket once the cap has been exhausted. In order to continue therapy services in the instance where a patient received care by a PT practicing in a physician's office without having to pay out of pocket once the cap was met, the patient would have to switch care to an outpatient PT setting in a hospital, thereby interrupting the consistency and potential quality of care they were receiving in the first place.

Thank you for your consideration of my comments.

Sincerely,

Stephen Messineo, P.T., M.S., Owner
All-Access Physical Therapy, Inc.
3 Tennis Drive
Shrewsbury, MA 01545

Submitter : **Mr. Phillip Hommell MBA, ATC, LA**Date & Time: **09/21/2004 04:09:02**Organization : **OrthoIndy**Category : **Other Health Care Professional****Issue Areas/Comments****Issues 20-29**

THERAPY - INCIDENT TO

Dear Sir/Madam:

I am very concerned over the recent proposal that would limit providers of "incident to" services in physician owned offices and clinics. If adopted, this would eliminate the ability of Certified Athletic Trainers, like myself, to provide these important services to our clinic clientele. In turn, it would reduce the quality of health care provided to Medicare patients and ultimately increase the costs associated with therapy services. By eliminating the physicians' and patients' choice of care and treatment, an undue burden would be placed on the currently stressed health care system, the patient, and the American tax payer.

During the decision making process please consider the following:

"X "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 extension to the physician's professional services. A physician has the right to delegate the care and treatment of his/her patients to trained individuals including but not limited to certified athletic trainers. This care will be provided by an individual whom the physician deems knowledgeable and qualified to administer treatment protocols. The physician's choice of trained and qualified therapy providers is inherent to the type of practice, medical subspecialty, and individual patient.

"X Because the physician accepts legal responsibility for the individual under his/her supervision Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or who is not qualified to provide care to their patients. It is imperative that physicians be allowed choose the avenues that best benefit their patients.

"X In many cases, the change to "incident to" reimbursement would render the physician unable to provide his/her patient with a comprehensive and time effective alternative to rehabilitation services. The patient would be forced to see the physician at one office and seek therapy treatments elsewhere. This can cause significant inconvenience and expense to the patient and their care givers.

"X 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 certified athletic trainers and other qualified health care professionals working "incident to" the physician, it is likely that the patient will suffer delays in health care. These delays would cause a decrease in the efficaciousness of local and immediate health care coverage thus leading to staggering increases in the number of medical complications that patients could suffer and an overall reduction in the patient's quality of life. Additionally one could only imagine the spike in extended hospital stays and the associated soaring costs to the insurance companies and the American tax payer.

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

"X Athletic trainers are highly educated. ALL certified or license athletic trainers must have a bachelor's or master's degree from an accredited college or university. Seventy (70) percent of all athletic trainers have a master's degree or higher and many hold dual credentials.

"X Athletic train

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am in support of CMS 42 CFR ?484.4, and strongly recommend the adoption of this rule. Physical Therapy services provided in a physician's office should be provided by a physical therapist that at a minimum has completed the same educational and license requirements as a physical therapist working in a non-physician owned setting. The level of care needs to be on the same level as in other settings to ensure patient safety and the appropriateness of the physical therapy services. My primary concern is for the patient and wise utilization of Medicare dollars.

My secondary concern is the misrepresentations of physical therapy services by someone with unequal or lessor training than myself. I have worked in the field of physical therapy for twenty-five years, and I am not about to let the physical therapy practice become known as some derivation of physical therapy that does not meet the same requirements of all licensed therapists.

Further,physical therapists and physical therapist assistants under the supervision of physical therapists are the only practitioners who have the education and training to furnish physical therapy services. Indeed, physical therapists are professionally educated at the college or university level in programs accredited by the Commission on Accreditation of Physical Therapy, an independent agency recognized by the U.S. Department of Education. As of January 2002, the minimum educational requirement to become a physical therapist is a post-baccalaureate degree from an accredited education program. All programs offer at least a master's degree, and the majority will offer the doctor of physical therapy (DPT)degree by 2005.

Respectfully submitted;
Craig Johnson PT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I oppose the implementation of Medicare provision that limits a patient's medically related care to Physical Therapists only. This provision denies the clients the ability, as mandated by a Physician referral, to utilize the benefits of Massage Therapy. All qualified health care providers should be allowed to provide services to patients with a physician's prescripton or under their supervidison.

Cordially,

Judith Dean, MEd., RN. NCTMB, CHt

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

As a person not yet on Medicare with known degenerative disease in both my hips and back I want to be able to continue to count on both massage therapy and chiropractic services in my later years. PT has never worked for me nor am I willing to be on medication or narcotics for the rest of my life.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I urge you not to pass this policy whereby a physician can only refer "incident to" services to physical therapists. All therapists should provide therapy services under and physicians supervision or with a prescription.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

see attached files

Attachment #2335

September 21, 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 Athletic Training Profession

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. This proposal should not be adopted because qualified health care professionals would no longer be able 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.
- 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.***
- 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.

- As a student of athletic training in a College of Health Sciences in an Academic Medical Center. My classmates and I are disappointed that CMS has taken such a myopic view of allied health professionals. I am confident and have data to support that we are competent allied health professionals who are experts in treatment and rehabilitation of the physically active. I am confident that your exclusion of athletic trainers as currently written in the proposal was an oversight. I am sure our legislative representative in Kentucky, particularly, Senator Jim Bunning would disagree with your stance. Senator Bunning was a professional athlete who was privy to the advantages and academic preparation and skills of a certified athletic trainer.

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,

Amelia R. Sesma, ATC
The University of Kentucky
Graduate Assistant Athletic Trainer
Men's and Women's Tennis
859-257-4222
Amelia@uky.edu

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Hi my name is Gregory Keith. I am an Athletic Training Student at Rowan University. I believe this proposal is limiting to my future profession and the jobs we are able to perform. There are many reasons why, but here are two of them. Physicians, not government workers, should decide what care and treatment are in the best interests of their patients, and who should provide it. Secondly, Athletic trainers' education and scope of practice ensure they are expert providers of outpatient therapy services. It is a function they perform many times each day. To say an athletic trainer cannot walk across the street from the collegiate athletic training room to the physician's office to administer the same therapy treatment to an older patient who has sprained an ankle jogging or walking the athletic trainer just provided to a track athlete just doesn't make sense. Athletic trainers are perfectly capable of handling outpatient therapy in most cases. This proposal will seriously limit the athletic training profession and needs to be rejected.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

REGARDING REDUCTION OF RVU FOR 36870 (percutaneous thrombectomy).

I am concerned and puzzled at the proposed decrease in the RVUs for non-facility thrombectomy of dialysis access. The decrease seems to be all from a decrease in the practice expense RVU, yet there has been no change in the way the procedure is performed or any decrease in the cost of supplies. In fact, under equipment I only see provision for an exam table. A flouroscopy machine is needed to perform these procedures and its cost is 100 times that of the table.

I am most concerned because I believe that a proposed 27% decrease in reimbursement for this code will change the care that many dialysis patients receive. Maintaining dialysis access is life sustaining for these patients. Having the procedures done in an outpatient setting greatly improves the quality of their life, but it may not be economically feasible with the proposed reduction in reimbursement. Patients can have emergent thrombectomy the same day and be back to their dialysis unit in a few hours then back home with their family later the same day when the procedure is performed in an outpatient facility specifically designed to care for dialysis patients. Often, when the procedure is performed in the hospital, the patient spends all day waiting for a procedure, then, it is too late to have dialysis in their outpatient dialysis unit so they are admitted to the hospital. This is very disruptive to their lives, not to mention the fact that it is much more expensive than having the procedure performed as an outpatient.

Again, I urge you to reconsider this drastic reduction in reimbursement for the code 36870. I cannot see that there has been any decrease in practice expense to justify the reduction and I am concerned that it will negatively impact the care of dialysis patients throughout the nation.

Thank you for your attention to this matter.

Terry Behrend MD
Balboa Nephrology Medical Group
San Diego, CA

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision. There are other valid therapies which are commonly more appropriate for patients and I fear seeing further limitation of patient advocacy and choice.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am opposed to restricting the use of any licensed therapist to just one specific therapist. I have used many different therapist over the course of needed therapy and have found that they all focus of different areas of the body to allow for greater healing and improvement overall. To restrict the use of these different types of therapy would hinder a patient ability to get the best overall care that is needed. It is also monopolizing therapy to allow only one specific type of therapist the ability to make a living and earn money for a skill that they all went to school to learn. There are many skilled individuals with many years of experience that have the desire to help people. To restrict their ability to earn a living while performing a service that they are very good at would be as ridiculous as allowing Bill Gates? Microsoft to be the only operating system allowed on computer.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Massage therapy is a viable health care and injury recovery modality. Qualified massage therapists work hand-in-hand with physical therapists and chiropractors and need the same considerations in receiving insurance reimbursement.

Thank you for your consideration in the matter.

Bob Lehnberg
411 Upper Creek Road
Bayside, CA 95524

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Please see attached file



**Department of Health and Human Services
Centers for Medicare and Medicaid Services (CMS)
Offices of Strategic Operations and Regulatory Affairs**

The attachment to this document is not provided because:

1. The document was improperly formatted.
2. The submitter intended to attach more than one document, but not all attachments were received.
3. The document received was a protected file and can not be released to the public.
4. The document is not available electronically at this time. If you like to view any of the documents that are not posted, please contact CMS at 1-800-743-3951 to schedule an appointment.

Submitter : Mrs. Louise capozzi Date & Time: 09/21/2004 05:09:03

Organization : Perfect Fit Inc.

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

I feel that Mastectomy products should be excluded from the face to face prescription requirement as effects of mastectomy are permanent & are nec. throughout the life of the recipient.It would cause undue hardship on all concerened if this new policy is implemented

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Mrs. Cindy Shields Date & Time: 09/21/2004 05:09:54

Organization : Mrs. Cindy Shields

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am opposing the position for having only pt to provide "incident to" care. I am a licensed massage therapist, I must have a license to practice my job, I am required to maintain continuing education units in order to renew my license. The state also requires that I pay a priveledge license fee. When I am compliant in all areas that are required of me, I am offended that there is a posting on the docket that would eliminate my profession to do the work that is critical for some people. I think that we should be given the priveledge to continue to do the work that we are licensed to perform.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Massage Therapy has been shown again and again in studies to be an effective treatment for many problems, from soft tissue injuries to any ailment aggravated by stress and anxiety. In many cases, because it is non-invasive and because there is a low cost per minute of time spent with the patient, it is a therapy of first choice. Physical Therapists are licensed to do hands-on work, but rarely are they extensively trained in nor do they use those manual techniques, relying instead on machines and exercises. The two therapies are complementary, and if you want results, both should be considered. There is now a national certification process to ensure basic levels of competency among massage therapists. Their efficacy has been proven over time as an integral part of healthcare systems in Canada and most if not all European countries. For more information on research, see "A Physician's Guide to Massage Therapy" by John Yates and check out the Touch Research Institute at the U. of Miami Medical School.

