

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a physical therapist in private practice in the Greater Philadelphia area and have been practicing for over 23 years. I sit on an advisory board at the Pennsylvania and American Physical Therapy Association. I want to make sure you are aware of the unprofessional care that takes place in some physician's offices when they attempt to provide "physical therapy" services.

I strongly support CMS's proposal that only physical therapists who have graduated from an accredited physical program be permitted to provide physical therapy services.

All professional degree programs at this point are at the Master's degree level and many are now granting a Clinical Doctorate degree at the completion of the physical therapy program. This entails a great degree of kinesiology, anatomy, physiology, biomechanics, clinical science and clinical foundations. Students now attend anywhere from 25-36 weeks of clinical residency programs before they are able to sit for the licensure exam.

In physician's offices, often untrained staff including minimally trained medical assistance are provided services to patients. These students attend a 9 month to 1 year technical school and are instructed in the basic tasks performed in a physician's office - scheduling, taking blood pressures, setting up patients, This does NOT qualify them to perform physical therapy!

Not only is this a misrepresentation of the professional service, it can also cause harm. Patients have told me the poor care they received in physician's offices - one patient even told me they were receiving an ultrasound treatment to their elbow and when the phone rang, the technician handed the patient the ultrasound head and said - "Here, you can continue this yourself!"

If Physical Therapists are to be held accountable for their actions and must demonstrate a "skilled" intervention, then they should be the ones providing treatment in ALL treatment settings.

Submitter : Mrs. Allison Hickenboth Date & Time: 08/26/2004 08:08:27

Organization : Carle Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attached Word document

Allison C. Hickenboth, ATC, LAT,
NREMT-B
Carle Sports Medicine
810 W. Anthony Dr.
Urbana, IL 61802

August 26, 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 highly educated professionals who are required to have a bachelor's or master's degree from an accredited college or university, pass a rigorous national certification exam, and become registered, licensed, or certified within their state of practice. Required curriculum for all athletic trainers includes, but is not limited to: human anatomy, human physiology, kinesiology, biomechanics, nutrition, acute care of injury and illness, statistics and research design, exercise physiology, therapeutic exercise, and therapeutic modalities. Seventy percent of all athletic trainers have a masters degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries 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,

Allison C. Hickenboth, ATC, LAT, NREMT-B

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

8/25/04

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.

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.

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

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

CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interest

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see the following attachment



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

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

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

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

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I would like to express my displeasure in what CMS is trying to achieve. Athletic Trainers help many populations today. We are educated in many different aspects of injury and care then physical therapists are. I work in a physical therapy clinic in the mornings and then go to my high school in the afternoons and I would like to say that we do most of the work. I write up programs for our patients, I work through the programs with many patients at a time, I do paperwork, I help with billing, the only thing I don't do is evaluations because we can not legally, which is a whole other issue. We have enough credentials to work with medicare patients just like physical therapists. Physical therapists are frightened of ATC's because what we achieve and what we can produce in a days time compared to their schedule. They are also afraid we are going to take patients away from them. We are much more disiplined in the aspects of care because we are by ourselves. By being the only one to do care, we at times have to provide rehabilitative services to over 15 athletes in a hour. You will not be able to find a physical therapist treat, tape numerous amounts of athletes, provide accurate information to athletes in need, and complete paperwork within an hours time. ATC's are good at what we do but we can be better if given the opportunity. All CMS is doing is narrowing the options medicare patients have for a great injury recovery. To conclude, if you ask anybody who had the pleasure to work with an ATC and they had a choice of who they would like to work with, MOST would choose an ATC.

Please take our plea in to consideration. We provide great service to the populations we can. We can also provide services to medicare patients. Most ATC's do in clinic's even though we are not supposed to b/c PT's would rather do an hour long evaluation when we can do a on-the-field evaluation in half the time.