Submitter : Mrs. Tonya Parker Date & Time: 09/21/2004 05:09:08

Organization : National Athletic Trainer's Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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.

Submitter : Mrs. sara williamson Date & Time: 09/21/2004 05:09:57

Organization : national athletic trainers' assocaiation

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

As a certified athletic trainer, I am outraged by the proposition to mandate that only physical therapists be able to provide medical services under the care of a physician. Certified athletic trainers receive adequate education regarding human anatomy & physiology, as well as injury recognition, evaluation, treatment & management, and rehabilitation. In fact, as an approved clinical instructor at an undergraduate NATA approved curriculum, I have observed first-hand and received feedback that our athletic training students who go on to physical therapy school are well beyond the other physical therapy students in their knowledge base. I believe if this proposition were to go through, it would be detrimental for the health profession and community. Physical therapists currently assist patients in a clinical setting, whereas athletic trainers help the physically active population in various realms, including but not limited to, high school, collegiate, and professional athletes. This care can be provided in the traditional settings such as the high school or university or in non-traditional settings such as clinics, hospitals, or even the workplace. In fact, corporations have begun hiring certified athletic trainers to help with prevention/wellness programs and to decrease the time allotted for workman's compensation injuries. Studies have shown that bringing the certified athletic trainer into the workplace has significantly decreased the number of injuries incurred on the job as well as decreasing the number of days lost due to injury, consequently increasing company productivity. If this measure goes into effect, athletic trainers will no longer be employed in these settings which obviously will have a huge domino effect. It has been proven that certified athletic trainers save health care providers a significant amount of money by providing the services they are capable of doing. For these reasons, I hope you carefully consider the implications and ramifications that will occur if you pass this proposition.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

DO NOT Support or Pass this policy limiting access to quality natural healthcare services to only physical therapists. All qualified health care providers should be allowed to provide services to patients with a physician's Rx or under their supervision. Elderly people with limited income need to retain their power to choose less invasive, less costly, human touch healthcare when appropriate for their well-being. Let us keep the human touch in Medicare options.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

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.
- 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.
- 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.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I have been in the massage therapy profession for over 10 years. Many times during this tenure I have worked with clients that were not helped by physical therapists, but better helped through gentle soft tissue massage.

Because the States do not all have licensure for massage therapy the standards for qualified therapists are different from state to state. Instead of eliminating massage therapy from medicare please revisit the thought processes in regard to massage helping those that need massage therapy, which is often more helpful and less expensive than physical therapy. National Licensure of massage therapists may be a better way to evaluate which therapists are qualified to provide soft tissue massage.

I owned my own therapy center for 8 of the last 10 years, therefore, I feel that my comments are valuable for consideration.

Thanks Warreen Phillips MT, Esthetician

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

To: Center for Medicare & Medicaid Services (CMS)
Dept. of Health and Human Services
Attn: CMS-1429-P
P. O. Box 8012
Baltimore MD, 21244-8012

URL: www.cms.hhs.gov/regulations/ecomments

Dear CMS,

as a citizen of Santa Cruz county, California, I am greatly concerned by Center for Medicare & Medicaid Services (CMS) designation of Santa Cruz as a "rural" county for terms of medical reimbursement rates.

As you may know, most insurance companies use these designations to determine the reimbursements they pay to our hospitals and doctors. The median price of homes in our county is currently \$630,000.00 - hardly the price for a home you might find in more rural counties. Yet despite the high cost of living in this county, our hospitals and doctors are still reimbursed as if living expenses in this county were a fraction of what they are.

The net effect of our being designated as a "rural" county is that we are losing medical staff to bordering counties designated as "urban" (these counties can pay their doctors and hospitals higher amounts than we can in Santa Cruz county). And we can not recruit new doctors to move to our county because they can easily bypass Santa Cruz county and work in the San Jose area for much higher wages.

In addition to this, the trauma center that has traditionally served Santa Cruz and Monterey counties (the San Jose Medical clinic) has just decided to shut its doors on December 1, 2004. This leaves citizens of our county in grave danger should they incur trauma injuries. And because our county is incorrectly designated a "rural" county for medical reimbursements, there are no business incentives for new hospitals, trauma centers, or doctors to set up shop in Santa Cruz county.

Please act immediately to update our county's reimbursements status from "rural" to "urban" in order to deliver congress' promise to "fairly and equitably adjust physicians' payments based on local variations in the cost of delivering care.?"

Thank you,

Mary Yokum

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL



The Voice of All Kidney Patients

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William Owen, Jr., MD
Thomas Peters, MD
Jay Wish, MD

Kris Robinson
Executive Director

September 21, 2004

BY ELECTRONIC SUBMISSION

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Baltimore, MD 21244-8012

Subject: CMS-1429-P, Comments Regarding Proposed Rule, Revisions to Payment Policies Under the Physician Fee Schedule for CY 2005

Dear Dr. McClellan:

On behalf of the American Association of Kidney Patients (“AAKP”), I am writing to comment on the CY 2005 physician fee schedule proposed rule, published in the *Federal Register* on August 5, 2004.

About AAKP. By way of background, the American Association of Kidney Patients (AAKP) (www.aakp.org), founded in 1969, is the nation’s only kidney patient-led and managed education and advocacy organization for people with kidney disease. Each year AAKP serves over 12,000 members and, through its programs, over 200,000 Americans who have either lost kidney function (and live with dialysis or transplant) or have chronic kidney disease (CKD). The *average* life expectancy for individuals following initiation of dialysis therapy is short, less than 5 years. But AAKP’s membership includes many long-term dialysis survivors (in some cases exceeding 30 years), who live full and productive lives only by aggressive attention to their health care, a core mission of AAKP. Indeed, most kidney patients face not only the challenge of kidney disease, but other medical conditions as well, such as diabetes and hypertension.

General Principles. AAKP reviews proposed government policies with respect to several core principles: Will the proposed policy change improve access and quality to care, and does the proposed policy change respect the principle that *a physician and patient make a joint determination of the care plan best suited for that patient?*

Comments. AAKP submits the following comments and questions in response to the proposed rule:

American Association of Kidney Patients
3505 E. Frontage Rd., Suite 315, Tampa, FL 33607
800-749-2257 • 813-636-8100 • Fax 813-636-8122
<http://www.aakp.org> E-mail: info@aaqp.org

1. CODING—TELEHEALTH” (FR 47510)

As a result of the revisions to the monthly capitated payment (MCP) that became effective on January 1, 2004, does CMS have any data that indicate that either access to nephrologists or other practitioners by ESRD patients, or quality of medical care to ESRD patients, has been improved or impaired? Does CMS have any studies underway or planned to examine this issue? Does CMS believe there are shortages of nephrologists or other practitioners available to ESRD patients in rural or other “underserved” areas, or have underway any studies to examine this issue? If so, in addition to extending telehealth reimbursement, does CMS have any proposals under development to improve ESRD patient access to nephrologists and other practitioners in rural or other underserved areas?

Does CMS plan any evaluation of telehealth services to ESRD patients to determine best practices?

Lastly, will telehealth services be available to ESRD patients in non-rural areas?

2. CODING—VENOUS MAPPING FOR HEMODIALYSIS (FR 47511)

AAKP has two questions about venous mapping. First, CMS only permits the operating surgeon to bill for venous mapping, and payment is only made with placement of an AV fistula. Why doesn't CMS provide reimbursement to non-surgical specialties for mapping, such as interventional nephrologists and radiologists, who are increasingly providing this service? And why does CMS only pay for venous mapping an AV fistula is placed, and not for other indications?

3. SECTION 623 (FR 47525)

Section 623 of the Medicare Modernization includes a provision to add-on to the composite rate for the difference between current payments for separately billable drugs and biologicals and payments based on the revised drug pricing methodology using acquisition costs. CMS has previously opined that the current payment policy creates financial incentives for use of separately billable drugs and biologicals. With the removal of these alleged incentives, does CMS intend to monitor or publish new clinical guidelines or indicators to ensure dialysis patients receive proper administration of separately billable drugs and biologicals?

Lastly, does CMS have longer term plans to revise payment for dialysis treatment and ancillary services?

CMS's analysis of the budgetary impact on the Medicare program of the proposed section 623 changes (see FR 47569) generally indicates an “overall” neutral or modest reimbursement increase for all types of dialysis facilities (independent/hospital, for profit/non-profit, urban/rural). However, does CMS have data which indicate the number of dialysis facilities which are operating at a loss in the United States, by corresponding facility characteristics?

AAKP appreciates the hard work of CMS personnel involved in improving the lives of kidney patients. If you require further information regarding this letter, please contact Kris Robinson, AAKP's Executive Director, at (800) 749-2257.

Thank you in advance for considering AAKP's comments.
Sincerely,

A handwritten signature in cursive script that reads "Brenda Dyson". The signature is written in black ink on a white background.

Brenda Dyson
President

cc: Brady Augustine
Barry Straub, M.D.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am opposed to limiting health care to physical therapist and/or chiropractors. As a massage therapist,I have done a lot of massage on elderly and some on persons of sever handicap, with remarkable results to their physical improvment and especially their mental emotional well-being. I have had two years of intensive training, and am certified in craniosacral and myofascial release therapies. Our services as massage therapist are just as extensive as chiropractors.

Please don't eliminate us from medicare payments.

THERAPY STANDARDS AND REQUIREMENTS

Massage therapist who are Nationally certified by the NCTMB should be able to receive reimbursement for massage or bodywork, since we do similar work of a physical therapist or chiropractor.

THERAPY TECHNICAL REVISIONS

Include massage therapist, as qualified therapist to receive medicare and medicaid reimbursement.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please allow Massage Therapy to be covered through Medicare and all facilities or offices (Hospitals, Dr. offices, or Chiropractors).

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To Whom It May Concern:

I am responding to the Center of Medicare and Medicaid services (CMS), APTA action alert with a comment on the of about physical therapy services being practiced in a physician's office by unqualified personnel. This practice affects me in many different ways, because I am an athletic training student planning to go on to physical therapy school after I graduate from athletic training. I have also had first hand experience in dealing with this situation, because I am also a physical therapy aide at a local hospital. There is a closely related subject that affects me especially deeply. It is that of unqualified personnel using physical therapy for billing orders. This is a touchy subject for both the physical therapist and the athletic trainer. They both feel that they can provide excellent care to the patient. However, the care they are entitled to provide really depends on the setting which they practice in, and the nature of the care they are understood of providing. This is a very difficult topic for me, the student athletic trainer and the future physical therapist, to pick a side to support. As I think about the fields of athletic training and physical therapy, they are both similar, but they also have their differences. The main difference between the athletic trainers and the physical therapists are the patient populations that they work with.

I can comment on these differences from the basis of my clinical experience in the athletic training room, and from my physical therapy setting in the hospital. From these perspectives, I get to see that the patient populations the athletic trainer works with are extremely different from what patient a physical therapist sees everyday. The education of an athletic trainer is geared more towards dealing with highly active populations; whereas the physical therapist's educational training is more targeted toward the public health issues. The athletic trainer and the physical therapist are both highly educated and trained professionals, who are capable of providing prevention of injury and rehabilitation services to their respective patient populations.

But, that is where the chief complaint and dilemma comes from. Is the athletic trainer sufficiently educated in dealing with the general population of medical problems? To provide physical therapy to the general population. Yes, the athletic trainer is educated in dealing with sport medicine-related injuries, and with neurological injuries that are sport related. But I do not believe that the athletic trainer has enough training to be able to prescribe rehabilitation programs to a patient who is dealing with Parkinson's syndrome or to a patient who has just had a stroke. A physical therapist on the other hand has received more in -depth training and education in these types of disorders. So to ensure that the patients are getting the best possible rehabilitation services, only the physical therapy and physical therapy assistant should be able to use the physical therapy billing codes. The physical therapists have spent countless hours training to become physical therapists, and they deserve to have their own separate billing codes, which only licensed physical therapists, can use.

In defense of the athletic training field, I do strongly believe that the athletic trainer can work in an orthopedic physical therapy clinic and in sport medicine clinics. The athletic trainer can provide excellent rehabilitation services to the active fraction of the general population. I feel that within the allied health profession, the athletic trainers should have their own billing codes that only they can use. This should help clear up any problems that the physical therapists have with the athletic trainers using their physical therapy billing codes. Because when it comes down to it, it is all about providing the best possible treatment for the patients.

Sincerely, Mike Moschella

ATS at Sacred Heart University

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I respectfully request that you do NOT pass this initiative that would allow physicians to prescribe "incident to" services performed by physical therapists only. EVERY qualified health professional deserves the opportunity to provide services to patients with a physician's order or under supervision. Patients, in conjunction with the advise of their physician, should have the right to choose services that are available from many health care disciplines.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THErapy - INCIDENT TO

I am a physical therapist with 20 years experience. I own a private practice in California and I strongly support the proposal that persons providing PT services incident to a physician meet the same qualifications that the individual states require for licensing for my practice. P.T.s are professionally educated at accredited university programs, licensed in their state and receive significant training in all areas of practice. Physical Therapists obtain continuing education in their specialty fields to keep abreast with up to date medical and rehabilitative advances. This background and training enables P.Ts to obtain positive outcomes for individuals and is significantly valuable in treating Medicare beneficiaries. Delivery of these services by unqualified personnel is harmful to the patient as they do not know up to date treatments, understand the physiological consequences of treatment, have expertise in outcomes or the background to truly affect significant change in motor and sensory function. If financial limitation of services becomes effective 1/1/06, patients requiring highly skilled evaluation and treatment may never receive services from a licensed physical therapist and exceed his/her cap. This would negatively affect outcomes as patients who require necessary (and not financially motivated) referrals to licensed therapists could be blocked from this expertise and not attain appropriate professionally formulated treatment plans and services.

Physical Therapy is a health profession. It is not just a job, or a few procedures learned on the job by an M.D. Those who undergo years of study, sit for state exams in licensure and continually upgrade their skills through continuing education are the only people qualified to evaluate and determine an appropriate treatment plan for physical therapy services.

Thank you for your consideration of my comments.

Sincerely,

Karen Nugent, PT, CHT

President, Hand & Physical Therapy Center of Marin, PT PC

5 Bon Air Road, Suite A105

Larkspur, CA 94939

handtherapy@earthlink.net

415-927-2007

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I want to express my strong disagreement with continuing to pay the doctors in Santa Cruz County far less than the doctors in Santa Clara County. Statistics show that the cost of living in Santa Cruz County is as much or more than it is in Santa Clara County. Santa Cruz County should no longer be considered a rural county. It has changed dramatically in the numbers of people and developments since it was categorized as rural. The huge discrepancy between payments to doctors in Santa Cruz and Santa Clara counties is causing many good doctors in Santa Cruz to re-locate and many more to choose not to locate here. The result is that there are fewer and fewer doctors available. It is very unfair and irresponsible to continue to underpay the doctors in Santa Cruz County, and I sincerely hope that you will take this opportunity to rectify the situation. Thank you.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

To whom this may concern:

I do not believe that it is lawfully correct for physicians to bill Medicare for practicing Physical Therapy. To begin a Physical Therapist or a Physical Therapist Assistant goes to school and is educated on how to practice Physical Therapy they obtain a degree. The PT or PTA has a degree to practice PT. Physical Therapy is not training an individual; everyone cannot just be trained in PT. A person has to go to school obtain a degree then take a test to be able to practice PT to actually have a treatment with a patient. I do not think it is fair for a patient to have a treatment done on them (Physical Therapy Treatment) when the person doing the treatment does not have the degree as a PT, and it is not fair to bill for the treatment. Given an example:

I am a Physical Therapist with a degree. I went to a college that offered the PT program; my instructors educated me on PT work. I graduated and now I have my own business. I treat any patient that wants to come to my office. If the patient is sick I give them medicine. I diagnose the patient, as what I think may be wrong with them. Is this correct am I as a PT allowed to diagnose a patient? Did I go to school to be a doctor? Did I get the proper education in Physical Therapy school to be a doctor? No I didn't therefore a doctor or anyone trained for Physical Therapy is not capable for giving a proper treatment to a patient that needs Physical Therapy!

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 17, 2004

Mark B. McClellan, MD, PhD
Administrator for CMS
U.S. Dept of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Regarding: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005, specifically, the topic of "Physical Therapy-Incident to"

Dear Sir:

I write to you today, in adamant support of the current version of the proposed CMS policy regarding physical therapy services being provided by qualified individuals, as defined in 42 CFR SS484.4, when provided in an outpatient physician's office. My name is George Wolff, MPT, and I have been a licensed physical therapist for 16 years.

Requiring that outpatient physical therapy services be provided by educated and trained physical therapists helps to ensure that patients are receiving the correct and most efficacious care, minimizing negative results, and improving cost effectiveness and positive outcomes. Minimal education requirements for a physical therapist are at the post baccalaureate level by nationally accredited universities, and the majority of schools will offer the DPT by 2005. The curriculum includes intensive studies in anatomy, physiology, kinesiology, physical medicine modalities and procedures, and other medically related topics which unequivocally qualify the physical therapist as the provider of choice of physical medicine modalities and procedures collectively known as physical therapy. In addition, research generated by physical therapists adds to the body of knowledge which forms utilization and treatment guidelines-who better to provide care?

To have physical therapy services provided by unqualified personnel other than a physical therapist or physical therapist assistant under the supervision of a physical therapist is wasteful at the very least and may be dangerous to the patient. Unrecognized adverse reactions to treatment by unqualified personnel can result in thermal burns, soft tissue injuries, fractures, or cardio-vascular crisis with more tragic consequences. Unqualified providers blindly rendering ineffective care can and do result in higher costs which, if the therapy cap resumes, may ultimately deplete the patient's ability to obtain qualified, efficacious care to assume an independent and healthful lifestyle. It would seem that the only purpose in the utilization of unqualified personnel is merely to thwart the Sark reforms and increase bottom line revenues.

Treatment provided by the physical therapist is rendered only after a thorough evaluation, is founded on evidence based scientific knowledge, and is constantly monitored and modified according to the pathological condition and patient response. The value of services is increased for patient and payer, and the return on investment becomes immediately apparent.

Please note that none of my income is derived from this patient population, as I treat industrial injuries, but as a taxpayer who looks at my W2 deductions for "Medicare Tax", I want to know that I am not having my tax dollars wasted. When the time comes for me to rely upon Medicare, I can only hope that my care is provided by the most qualified professional. Professionally and ethically, I am also moved to voice my opinion on this topic for the same reasons...fiscal responsibility in providing the most cost effective and efficacious care to patients who require it to remain independent and valuable members of society. It leads to the same conclusion--physical therapy provided by a qualified physical therapist.

The efforts of the CMS to provide cost effective, safe, and efficacious medical care for the aging population of today and the future is to be lauded, and the proposed requirement that physical therapy services "incident to" be provided by qualified physical therapists is a significant and critical

step in that direction.

Thank you for your consideration.

George P Wolff, PT



Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

MASTECTOMY PRODUCTS SHOULD BE EXCLUDED FROM THE FACE TO FACE PRESCRIPTOIN REQUIREMENTS.THESE PRODUCTS ARE NECESSARY THROUGHOUT THE LIFE OF THE MASTECTOMY PATIENT. SHE WILL NOT GROW ANOTHER BREAST! AND IF AT SOME POINT SHE OPTS FOR RECONSTRUCTION SHE WILL NO LONGER NEED THE PROSTHESIS. THIS ADDITIONAL REQUIREMENT WOULD BE UNNECESSARY AND COSTLY FOR THE PATIENT, THE DOCTOR AND MEDICARE.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

As a physical therapy educator, I am very aware of the educational background and qualifications required to become a physical therapist. I would urge CMS to adopt rules that safeguard the patient by allowing only qualified personnel to provide physical therapy services in physician's offices or any other setting. The educational background of a physical therapist generally includes 3 full years of graduate work past the bachelor's degree. Extensive background in anatomy, physiology, and tissue response to disease or injury in addition to the knowledge of the appropriate examination and interventions available are essential in providing quality care. The profession is moving toward evidence-based practice which is important in providing cost-effective care.

It is a disservice to patients to pay for "physical therapy" services provided by unqualified personnel. Physical Therapy management of a patient requires ongoing assessment and revision of the intervention based on the patient response. An individual without the educational background of a physical therapist does not have the skill to do this.

In my own experience I have seen individuals with only on the job training provide "physical therapy" services in physician's offices. These services were generally modalities or physical agents such as heat treatment which made the patient feel better for a short period of time but should be used as an adjunct to other therapy. Patients also need to learn how to prevent further injury and regain maximum function. The knowledge required to teach this to the patient is gained throughout the physical therapy education and cannot be adequately taught on the job.

Again I urge you to require that provision of physical therapy services "incident to" a physician should meet the qualifications of a physical therapist.