Thank you for you time,

A frustrated Certified Athletic Trainer

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

comments on the incident to proposal

Emily Swisshelm
University of Charleston
2300 MacCorkle Ave. S.E.
Charleston, WV. 25304

August 16, 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 this letter concerning the proposed law that would limit the work and services that certified athletic trainers provide. I am a student at the University of Charleston where I am a part of the athletic training program. It is a vigorous program with an outcome based learning system. The program is an accredited program, which means the program has standards that must be met it loses its accreditation. We are required to take courses such as lower and upper extremity, anatomy and physiology, nutrition, prevention and care of injuries, cytology and microbiology and other foundational courses that will help us to receive the best education possible. Knowing that each athletic training student has to take programs like mine to graduate makes me sure that they are qualified to provide care outside of the athletic field.

By limiting athletic trainers work environment you also increase workload for physicians and make their jobs much harder. They are responsible for their patients and their patients care. Physicians are responsible for deciding who is qualified to take care of them. This proposal takes away that right of the physician and insults their education and intelligence. This proposal also affects the patient. They will not receive the best of care and will end up paying for more. They will have to wait longer to receive the care because of the shortage of health care providers.

By approving this proposal by CMS, it would improperly provide physical therapists, occupational therapists, and speech and language therapists exclusive rights to Medicare reimbursement. It also would improperly remove the states' right to license and regulate the allied health care professions that are qualified. The proposal seems to benefit only the interests of a single professional group, neglecting the interests of all other allied health care professions.

Each day the health care of high school and college athletes is put into the hands of well-qualified athletic trainers. The best athletes in the world trust their health to athletic trainers. Dozens of athletic trainers have traveled to Athens to

care for our Olympic athletes. How is it that we can trust athletic trainers to treat these people but they can not be trusted with the care of a car accident victim or an elderly woman trying to rehabilitate and injured hip? With all these facts I can not see one reason why this proposal should stand. Thank you for your time.

Sincerely

Emily Swisshelm

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 10-19

THERAPY ASSISTANTS IN PRIVATE PRACTICE

Dr. McClellan, I agree with your proposal to eliminate the personal (in the room) supervision requirement for PT Assistants. Direct (on the premises) supervision is very appropriate for PTAs. They are adequately educated and trained to provide safe treatment to patients, without the personal supervision by a physical therapist. I am a physical therapist with 28 years experience, and have employed PTAs in my business. The PTA is licensed in Montana to provide care to patients with indirect (off premises) supervision, an even more liberal supervisory requirement than your proposed requirment. The current rule is clearly unnecessary, and the proposed rule is a reasonable compromise.

Thank you.

Submitter : Mrs. Amanda Campbell Date & Time: 08/27/2004 02:08:04

Organization : National Athletic Trainer's Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To whom it may concern:

For some reason there is an on-going battle between physical therapists and athletic trainers. I am fortunate to have a unique understanding of both, as I am a certified athletic trainer as well as a licensed physical therapist assistant. There is room enough for all of us in healthcare.

It is hard for me to believe that one could think that an athletic trainer is not qualified to treat a medicare patient under the guidance of a physician. Speaking with a view from both positions, I can tell you that it was much more difficult to become a certified athletic trainer than a licensed physical therapist assistant. It required more clinical hours, more education and a much more difficult certification exam, which included a practical section not required in physical therapy. Furthermore, athletic trainers must complete continuing education hours in order to remain certified. These continuing education hours ensure that we active in our field and aware of developing treatment methods and technologies. Unfortunately, continuing education is not required in many states for physical therapists and physical therapists assistants.

In summary, it would be very sad to see athletic trainers taken out of this realm of patient care. Not only would the patient lose a valuable treatment option, but this would also be a detrimental blow to the field of athletic training. A profession of highly trained, highly educated, well qualified individuals.

Best regards,

Amanda Campbell ATC, PTA, CSCS
Clarksville, Indiana

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Corinna Schmidt
1134 Court St.
Alameda, CA 94501

August 26, 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 the needed services.

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

? 'Incident to' has 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 like certified athletic trainers, or physician extenders, whom the physician deems knowledgeable and proficient.

? 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.