Submitter : Mrs. Debora Clemans Date & Time: 09/21/2004 06:09:41

Organization : AMTA

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am opposed to this program. I am a massage practitioner and want to see Medicare clients be able to receive massage treatment with the practitioner of their choice.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1429-P; Sections 303 and 623
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005:

Attachment #2364



Bone Care Center 1600 Aspen Commons Middleton, WI 53562 Phone: (608) 662-7800 Fax: (608) 662-0032

September 21, 2004

Dr. Mark McClellan
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1429-P
PO Box 8012
Baltimore, MD 21244-8012

**Re: CMS-1429-P; Sections 303 and 623
Medicare Program; Revisions to Payment Policies Under the
Physician Fee Schedule for Calendar Year 2005:**

Dear Dr. McClellan:

Bone Care International (“BCI”) is pleased to provide comments with regard to the proposed rule CMS-1429-P, “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005” 69 F.R. 47488 (August 5, 2004) (hereinafter “Proposed Rule”). BCI will be commenting on the provisions of the Proposed Rule designed to implement Section 623 of the MMA, and Section 303 of the MMA which is related thereto. BCI is a specialty pharmaceutical company dedicated to improving patient outcomes by delivering unsurpassed Vitamin D hormone therapies to patients with chronic kidney disease.

BCI commends the Centers for Medicare & Medicaid Services (“CMS”) for its on-going work to improve and clarify the Medicare reimbursement policies affecting the reimbursement of separately billable drugs and biologicals used to treat end stage renal disease (“ESRD”). We support the goal of the Medicare Prescription Drug, Improvement and Modernization Act (“MMA”) of 2003 to pay for these items in a manner that is fair to the Medicare program and its beneficiaries, as well as to ESRD facilities and the manufacturers of innovative drugs and biologicals, while promoting quality of care for ESRD patients.

We know that CMS faces a very substantial implementation challenge, and we would like to assist CMS in this important process. We hope that the comments that we offer in this letter will contribute to the implementation process, as the decisions that CMS makes in the implementation effort are critically important to ensuring appropriate access to high quality ESRD services and items, including separately billable ESRD drugs and biologicals, and promoting cost savings for the Medicare program.

BCI does have several suggestions that will, in our view, make the implementation of the separately billable drug and biological provisions of Sections 303 and 623 of the MMA more consistent with the Congressional intent. Specifically, BCI believes that CMS should (1) provide some mechanism which will allow price increases to be realized into the “acquisition cost” reimbursement methodology in less than 2 quarters, (2) maintain quality of patient care by providing the add-on to those facilities that actually use separately reimbursable ESRD drugs, (3) provide the ESRD community with additional information regarding the data CMS used to calculate its proposed add-on payment to the composite rate and (4) refine the rate of annual increase in Average Wholesale Prices (“AWPs”) used to calculate the composite rate “add-on”.

Our support of the MMA is very much in keeping with our historical approach to pricing issues. We have always priced our product substantially lower than the average price at which branded Vitamin D products are available in the United States market. As the Office of the Inspector General (“OIG”) report confirms, the alternate branded Vitamin D competitor (which accounts for approximately seventy-five percent of the relevant market) has an ASP that is almost *twice* the price at which we currently offer our product. Medicare vitamin D costs could be reduced by approximately *two billion dollars* from 2004 to 2008 with a reversal of relevant vitamin D product market shares, or if the competitor price was similar to the price we offer providers.

Our support of the MMA is also a consequence of our desire to assist CMS and Congress in making drugs and biologicals available on a more affordable basis while enhancing patient quality of care. We take seriously the need to respond to the public’s request that the manufacturers of drugs and biologicals find ways to provide affordable therapies which enhance quality of care and cost savings. Having stated this, the current proposal does not distinguish between an affordable agent that is clinically comparable to more affordable agents in a similar therapeutic class.

1. Sections 303 and 623 of the MMA - CMS Should Permit a Mechanism for Reasonable Price Increases to Be Realized More Quickly into ASP.

The OIG Report on “Medicare Reimbursement for Existing End-Stage Renal Disease Drugs” issued in May, 2004, expressly states: “In calculating future growth rates, we looked exclusively at past monthly growth rates for the reimbursement for separately billable drugs. We did not account for the potential effects of future changes.... Therefore, we would like to stress that CMS should update our projections as new reimbursement data become available.”

The CMS proposed rule relating to separately billed drugs, 42 CFR § 414.904(f), (which forms the basis for the spread that is incorporated into the composite rate drug add-on), proposes that the payment limits be updated quarterly. However, this will build in a two quarter lag in updating prices.

There will, of course, likely be price increases during the course of 2005. The proposed quarterly update will base ASP for a quarter on the ASP reported two quarters before. For ESRD facilities, this lag in incorporating acquisition price increases raises the very real risk that most

ESRD facilities will be “under water”—and seriously “under water” at that—when they attempt to purchase ESRD drugs and biologicals for required utilization to ensure quality of care for ESRD patients. The fact that the OIG has already determined that all but the four largest chains actually acquire their product at ASP *plus* four percent underscores the risk here.

The means of addressing this problem is challenging to identify. However, it is of great importance for all vested parties and we would welcome CMS’s and other interested parties’ thoughts on this important topic. Our recommendation is to provide a retrospective payment process that will keep providers whole and is consistent with CMS system capabilities.

2. Section 623 of the MMA - CMS Should Apply its Drug Add-on to Those ESRD Facilities that Use Separately Reimbursable Drugs for Their Patients.

In order to preserve high quality care to ESRD patients and prevent cost shifting behavior, CMS should condition the receipt of the composite rate add-on payment to a facility’s provision of a full range of separately reimbursable drugs and biologicals to the relevant patient. A variety of policy reasons underscore the need to proceed in this fashion.

We have two concerns if CMS were to provide the add-on without regard to what separately reimbursable drugs and biologicals are used by a dialysis facility. First, some facilities may be tempted to not provide medically necessary drugs and biologicals because they will receive the add-on payment regardless of whether they use the necessary drugs or biologicals. In other words, there will be no financial incentive to provide necessary care and, in many cases, a financial disincentive as the result of a negative ASP to AAC spread. A reduction in drug utilization would have a negative impact on overall patient quality of care, a result which is contrary to the legislative intent of the MMA.

Second, we are concerned that, as Part D covered alternatives to separately reimbursable Part B drugs and biologicals become available (as in the case of the oral version of Hecitorol), facilities will receive the add-on payment to the composite rate, but move the payment for their drugs and biologicals to Part D. It is our position that utilization of injectable drugs and biologicals (vs. oral) enhances patient compliance and clinical outcomes.

We understand that the demonstration project required by MMA 623(e), which is designed to study bundling of all drug payments into the ESRD rate, would - if implemented for all ESRD facilities - potentially address this problem. However, the demonstration project only covers some facilities, and is designed to take place over a three year period. We also acknowledge that CMS is required by MMA 623(f) to submit a report to Congress by October 1, 2005, on the design and implementation of a bundled ESRD composite rate prospective payment system. The question is what steps can and should be taken in the interim, before such a system is implemented.

Significantly, CMS has already acknowledged that it has the authority, under the MMA, to apply the composite rate add-on to some subset of all ESRD facilities. We believe that our proposal (to condition the receipt of the composite rate add-on payment to a facility’s provision of a full

range of separately reimbursable drugs and biologicals) is the most appropriate one for CMS to adopt.

3. Section 623 of the MMA - CMS Should Provide the ESRD Community Additional Information Regarding the Data Used to Calculate Its Proposed Adjustment to the ESRD Composite Rate for a Drug Add-On.

We also have concerns about the data that CMS proposes to use to calculate the adjustment to the ESRD composite rate for the drug add-on. Beginning with 2004 AWP, at the current reimbursement rate of 95 percent of AWP, CMS suggests that it should add three percent to those AWP based on “historical trends of AWP” to update its calculation to 2005. *See* 69 F.R. at 47528.

The basis for this three percent figure is not explained in the preamble to the proposed rule, although it appears to be a number derived from the AWP for *all* drugs, as opposed to using the AWP for just ESRD separately billable drugs and biologicals. The source for this 3% figure is not provided. Nor is the time frame used to establish the “historical trend” discussed. Accordingly, we and other interested parties are left unable to provide meaningful comments on this CMS proposal.

Having shared this concern, we wish to commend CMS for not using the 2003 Single Drug Pricer file in setting the base 2004 reimbursement. We are pleased that CMS has selected the more recent and, therefore, more relevant prices from the 2004 file.

We recommend that CMS create an update factor utilizing current data that is specific to drugs used during dialysis.

4. Section 623 of the MMA - CMS Should Modify its Proposed Methodology for the Calculation of the Composite Rate Drug Add-on by Employing a More Appropriate Update Factor to AWP Pricing.

Section 623(d) of the MMA, which added §1881(b)(12)(B) and (C) of the Social Security Act, expressly requires CMS to compute the drug add-on to the ESRD composite rate for 2005 by “adjusting” the spread “to 2005” using a means determined to be “appropriate.” *See* §1881(b)(12)(B)(ii). We do not believe it is appropriate for CMS to use a three percent update figure that appears to be based on a “historical trend” for all drugs. This seems particularly clear where, as here, the historical trend for ESRD separately billable drugs and biologicals is in excess of the three percent figure proposed by CMS.

It is our concern that the 11.3% add-on percentage for providers may not be adequate to keep them whole as stated in the MMA. An inadequate add-on may have an effect on quality outcomes and the level of patient care currently being provided. Consideration of an upward adjustment to the add-on is recommended.

We thank CMS, again, for its continued and impressive effort to fully and thoughtfully implement the many changes required by the MMA.

Sincerely,

A handwritten signature in cursive script, reading "Paul L. Berns", followed by a vertical line.

Paul L. Berns
President and CEO
Bone Care International

cc: Mr. Herb Kuhn, CMS
Ms. Mary Kay Mantho, HHS
Mr. Brady Augustine, CMS

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THErapy - INCIDENT TO

Utilizing other than appropriately trained individuals (licensed physical therapists and assistants under the supervision of a physical therapist) will result in mediocre care for Medicare patients. I own a physician practice management company as well as being a practicing licensed physical therapist in Oklahoma. I have had numerous opportunities to witness substandard patient care because physicians would utilize non-trained help to treat patients. Their interest in these circumstances is the cost of staff. The lower the cost of staff, the more likely the physician is to utilize ancillary services. If PT is not mandated to be provided by licensed PT's or PTA's under their supervision, physicians will start referring therapy to their in-house staff, who will be trained by unqualified persons, supervised by unqualified persons and who will treat Medicare patients as unqualified staff.

Additional concerns are also:

1. Those physician owned therapy clinics will continue to reduce the qualifications of their staff.
2. More patients will be treated per day with lowly paid unqualified staff under the direction of the physician because they will see it as a revenue source.
3. The use of palliative modalities will take the place of treatment based therapeutic exercise programs that can take the patient from dependent to independent. Palliative modalities can be performed by any technician with a limited educational program rather than utilizing a highly trained skilled PT.

The result of non licensed personnel in a physicians office will be reduced quality of care, reduced excellence of outcomes, continued blaming of PT as a profession for substandard care, increased litigation from poor outcomes and substandard care, and eventually the abandonment of physical therapy from the Medicare program due to substandard care. All of this will come from the non-utilization of appropriately trained therapists who believe that strong education requirements protect Medicare patients.

Finally, the concept that therapy as incident to somehow assures the physician will supervise the staff treating the Medicare patient is fallacious. The physician will be treating patients himself, and as he sees revenue increasing from therapy treatments, he will further distance himself from the therapy space as he tries to maximize space. This will further inhibit patient outcomes, lead to greater malpractice risk, and assure the Medicare patient will be limited in the choices they make for their own care.

In conclusion, please require that Physical Therapy incident to a physician's care, be provided by a Licensed Physical Therapist, a graduate from an accredited institution educating physical therapists, and one who is licensed by the state in which they work. Thank you.

Michael Strakal PT - Oklahoma

Submitter : Mrs. Sofija Seymour Date & Time: 09/21/2004 06:09:51

Organization : Hand & UE Center of NE Wisconsin

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I am a physical therapist licensed in the state of Wisconsin. I graduated 5 years ago from Marquette University with a Master's of Physical Therapy (a program accredited by APTA). This was a six year program. I continue to take annual continuing education courses and attempt to stay abreast of the most recent research so that I may provide patients with the most optimal care. I feel it is inherent that physical therapy services be provided by a licensed PT and/or PTA to ensure that patients are receiving the most appropriate care for their rehabilitation. The amount of schooling we receive is one indication of the extensive knowledge base that is needed to perform PT services to the appropriate patient at the appropriate time. I do not feel that other professionals (ie: ATC, massage therapist) are taught the necessary evaluation skills to provide physical therapy services. Each of these professions have services which they can provide in the appropriate environment, but they are not skilled physical therapy services, are not provided by a licensed physical therapist, and therefore should not be coded as physical therapy services.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 20, 2004

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

Re: Therapy ? Incident to

Dear Sir/ Madam;

As you know, CMS has proposed changing the ?Therapy-Incident to? rules as they relate to the delivery of therapy services. I write to you voicing my concerns on this issue. If adopted, these changes would greatly narrow the ability of qualified health care professionals to provide rehabilitation services. It would reduce the quality of health care for Medicare patients and in effect authorize a monopoly where only one group of individuals could provide these services. This would ultimately increase costs and diminish a patient?s right of choice in determining their health care providers. It would particularly impact patients in rural settings where there are no practitioners who meet the qualifications under this proposed change and, in effect, deny them care.

Since 1965 ?incident to? has been utilized by physicians to allow them to direct therapy services to qualified health care practitioners such as Certified Athletic Trainers. There has never been a problem with this in the past and there is no problem that warrants a change to this program now. Certified Athletic Trainers are highly educated and credentialed health care professional?s that work on a daily basis with active individuals that include the elderly and those who qualify for Medicare. They are present at Senior Olympic Games and sporting events throughout the country. They are NOT ?personal trainers? but rather educated professionals recognized by the American Medical Association as qualified health care practitioners.

In proposing this change, CMS appears to be bowing to the interests of a single profession seeking to establish themselves as the sole provider of therapy services and that profession has complete authorship in this area of rehabilitative services. This is not right. It is not necessary for CMS to institute these proposed changes as it does nothing to benefit Medicare beneficiaries but rather deters their access to health care. Please do the right thing and reject #CMS-1429-P. Thank you.

Sincerely,

Mike Fine, ATC
901 12th Ave
PO Box 222000
Seattle, WA 98122

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am opposed to this change. It is known that physical therapist do not do Manual or MFR for patients that need the therapy because it is not cost effective. Physical Therapist try to help patient thru exercise and stretching in alot of cases this alone does not work. MFR Myofascial Release and other Soft tissue technics (which PT's aren't thought are Essential in a patients recovery. That is why Pysicians are having it performed in-office. it is Cost effective and greatly benifits the patient. The American Medical Association is in the process of discussions on modifying Manual therapy CPT codes for Massage Therapist that are Qualified and Experienced in Medical application of massage therapy. We can not make patients wait until they are in a Pain Management Program before they receive true Soft tissue therapy.

Thank you

Marvin Joiner BS,RMT,MMP

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

OTHER - INCIDENT TO

I am a board Certified Primary Care physician with a Certificate of Added Qualification (CAQ) in Sports Medicine. My daily practice involves treating post-operative orthopedic patients and recreational senior athletes. I provide hands on rehabilitation services with the assistance of licensed Physical Therapy Assistants. I have also employed exercise physiologists, athletic trainers, and physical therapists. Based on my ten years of experience it is not appropriate to limit the providers of 'incident to' services in my office. Over ten years I have worked with a dozen physical therapists. Some are good, some are not. Some have not offered any services that were not adequately and professionally provided by physical therapy assistants under my direct supervision. I see this proposed change as a way of physical therapists trying to monopolize the market. While they are lobbying for this change they also are lobbying for direct access. Additionally, the Florida physical therapy organization (FAPTA) EXPLICITLY tells their members NOT to work for a physician! Obviously, they are trying to legally corner the market. They have no independent, third party conducted research to prove that this provides a clinically superior and cost saving benefit. My experience shows just the opposite. The physical therapy centers in my neighborhood have one licensed physical therapist and 5-7 technicians. The therapist does the notes while the technicians do all the work. They are given production goals based on modalities not outcomes. The system has been based on the physicians being responsible for the diagnosis and treatment of the patient. Physicians must have the ability to directly provide 'incident to' services and choose the most appropriated practitioner for that situation. This will improve access and control costs. For two years I have been attempting to hire a physical therapist. They are in limited supply and have unrealistic expectations. As I stated earlier, the Florida division of the APTA doesn't want PT's working for physicians and prevents advertisements for PT's in their publication if the clinic is owned by a physician. Limiting 'Incident to' services to only PTs would restrict care in my geographic area and be a hardship to my patients. Please do not change the present 'Incident to' program. There is no clinical justification for limiting these services to only physical therapists. Sincerely, Barry S. Garcia, D.O.,FAOASM

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Re: Therapy ? Incident To

Dear Sir/Madam:

I do not believe that it is in the best interest of the patients and health care providers to restrict therapy services to a few select groups.

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.

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.

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 unjustified.

Certified Athletic Trainers are just as competent and qualified to treat injuries that occur from physical activity as any other healthcare profession. All ATC's have a bachelor's degree, and many hold master's degrees and have years of clinical experience. With a concentrated scope of practice, our professional preparation actually gives us a specialization in working with patients, as well as a unique approach in our treatment methods.

This proposal can be, and is seen by some as an attempt to give exclusive provisions under the Medicare rules. This is not good.

Please accept these comments in opposition to the CMS proposal. The changes will have a negative impact on the healthcare community.

Sincerely,

John Lowry MS, ATC, CSCS
Saginaw Valley State University
7400 Bay Road
University Center, MI 48710
(989) 964-7319
jlowry@svsu.edu

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

OTHER - INCIDENT TO

Since 1965 physicians have had the right to delegate the care of their patients to trained individuals whom they deem knowledgeable and trained in the protocols to be administered, based on their type of practice and medical sub-specialties, plus the individual needs of the patients. What has changed? Physicians are still responsible for the care of their patients and their outcomes.

When there is a documented national shortage of credentialed allied and other health care professionals available to provide care to Medicare patients why would Medicare further limit physician and patient options when choosing professional that are qualify to provide that care. The senior population in this country is at an all time high and continuing to grow. This trend is not going to go away but is forecast to remain steadily growing for many years to come. With the dramatic increase of injuries men and women 65+ today are experiencing, thanks to being more physically active than ever before, many physicians have been recruiting Certified Athletic Trainers (ATCs) to provide injury assessment and rehabilitation to their patients. ATCs are highly-skilled health care professionals trained to prevent, evaluate, manage and rehabilitate injuries sustained by athletes and active individuals of all ages. Almost every American professional and college sports team, and one third of all high schools, have ATCs on staff.

ATCs have a bachelors degree and over seventy percent have a master's degree or higher, which is comparable to physical therapists, occupational therapists, nurse practitioners, physician assistants, speech therapists and similar mid-level health care practitioners. If ATCs are qualified to prevent, evaluate, manage and rehabilitate injuries for the top athletes in this country, including many who competed at the Summer Olympics in Athens, then they are qualified to prevent, evaluate, manage, and rehabilitate injuries for Medicare beneficiaries.

These individuals have worked hard to distinguish themselves as health care professionals in the field of body mechanics and therapy services. Limiting their ability to provide that care in a multitude of settings, whether it is immediate care on the sport playing field, urgent care at the hospital emergency room or primary care clinic, or on-going therapy at the physician's office, is a disservice to those covered under Medicare. Especially when the number of those needing the services has expanded and those qualified are in such short supply and high demand.

The most costly toll of this restrictive policy will be further physicians turning away Medicare patients because of the restrictions in their care. This happens all too often now, don't further exacerbate the problem ? let the physicians decide what is best for their patients not the bureaucrats.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please regard the following attachment regarding the 'Therapy-Incident To' proposal.

Thank you for your consideration,
Patricia M. Hill, MA, SPT

CMS-1429-P-2372-Attach-1.doc

Attachment # 2372
September 19, 2004

Patricia M. Hill, MA, SPT
8002 Willet Trail
Austin, Texas 78745

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

RE: Medicare Program; Revisions to Payment Policies Under the Physician
Fee Schedule for Calendar Year 2005

To Whom It May Concern:

I am a second year physical therapy student at Texas State University in San Marcos, Texas. As I approach the time to enter the healthcare field as a practicing physical therapist, I feel the need to comment to the Centers for Medicare and Medicaid Services (CMS), regarding the proposed rule for "Therapy-Incident To" care as it is provided in physician's offices.

I am in strong support of the proposal which would require that outpatient services that are billed as "physical therapy" services be provided by a licensed physical therapist or physical therapy assistant under the direct supervision of a licensed physical therapist. The establishment of standards for the care that is provided to patients while in a physician's office is crucial to the overall health, well-being, and recovery of these persons. Such standards may only be achieved if the provider of these services is required to attain licensure through completion of an accredited professional physical therapist program.

While the state of Texas requires that all physical therapy services rendered to a patient be supervised by physician referral and approval, the final responsibility for the well-being of each patient falls on the professional liability of the practicing physical therapist. Because of this responsibility, physical therapists are required to know much more than the simple mechanics of performing rehabilitative services. As documented by the Physical Therapy Practice Act of the American Physical Therapy Association, physical therapy technicians are allowed to perform only the simplest tasks of setting up and taking down exercise equipment for patients, and at no time, are they allowed to prescribe, alter, or independently perform rehabilitative services on patients. The reason for this restriction is to insure that each patient is treated by a trained professional both

to minimize any risk, and to maximize the benefit to that patient. Why should we expect anything less of outpatient services provided in a physician's office?