? The change to ?incident to? services reimbursement would render the physician unable to provide his/her patients with comprehensive and quickly accessible health care, causing significant inconvenience and additional expense to the patient. This could also cause delays because of an increase in the workload of physicians, who are already too busy, thus taking away from the physician?s ability to provide the best possible care. Patient?s recovery would be hindered and/or recovery time increased, ultimately adding to the medical expenditures of Medicare. These issues may lead to physicians eliminating or limiting the number of Medicare patients accepted.

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

? Athletic trainers are employed by educational institutions, industrial and clinical settings, and professional sports teams to work with active people to prevent, assess, treat, and rehabilitate injuries sustained.

? To allow only physical therapists and PT assistants, occupational therapists and OT assistants to provide ?incident to? services would improperly provide those groups exclusive rights to Medicare reimbursement and remove the states' right to license and regulate the allied health care professions deemed qualified.

? CMS, in proposing this change, offers no evidence of any problem in need of fixing. It appears this is being done to appease the interests of a single group seeking to establish themselves as the sole provider of therapy services.

? For CMS to suggest athletic trainers are unqualified to provide the same services to a Medicare beneficiary who becomes injured from sailing in a

race and goes to their physician for treatment is outrageous and unjustified. Research shows the quality of services provided by athletic trainers is equal to those provided by physical therapists.

In summary, it is not advantageous for CMS to institute any proposed changes unless the purpose is to restrict health care access. If that is the purpose, why have Medicare?

Sincerely,

Corinna Schmidt, MS, ATC

Submitter :

Date & Time:

08/27/2004 03:08:43

Organization :

Category :

Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I wish to comment on the August 5th proposed rule on 'Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005.' I am in support of this proposal for several reasons. There are specific standards set for important reasons when health care is administered. The importance of licensure as a standard for rendering any health care related services is vital, not only for the services received but also for the potential liability involved. It is the only way to guarantee that only qualified practitioners are rendering skilled services specific to their licensure and qualifications. It is the only way to guarantee that patients will receive the exact and specific services that are required for their dysfunctions. Physical therapists spend an average of six to seven vigorous years obtaining their education and training specifically in their professional degree and are the only qualified personnel to administer physical therapy related health care services. The physical therapy profession is becoming more and more advanced and requiring more certifications to ensure that they are not only accountable and qualified, but able to medically screen and differentially diagnose to prevent further unnecessary costs to health care. It would be impractical and foolish to imagine that anyone other than a licensed physical therapists could administer the physical therapy related services that are required for patients. Too many things would be overlooked and undertreated otherwise. As patients are living longer and medical technology is becoming more advanced, patients are also becoming more and more ambiguous and complicated. With the education and training that physical therapists receive, they are the only skilled and qualified professionals who can comb through the web of complications that patients are presenting with in these days. By doing so, they are able to drive down the costs of health care and not abuse the system since they are the only ones who know what is medically necessary and considered skilled intervention. Any unskilled person delivering this type of service to a patient could in fact, create more harm to that patient. They may not be able to screen for complications and may render a service incorrectly and potentially cause further damage to their dysfunctions/disabilities. In addition, with the therapy cap that will take place on January 2005, it is vital that only professionals licensed to administer physical therapy to patients be doing so. With limited visits/treatments it is critical that licensed professionals administer the services needed in a more efficient and effective manner so as to not negatively impact their outcomes and further drive the costs of health care up. If you were the patient, would you want someone who was licensed to administer your therapy related services so you can become less disabled quicker or would you be willing to give up your treatments/visits to someone who may not be able to administer your treatments effectively to you? Thank you very much for your consideration on my comment.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY STANDARDS AND REQUIREMENTS