While physical therapists do undergo extensive training in the biomechanics and physiology of the musculoskeletal system, we are also trained in the recognition of all forms of systemic disease processes, and are constantly on the look-out for circumstances which may put a patient at risk while participating in rehabilitative activities. These circumstances might involve such things as prescription drug interactions, the development of peripheral neuropathy, the development of circulatory dysfunction, the development of cardiopulmonary dysfunction, or the presence or growth of a cancer.

In addition to minimizing the risk to the patient, the only way to insure that the patient is receiving maximal benefit for their time in physical therapy is to have these services provided by an appropriately trained professional. With the issue payer limitations and caps placed on such benefits as physical therapy, it is of growing concern that we maximize the time and money that each patient may spend on "physical therapy" services. While physicians are trained in the overall health and function of the human body, physical therapists spend years focusing on the nervous and musculoskeletal systems. As such, licensed physical therapists are the most competent providers of rehabilitative services involving these systems.

As the law currently stands, physical therapists may only bill Medicare patients for services that are provided in a direct one-on-one situation with the patient and the provider. This insures that the patient is receiving the most "bang for their buck" so to speak. In order for a physician to see the same amount of progress, they would have to spend an equivalent amount of time with their patients. How many physicians do you know that are able to spend an hour with each one of their Medicare patients? Running a patient through a rehab protocol without being able to assess their progress, assess risk, and make revisions when necessary is simply not providing the highest level of care that each patient deserves.

I worked as a physical therapy technician for several years before beginning my training to become a physical therapist. As a "tech", I provided a variety of services to patients, including the application of modalities, the performance of exercise routines, and the development of home exercise programs. As a student who has now completed the bulk of my physical therapy education, I can now tell you for a fact that it is what you don't know that can hurt you, and your patients.

The point that I wish to emphasize is that it is not simply an issue of who can provide a certain service. The real issue is the patient, and their quality of life, which should be the ultimate goal of all healthcare providers. It doesn't take an extensive education to set someone up on a leg-press machine, or to perform an

ultrasound. It does, however, take extensive training to be able to know when such activities are appropriate, and to know how to prescribe activities and care that will insure the most expedient return to the most full life possible. This is what physical therapists are trained to do.

Each patient is an individual, and their care must be customized. The most beneficial outcomes can be achieved through a collaborative effort between the team of the physician, the physical therapist, and the patient.

Thank for you for your time and consideration in this matter.

Sincerely,

Patricia M. Hill, MA, SPT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

OTHER - INCIDENT TO

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 profession 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.

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.

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.

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

Attachment # 2373

Kevin Parker, ATC
1801 Echo Hollow Rd
Eugene, OR 97402

9/21/2004

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,

Kevin N Parker, ATC

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

This is no good! Physical Therapist are not the only rehab/speciliast around. Massage therapy is/and should be regonized. How can you ingore the facts

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1429-P; Sections 303 and 623 - Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

Attachment #2375



Bone Care Center 1600 Aspen Commons Middleton, WI 53562 Phone: (608) 662-7800 Fax: (608) 662-0032

September 21, 2004

Dr. Mark McClellan
Centers for Medicare and Medicaid Services
Department of Health and Human Services
CMS-1429-P
PO Box 8012
Baltimore, MD 21244-8012

**Re: CMS-1429-P; Sections 303 and 623
Medicare Program; Revisions to Payment Policies Under the
Physician Fee Schedule for Calendar Year 2005:**

Dear Dr. McClellan:

Bone Care International (“BCI”) is pleased to provide comments with regard to the proposed rule CMS-1429-P, “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005” 69 F.R. 47488 (August 5, 2004) (hereinafter “Proposed Rule”). BCI will be commenting on the provisions of the Proposed Rule designed to implement Section 623 of the MMA, and Section 303 of the MMA which is related thereto. BCI is a specialty pharmaceutical company dedicated to improving patient outcomes by delivering unsurpassed Vitamin D hormone therapies to patients with chronic kidney disease.

BCI commends the Centers for Medicare & Medicaid Services (“CMS”) for its on-going work to improve and clarify the Medicare reimbursement policies affecting the reimbursement of separately billable drugs and biologicals used to treat end stage renal disease (“ESRD”). We support the goal of the Medicare Prescription Drug, Improvement and Modernization Act (“MMA”) of 2003 to pay for these items in a manner that is fair to the Medicare program and its beneficiaries, as well as to ESRD facilities and the manufacturers of innovative drugs and biologicals, while promoting quality of care for ESRD patients.

We know that CMS faces a very substantial implementation challenge, and we would like to assist CMS in this important process. We hope that the comments that we offer in this letter will contribute to the implementation process, as the decisions that CMS makes in the implementation effort are critically important to ensuring appropriate access to high quality ESRD services and items, including separately billable ESRD drugs and biologicals, and promoting cost savings for the Medicare program.

BCI does have several suggestions that will, in our view, make the implementation of the separately billable drug and biological provisions of Sections 303 and 623 of the MMA more consistent with the Congressional intent. Specifically, BCI believes that CMS should (1) provide some mechanism which will allow price increases to be realized into the “acquisition cost” reimbursement methodology in less than 2 quarters, (2) maintain quality of patient care by providing the add-on to those facilities that actually use separately reimbursable ESRD drugs, (3) provide the ESRD community with additional information regarding the data CMS used to calculate its proposed add-on payment to the composite rate and (4) refine the rate of annual increase in Average Wholesale Prices (“AWPs”) used to calculate the composite rate “add-on”.

Our support of the MMA is very much in keeping with our historical approach to pricing issues. We have always priced our product substantially lower than the average price at which branded Vitamin D products are available in the United States market. As the Office of the Inspector General (“OIG”) report confirms, the alternate branded Vitamin D competitor (which accounts for approximately seventy-five percent of the relevant market) has an ASP that is almost *twice* the price at which we currently offer our product. Medicare vitamin D costs could be reduced by approximately *two billion dollars* from 2004 to 2008 with a reversal of relevant vitamin D product market shares, or if the competitor price was similar to the price we offer providers.

Our support of the MMA is also a consequence of our desire to assist CMS and Congress in making drugs and biologicals available on a more affordable basis while enhancing patient quality of care. We take seriously the need to respond to the public’s request that the manufacturers of drugs and biologicals find ways to provide affordable therapies which enhance quality of care and cost savings. Having stated this, the current proposal does not distinguish between an affordable agent that is clinically comparable to more affordable agents in a similar therapeutic class.

1. Sections 303 and 623 of the MMA - CMS Should Permit a Mechanism for Reasonable Price Increases to Be Realized More Quickly into ASP.

The OIG Report on “Medicare Reimbursement for Existing End-Stage Renal Disease Drugs” issued in May, 2004, expressly states: “In calculating future growth rates, we looked exclusively at past monthly growth rates for the reimbursement for separately billable drugs. We did not account for the potential effects of future changes.... Therefore, we would like to stress that CMS should update our projections as new reimbursement data become available.”

The CMS proposed rule relating to separately billed drugs, 42 CFR § 414.904(f), (which forms the basis for the spread that is incorporated into the composite rate drug add-on), proposes that the payment limits be updated quarterly. However, this will build in a two quarter lag in updating prices.

There will, of course, likely be price increases during the course of 2005. The proposed quarterly update will base ASP for a quarter on the ASP reported two quarters before. For ESRD facilities, this lag in incorporating acquisition price increases raises the very real risk that most

ESRD facilities will be “under water”—and seriously “under water” at that—when they attempt to purchase ESRD drugs and biologicals for required utilization to ensure quality of care for ESRD patients. The fact that the OIG has already determined that all but the four largest chains actually acquire their product at ASP *plus* four percent underscores the risk here.

The means of addressing this problem is challenging to identify. However, it is of great importance for all vested parties and we would welcome CMS’s and other interested parties’ thoughts on this important topic. Our recommendation is to provide a retrospective payment process that will keep providers whole and is consistent with CMS system capabilities.

2. Section 623 of the MMA - CMS Should Apply its Drug Add-on to Those ESRD Facilities that Use Separately Reimbursable Drugs for Their Patients.

In order to preserve high quality care to ESRD patients and prevent cost shifting behavior, CMS should condition the receipt of the composite rate add-on payment to a facility’s provision of a full range of separately reimbursable drugs and biologicals to the relevant patient. A variety of policy reasons underscore the need to proceed in this fashion.

We have two concerns if CMS were to provide the add-on without regard to what separately reimbursable drugs and biologicals are used by a dialysis facility. First, some facilities may be tempted to not provide medically necessary drugs and biologicals because they will receive the add-on payment regardless of whether they use the necessary drugs or biologicals. In other words, there will be no financial incentive to provide necessary care and, in many cases, a financial disincentive as the result of a negative ASP to AAC spread. A reduction in drug utilization would have a negative impact on overall patient quality of care, a result which is contrary to the legislative intent of the MMA.

Second, we are concerned that, as Part D covered alternatives to separately reimbursable Part B drugs and biologicals become available (as in the case of the oral version of Hecitorol), facilities will receive the add-on payment to the composite rate, but move the payment for their drugs and biologicals to Part D. It is our position that utilization of injectable drugs and biologicals (vs. oral) enhances patient compliance and clinical outcomes.

We understand that the demonstration project required by MMA 623(e), which is designed to study bundling of all drug payments into the ESRD rate, would - if implemented for all ESRD facilities - potentially address this problem. However, the demonstration project only covers some facilities, and is designed to take place over a three year period. We also acknowledge that CMS is required by MMA 623(f) to submit a report to Congress by October 1, 2005, on the design and implementation of a bundled ESRD composite rate prospective payment system. The question is what steps can and should be taken in the interim, before such a system is implemented.

Significantly, CMS has already acknowledged that it has the authority, under the MMA, to apply the composite rate add-on to some subset of all ESRD facilities. We believe that our proposal (to condition the receipt of the composite rate add-on payment to a facility’s provision of a full

range of separately reimbursable drugs and biologicals) is the most appropriate one for CMS to adopt.

3. Section 623 of the MMA - CMS Should Provide the ESRD Community Additional Information Regarding the Data Used to Calculate Its Proposed Adjustment to the ESRD Composite Rate for a Drug Add-On.

We also have concerns about the data that CMS proposes to use to calculate the adjustment to the ESRD composite rate for the drug add-on. Beginning with 2004 AWP, at the current reimbursement rate of 95 percent of AWP, CMS suggests that it should add three percent to those AWP based on “historical trends of AWP” to update its calculation to 2005. *See* 69 F.R. at 47528.