I am writing in opposition to CMS-1429-p. It appears that these revisions have specifically targeted certain professions and deemed them unqualified to carry out services. In my opinion, CMS should first assess the quality of the education and standards of certification of that profession before passing judgement. After reviewing these standards, should one profession who treats medicare patients be compared to the other? Are MD's more qualified than DO's?; Chiropractors more qualified than Physical Therapists?. Certified athletic trainers carry a 4 year bachelor degree and are required to attain 80 continuing education units every 3 years. The education of an athletic trainer consists of many courses which parallel the education of physical therapists. Continuing education courses taught to improve our ability to serve our patients are attended by both PT's and ATC's and usually taught by medical doctors. This current proposal suggests that ATC's are less qualified than a physical therapist assistant. Physical therapist assistants carry an associates degree and in some states (NY for example) do not need to pass a licensure or cerification exam. They are also not required to attain continuing education units to enhance their quality of care. Athletic trainers are required to pass a national certification exam. This is unique to any other type of therapy profession in that our qualifications are consistent nationwide. Our profession was recognized by the American Medical Association in 1991. In evaluating the standards of qualification for ATC's, I would like to offer for review ARTICLE 162 of the New York State Dept of Education as to the domains of practice for athletic trainers. In my career, I have never met a physical therapist,PTA,occupational therapist or COTA that wasn't supportive of my profession. I fully respect the PT,PTA,OT,OTA and work with these individuals on a daily basis. I have the full support of my staff in writing to CMS with my concerns. I fear however that the approval of this proposal will not only hurt the relationships we have built together as a staff, but also hurt the patient.

In conclusion, I would like to present one final question for thought in defense of my profession. If ATC's are deemed unqualified to perform therapy services, why are so many PT's also cerified as ATC's?

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Certified athletic trainer(ATC) is a professional health care provider. ATC has knowkedge of rehabilitation for injured people who experience physical difficulties. There is obvous educational back ground to be health care professional. Medicare should not limit to provide quality of care by ATC for people suffering from physical disability.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I find the proposed changes are directed from one organization (American Physical Therapy Association or American Occupational Therapy Association, possibly both). I don't know how much money a lobbyist paid to get a ruling change, but I am sure it came from this long standing worksetting turf war's between the organizations I mention above and the National Athletic Trainer's Association, which support Certified Athletic Trainer's.

I would like to mention the medical team that was the sole medical staff for the U.S.A Olympic Athletes and teams.

Medical Doctor's : David Weinstein, MD, Gloria Beim, MD, Sheldon Burns, MD, Larry Drum, MD, Robert Frederick, MD, Sandra Glasson, MD, Jo Hannafin, MD, James Montgomery, MD, Scott Rodeo, MD, Steve Simmons, MD.

Certified Athletic Trainer's: Brett Altman, ATC, Aaron Brook, ATC, Tammy Brockman, ATC, Vincent Comiskey, ATC, Daniel Dodson, ATC, Emery Hill, ATC, Don Kessler, ATC, Kathleen Koehler, ATC, David Kuhn, ATC, Gary Lang, ATC, Elicia Leal, ATC, Gina Magio, ATC, Nick Metskas, ATC, Allison Noggle, ATC, Steve Paulseth, ATC, Adam Pecina, ATC, Chrissy Price, ATC, Don Rackey, ATC, Jack Ransone, ATC, Jasper Richardson, ATC, Ted Robbins, ATC, Robert Rodriguez, ATC, Ed Ryan, ATC, Lonnie Sellers, ATC, Casey Smith, ATC, Debbie Van Horn, ATC, Wendy Veatch, ATC, and Scott Weiss, ATC.

If the United States Government sends a very qualified medical staff comprised of Medical Doctors and Certified Athletic Trainer's to care for our most prized athletes then why is medicare deciding to banish our profession of athletic training to providing care to medicare patients.

Athletic trainer's are very cost effective way of providing intervention immediately after a pt. is being seen by the physician. No lag time of care to set up a physical or occupational therapy appointment. ATC's provide for physicians immediate care to patients and it is at a much lower cost than seeing a physical therapist or occupational therapist!

Thank you for hearing me out and I hope you decide in favor of the profession of certified athletic trainer's.