The basis for this three percent figure is not explained in the preamble to the proposed rule, although it appears to be a number derived from the AWP for *all* drugs, as opposed to using the AWP for just ESRD separately billable drugs and biologicals. The source for this 3% figure is not provided. Nor is the time frame used to establish the “historical trend” discussed. Accordingly, we and other interested parties are left unable to provide meaningful comments on this CMS proposal.

Having shared this concern, we wish to commend CMS for not using the 2003 Single Drug Pricer file in setting the base 2004 reimbursement. We are pleased that CMS has selected the more recent and, therefore, more relevant prices from the 2004 file.

We recommend that CMS create an update factor utilizing current data that is specific to drugs used during dialysis.

4. Section 623 of the MMA - CMS Should Modify its Proposed Methodology for the Calculation of the Composite Rate Drug Add-on by Employing a More Appropriate Update Factor to AWP Pricing.

Section 623(d) of the MMA, which added §1881(b)(12)(B) and (C) of the Social Security Act, expressly requires CMS to compute the drug add-on to the ESRD composite rate for 2005 by “adjusting” the spread “to 2005” using a means determined to be “appropriate.” *See* §1881(b)(12)(B)(ii). We do not believe it is appropriate for CMS to use a three percent update figure that appears to be based on a “historical trend” for all drugs. This seems particularly clear where, as here, the historical trend for ESRD separately billable drugs and biologicals is in excess of the three percent figure proposed by CMS.

It is our concern that the 11.3% add-on percentage for providers may not be adequate to keep them whole as stated in the MMA. An inadequate add-on may have an effect on quality outcomes and the level of patient care currently being provided. Consideration of an upward adjustment to the add-on is recommended.

We thank CMS, again, for its continued and impressive effort to fully and thoughtfully implement the many changes required by the MMA.

Sincerely,

A handwritten signature in cursive script, reading "Paul L. Berns", followed by a vertical line.

Paul L. Berns
President and CEO
Bone Care International

cc: Mr. Herb Kuhn, CMS
Ms. Mary Kay Mantho, HHS
Mr. Brady Augustine, CMS

Submitter : Katherine Grubb Date & Time: 09/21/2004 07:09:04

Organization : Katherine Grubb

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I wish to comment on the August 5 proposed rule on "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005" regarding requirements for individuals providing outpatient physical therapy services in doctors' offices. The proposed rule requires these providers to be graduates of an accredited professional physical therapist program or to meet specific requirements for grandfathering or special requirements for foreign-trained PT's. That is, the proposed rule requires providers of "physical therapy" in doctors offices to be REAL physical therapists, not unqualified personnel without any professional standards.

When I graduated from my physical therapy program in 1984, I graduated with 158 semester units and a minor in gerontology. This was in 1984. I am planning to return to school within the next year to obtain my doctorate in physical therapy. Physical therapy is not a day at the spa. This is real rehabilitation for real musculoskeletal and neuromuscular disorders.

As of January 1, 2006, Medicare will place a financial limit on therapy provided. Under the current Medicare policy, a patient could exceed his/her cap on therapy in a doctor's office without ever seeing an actual physical therapist. These proposed revisions are important. Your parents and mine deserve real therapy from real therapists.

Section 1862(a)(20) of the Social Security Act 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. That is, the services must be performed by graduates of accredited professional physical therapist education programs. I strongly support the provisions in the proposed fee schedule which are consistent with the Social Security Act and necessary to protect our disabled and senior citizens from unqualified providers of service.

Thank you for your consideration of my comments.

Sincerely,

K. Grubb, PT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

This should be open to any Licensed health care professional and stay that way. Massage therapy, PT assts, etc should be included as massage & alternative therapies are becoming a "staple" in health care.

Fixed income folks and the general public frequently receive massage therapy or some variation of, to keep muscles supple, and joints in good working condition to become or stay free from pain. These treatments increase not only their physical well-being but also their mental. They are becoming a vital treatment for everyone, not limited to healthy people.

To decrease the options from Medicare A&B for these services hurts your patients. Please keep this in mind before passing a law that takes these vitally important therapies away from your focus group of clientele.

Submitter : Miss. Joanna Webber Date & Time: 09/21/2004 07:09:28

Organization : Knoxville Comprehensive Breast Center

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I work for a surgeon that performs surgeries such as a modified radical mastectomy on a full time basis. His patients that need additional services benefit from massage therapy as much as physical therapy. Physical therapy provides exercises to increase and maintain ROM, but they do not provide the therapeutic touch that is needed to allow tense muscles to relax. If the muscles stay tight, it can cause skeletal misalignment and cause the patient the need to see a chiropractor as well as other therapists for many problems. Allowing a massage therapist to work with these types of patients in a medical facility allows the patient to feel better faster. The faster a patients heals and is no longer in need of medical services, the less money the insurance companies have to pay out in the long run. The more you are able to catch the problem in advance by a simple manipulation of soft tissue to prevent more problems developing, the less healthcare professionals the patient has to see and the less money the insurance company has to pay out.

In conclusion: Allowing a Massage therapist to work with patients in a medical setting can save the insurance more money.

Thank you for letting LMT's stay working within the medical realm.

Joanna L. Webber, LMT

Submitter : Mrs. Roxanna Kramer Date & Time: 09/21/2004 07:09:09

Organization : Mrs. Roxanna Kramer

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a post mastectomy survivor of 24 years and will be on Medicare in a few years. I believe mastectomy products should be excluded from face-to-face prescription requirements. When a doctor writes a prescription for post mastectomy products and writes "lifetime need", why in the world would we need to spend Medicare and other insurance monies for an extra office visit to get another prescription, to say nothing of the office expense involving the paperwork. I am here to inform anyone who does not know, that in 24 years, my breast did not grow back and will not; therefore, a prescription stating "lifetime need" is certainly sufficient.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Attached is a letter addressing this issue.

Attachment #2380

Lauren Small
Arizona School of Health Sciences
5850 E. Still Circle
Mesa, AZ 85206

September 11, 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, and pass a national board exam prior to certification. 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.
- Certified 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 certified athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured during physical activity 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,

Lauren Small ATC/L, EMT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 1-9

PRACTICE EXPENSE

I understand you categorize Santa Cruz County, CA, as a rural county and the City of Santa Cruz as a rural community. That categorization results in our doctors receiving very low Medicare reimbursements. HAS NOBODY ON YOUR STAFF VISITED SANTA CRUZ COUNTY OR CITY IN THE LAST DECADES??? Someone needs to tell you that we're no longer rural and haven't been for at least 20 years. Come on CMS. Get with reality!!!

Because you arbitrarily call us rural, our doctors flee to areas you label as urban, where the Medicare reimbursement is more realistic.

PLEASE re-examine the 'ruralness' of Santa Cruz County and City so that your categorization will more accurately reflect our status.

JAMES NEE
Santa Cruz, CA

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>

Attachment #2382

Matthew Barber, LAT
2405 Northwestern Ave.
Racine, WI 53404

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 and place an undue burden on the health care system.

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

- 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.
- 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.
- 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. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint the 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 accompanied 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 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,

Matthew Barber, LAT

Submitter : Mrs. Nicole Howe, L.M.T. Date & Time: 09/21/2004 07:09:05

Organization : Mrs. Nicole Howe, L.M.T.

Category : Other

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

The appropriate use of trained technicians has been a standard of practice in neuropsychology for many decades, and there are published criteria for carrying this out in an ethical manner. The use of technicians allows for the neuropsychologist to provide additional services to more patients in need, not unlike any other physician that uses technical assistance in their daily work.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a Physical Therapist working in Mesa, Arizona. It has been my privilege to practice with my company for 2 years now. For the record, I am a card carrying member of the American Physical Therapy Association and the Arizona Physical Therapy Association and I have even held offices on the district level of the AzPTA.

I am writing this note as a comment to the suggest that the Certified Athletic Trainer, or ATC, can work with the Medicare patient in an Outpatient Rehabilitation setting.

Mine has been the privilege to work with both Physical Therapy Assistants (PTA's) and ATC's in my orthopedic rehabilitation setting. Both are so valuable to me as a PT and without them, my work would be so incomplete.

As best as I know these requirements, the ATC has a 4 year degree in learning how to rehabilitate injured tissue and in Arizona required by their state board to receive a certain number of Continuing education credits to preserve their license. The PTA has a 2 year degree and is not required by our state board to receive continuing education for the renewal of their licensure. I am not suggesting that the ATC is better than the PTA. But from what I described above, I cannot understand how a PTA can progress a patient than the ATC

On a personal note I have worked with athletic trainers and therapy assistants and I cannot say enough of their positive influence and counsel. I value them both as vital members of the rehab team and hope they are in my professional future. I would hope that CMS would consider making a change to this law to include the valuable ATC to the medicare rehabilitation team.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached documents also.

Dear sir or madam,

As a certified athletic trainer, I felt the need to write you on the topic the of "incident to" in physician owned practices. I have been employed by a physical therapy clinic for the past ten years. During that time I have treated a number of medicare patients. Although some are not what you might consider athletes, many of them are more active than myself. (I am 33 and play in an adult hockey and baseball league.) They run in road races, play tennis, racquetball, volleyball, etc. Or they have had physicaly demanding lives and jobs. Not athletes you say?

I was also employed by an area high school, and university, and I have seen a variety of injuries in all three settings. During the rehabilitation of all the injuries I've worked with, I have yet to find the human body that progresses in a different fashion from the next. Sure, some may heal slower than others, and some may have other conditions associated with it that may change the way the course of rehab, but they are all still human beings. And they are all entitled to the same care. I have worked with several high caliber athletes in my time. Several are professional hockey players, and several Olympians. I can't believe that the federal government will allow me to work on those human beings, but not the medicare patient. This is an outrage! Many of the medicare patients I've worked with said they would not have known I wasn't a physcial therapist if I had not told them otherwise.

Athletic trainers are not sub par healthcare providers. We are top notch healthcare providers that take pride in our work, and what we stand for as an organization. It would be a great injustice to the elderly community if they are restricted from our care and expertise.

I hope this letter and the enclosed attachments, help you to see that allowing this change to take place will hurt the healthcare industry in this country, not help it.

Thank you.

P.S. Please see attached documents also.

Attachment #2387

Charles A. Marino III ATC
615 Main Street
East Haven, CT 06512

September 21, 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 any trained individual (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,
Charles A. Marino III, ATC
615 Main Street
East Haven, CT 06512

September 2004

**The Coalition to Preserve Patient Access
to Physical Medicine and Rehabilitation Services**

The Centers for Medicare and Medicaid Services (CMS) published in the August 5, 2004 Federal Register, pages 47550-47551, a proposal that would limit reimbursement of physicians for "Therapy-Incident To" to a narrow group of providers: physical therapists, occupational therapists and speech and language therapists. Currently CMS regulations allow the physician the freedom to choose any qualified health care professional to perform therapy services at the physician's office or clinic.

We do not support this proposal or similar ones contained in the Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005 (CMS docket # 1429-P). We believe the provisions, which will restrict the physician's ability to determine the type of health care provider who administers "Therapy-Incident To" services, are poorly conceived and could have a detrimental effect on the welfare of Medicare patients.

Official Statement

We, the official representatives of the undersigned organizations, wish to formally state our position on Medicare's proposed changes to the "Therapy-Incident To" services. We believe the health and well being of the Medicare beneficiary should be the primary consideration. To this end, physicians and all other medical professionals authorized to order "Therapy-Incident To" services should have the continued medical authority to determine proper care and treatment for the patient and to select the best available, most appropriate health care professional to provide that care, including "Therapy-Incident To" services. A number of complex factors affect a physician's choice of the most appropriate health care professional to provide "Therapy-Incident To" services in his/her office or clinic. Some examples are type of medical practice; geographic location such as rural or medically underserved areas; availability of qualified allied health care personnel; and patient access to Medicare and secondary health care system providers. The physician is best equipped to make these medical decisions. We believe any attempt by government entities or other organizations to change this heretofore established right and purview of the physician clearly is not in the best interest of the patient.

We unequivocally request that no changes be made to Medicare or other provisions affecting "Therapy-Incident To" services reimbursement from CMS.

Sincerely,
Charles A. Marino III, ATC
Member of the National Athletic Trainers' Association.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I oppose the proposed change to allow the use of unlicensed technicians to administer diagnostic psychological tests. The use of techs is an unregulated practice that does not allow for protection for the consumer and diminishes the quality of service.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Jeffery L. Dawes
 Rt. 1 Box 3085
 Doniphan, MO 63935
 9/21/04
 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 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.

? 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.

I can not believe there is even consideration for this type of legislation, when it is obvious there is a conflict of interest between the APTA and the patient. All this does is limit patient and Dr.?s choices on who can provide appropriate services. I will continue to be involved in patient rights matters, especially when other professional organizations try to limit my professional practice of rehabilitation services in order to advance their own cause. The only one hurt here is the patient. If this were to even be feasible the legislation should be written to include all individuals who are already by state practice act allowed to provide ?Incident To? services.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached letter.

Attachment #2390
Dawn M. Hankins, PhD, ATC/L
Curriculum Director – Athletic Training
Associate Professor of Health and Human Performance
McKendree College
701 College Road
Lebanon, IL 62254

September 21, 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.

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- 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.
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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.*
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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 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.
- I find it professionally offensive to infer that I do not have the qualifications necessary to treat these patients. My professional experience spans 23 years and includes outpatient therapy (including FCE and work hardening) as well as high school and college experience. My academic qualifications include the attainment of a PhD as well as scholar work within my professional subject area, involvement within our professional organization and attendance and participation in yearly continuing education specific to prevention, assessment, treatment and rehabilitation of patients/athletes. As an educator and curriculum director I work very hard to ensure that our students are provided a very strong foundation both didactically as well as clinically in treating physically active individuals. We need to quit pigeon-holing patients into classifications based on insurance, age and activity, but instead see all as physically active and treat accordingly. The issue should not be who should treat the patient based on how he/she received the injury, the issue should be he/she is injured and needs evaluation and treatment to return safely to their pre-injury functional level.

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,

A handwritten signature in black ink, appearing to read "Dawn M. Hankins". The signature is fluid and cursive, with the first letter 'D' being particularly prominent.

Dawn M. Hankins

Submitter : Ms. MARY HOOVER-MATTER

Date & Time: 09/21/2004 08:09:37

Organization : DEACONESS HOSPITAL

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am writing to express my support of the proposed personnel standards for physical therapy services that are provided in the physician's office. It is imperative that strict guidelines are enforced to ensure each individual meets the professional qualifications to provide skilled physical therapy services to patients. The extensive education, clinical internships as well as ongoing continuing education ensure that patients receive safe and efficient quality care for the conditions for which they are presenting. Physical therapist receive extensive training in the area of anatomy, physiology as well as the indications and contraindications of the various treatment modalities utilized within our scope of practice. This enables us to appropriately introduce these treatment techniques into our patient's therapy program, closely monitor them for an appropriate response and then modify accordingly. Physical therapist also have a strong interest in ensuring effective and efficient quality of care and thus incorporate outcomes tracking into their clinical practice.

Thank you for your consideration of these comments.

Sincerely,

Mary Hoover-Matter, PT GCS

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Passing a policy where a physicians can only refer 'incident to' services to physical therapists, will be devastating to senior citizens. It is also a discriminatory practice which will irreparably harm various state-licensed and regulated health care professionals. I have personally worked for 1 year in my profession as a state-licensed massage therapist and 30 years as an LPN. helping seniors. . ***As a geriatric care provider & as a nurse for 30 years quite often I found massage to be more therapeutic than any medicine one can provide PLUS TOO many other benefits to be able to mention here.** All nationally recognized and state-licensed and qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision. Many states have current laws which allow state-licensed health care professionals to provide services by physician prescription, and require private health insurance to pay for services rendered as such.

PLEASE DO NOT PASS THE POLICY WHEREBY A PHYSICIAN CAN ONLY REFER 'INCIDENT TO' PHYSICAL THERAPISTS. ALL HEALTH CARE PROVIDERS SHOULD BE ABLE TO PROVIDE SERVICES WITH A PHYSICIANS PRESCRIPTION OR UNDER THEIR SUPERVISION THANK-YOU Judith A.MoatsLPNLMT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

The proposed language for ?424.80 indicates that the supplier shares joint responsibility for Medicare overpayment with the entity submitting claims on their behalf. Given this liability, claims information should be given directly to the supplier. Physicians want to protect themselves from involvement in upcoding activities. This will be helped immensely by requiring Contract Management Groups to provide claims data and not just provide "access" to such data. In the past "access" to such data has been purposely made very difficult to individual physicians by large Contract Management Groups through direct and indirect threats of termination without cause. Another tactic has been making it logostically difficult to view the information, either by pure geography (making one go to corporate headquarters, often in another state), or by hiding the information in reams of paper data that would take days to decipher. This is all to hide the profits that Contract Management Groups make on the backs of practicing physicians, particularly in Emergency Medicine. Any physician held liable for overcoding/overbilling should be required to have full billing access.

Dominic A. Johnoson, MD, FAAEM

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To: Mark McClellan,MD

I am a PT and feel strongly about the 'incident to' provisions being addressed.

I feel that charging for PT services that are not done by PT's is misleading and should be illegal. How can a physcian or an AT or a massage therapist provide services that are to be done by a licenced PT? Isn't that implied by the charge?

I think allowing this would open up a can of worms in the liability arena, with under qualified people providing services that by title should be performed by a PT. Who is profiting by this? The MD? The provider? If it states that PT services have been done, then lets make sure they were done by a PT!

Respectfully yours,

Kristen Wood, PT

Submitter : Mrs. Pamela Halvorson Date & Time: 09/21/2004 08:09:51

Organization : Iowa Occupational Therapy Association

Category : Occupational Therapist

Issue Areas/Comments

GENERAL

GENERAL

I am a rehabilitation manager for a community hospital in Iowa. I am also the reimbursement and communication liason for the Iowa Occupational Therapy Association. My comments are in support of restriction to billing for 'incident to' services that are not provided by qualified occupational and/or physical therapists. In a doctor's office in my community there is an unlicensed person providing 'pain' treatments using microcurrent modalities. This individual has no college education, no license to practice as a healthcare provider of any kind, and the only training he has received is by the company providing the machine. He bills his services under the GP (physical therapy) modifier and is reimbursed at the same rate as a licensed physical therapist.

Physicians at this time have no criteria to prove that any individuals providing care as 'incident to' services have necessary training and credentials to be competent. Physicians have one reason and one reason only to use personnel that are not credentialed physical and occupational therapists - cost of staff. A physician can pay an entry level athletic trainer about \$15.00/hour instead of an entry level physical therapist at \$23.00/hour.

Physicians do not have to complete Medicare certifications and re-certification - another method to assure that services are medically necessary. In the example of the unlicensed person in my community this individual has been doing 'treatments' up to 5 years on the same individuals every week - with no denial from Medicare. Why? because it's being done in a physician office. If we were performing this same modality in my outpatient hospital clinic the physical therapist would be developing a treatment plan, setting measurable goals, writing daily notes and timing every treatment to the minute. It is time that CMS recognizes the overt over utilization of 'incident to' services.

In the case of Athletic trainers in particular I have concerns since core education is certainly not on working with Medicare populations and comorbidities that accompany the elderly clients.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 21, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
PO 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. Consumers deserve a choice to whom is providing their health care. Physicians should be determining which health care provider is better suited to provide rehabilitation for their patients.

Each of these equally qualified medical professionals deserves 'equal footing' in terms of reimbursement for the rehabilitation codes. In today's world of rehab, consumers are exposed to and cared for by certified athletic trainers in physicians offices, rehabilitation companies, and industrial settings. If adopted, this would eliminate the ability of qualified health care professionals to provide these important 'incident-to' services.

Why now, is this proposal questioning the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service? Physicians continue to make decisions in the best interests of the patients. It is IMPERATIVE that Medicare and private payers continue to support physicians in these endeavors and not impose any limitations or restrictions as to who the physician can utilize to provide ANY 'incident-to' service.

CMS is surely receiving comments from Physical Therapists and Physical Therapist Assistants regarding this proposal. The APTA strongly opposes the use of 'UNQUALIFIED PERSONNAL' to provide services described and billed as physical therapy services. These individuals will speak of the 'negative impact' that will be created by allowing unqualified individuals to provide services that are billed as physical therapy services in physician's offices. I could not agree more! Unqualified individuals should not be providing any medical service.

What those individuals will not tell CMS is this:

' All certified or licensed athletic trainers MUST have a bachelor's or master's degree from an accredited college or university.

' Core coursework for an ATC includes:

Human physiology and anatomy

Kinesiology/biomechanics

Nutrition

Acute care of injury and illness

Exercise physiology

Stats and research design

' 70% of all ATCs have a master's degree or higher.

' The services and education of ATCs are comparable to other health care professionals including PTs, OTs, RNs, speech therapists, and many other mid-level health care practitioners.

' A Physical Therapy Assistant has 2-4 years less educational experience compared to an ATC, yet a PTA has a legislative right to be reimbursed for services. Why is this so?

Allowing only PT,OT, speech therapist to provide ?incident-to? outpatient therapy services would improperly provide these groups EXCLUSIVE rights to Medicare reimbursement and DENY the consumer access to quality health care professionals affecting the quality of health care being provided and possibly the costs.

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

Michael McKenzie Med, ATC, CSCS
Head Athletic Trainer
Wilmington Friends School
101 School Rd.
Wilmington, DE 19803