Sincerely, Sean J. Monteyne MS., ATC/L.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

see attached

THE CENTER FOR RHEUMATOLOGY, LLP

DIAGNOSIS, CARE & RESEARCH

1367 Washington Avenue – Suite 101

Albany, New York 12206-1047

Phone: 518-489-4471

Fax: 518-489-4506

Norman Romanoff, MD
Joel Kremer, MD
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Betsy Fuchs, MD
Dorota Hausner-Sypek, MD
Natalia Veselova, MD
Victoria Michaels, MD
Mari Kaymakcian, RPA-C

Christine Barr, RN
Lisa Schroeder, RN
Tanya Sommers, RN
Jennifer Funaro, RN
Research Coordinators

Matthew Mc Garvey, MBA
Practice Administrator

Donna Gaffney
Practice Manager

August 4, 2004

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

Dear Mr. McClellan:

We are writing to officially comment on the proposed rule [CMS-1429-P] that has recently been handed

Our practice of 8 physicians provided approximately 5,100 services to Medicare beneficiaries during the year 2003, representing 28 percent of our entire practice. Our group collectively forms the largest single specialty group in the upstate of New York, serving patients that encompass a 200-mile radius. Rheumatologists administer care for Rheumatoid Arthritis, but those with Osteoarthritis, Osteoporosis, Lupus, Fibromyalgia, Gout, Psoriasis, Sjogren's Syndrome, Lyme Disease, Scleroderma and many other connective tissue and musculoskeletal diseases.

2005 Physician Fee Schedule

We applaud the effort of CMS and Congress to ensure a 1.5% increase in the Medicare conversion factor. Annual increases are essential to keep up with the increasing costs of operating physician practices.

In –Office Infusion Administration:

The increase in the reimbursement for infusion administration codes (90780 & 90781) for non-oncology services is a significant step in the process of reform. Further reductions in overall payments to office-based providers and restrictions on patient access to care, especially for a new wave of emerging and highly effective biologic

We are pleased that PRIT and CMS has also recognized the significance of the issue of inequity in the administration of physician office infusions between oncology and non-oncology specialists.

We have full confidence that the AMA's CPT editorial panel will find that reimbursement be based on the service that is being administered, rather than the specialty of the physician practice. We also encourage the use of administration codes fairly, and based on the costs of providing such a specialized service. A favorable decision for oncology specialists, including oncology, will be necessary in order to preserve access to these drugs that have made a difference in care.

Average Selling Price:

Please answer the following questions, as related to the implementation of an Average Selling Price methodology. Now that a definition of Average Selling Price has been clearly defined, what is the rationale for the payment mechanism being only 6% over the established Average Selling Price? Will CMS be making any recommendations to commercial payors to adopt usage of an ASP system?

We look forward to seeing CMS address our issues swiftly and judiciously in order to preserve access to care for patients and fair reimbursement for providers.

Thank you. On behalf of the physicians and staff of the Center for Rheumatology, LLP,

Donna M. Gaffney

Practice Manager

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

It is unthinkable to make such rulings that hinder the duties of an athletic trainer as a health care provider. We are professionals in physical care of the human body first, and foremost. The majority of ATC's have master's degrees and are dedicated to caring for people in need. Rules like this, 1) make healthcare cumbersome, 2) deny good work for qualified persons, and 3) assure the prolonged suffering of people in need.

Submitter : Mrs. Sara` Ebel Date & Time: 08/27/2004 02:08:29

Organization : Performance One Athletic Development

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

August 26, 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. I find it insulting to the athletic training profession that although we are licensed and permitted to prevent, assess, treat and rehabilitate high school, college, professional and Olympic athlete's injuries everyday under the direction of a physician, we are not permitted under this proposal to administer therapy services to an individual with a sprained ankle if they fall under Medicare coverage. Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists. CMS, in proposing this change, offers no evidence to refute this finding or that there is a problem in need of fixing.

History shows that there have never been any limitations or restrictions placed upon a 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 as to who is or is not qualified to provide 'incident to' services. I for one would want my physician to make decisions for my best interest and not because he is forced to choose someone else because of this proposal. By all appearances, this proposal by CMS 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 proposal will not only narrow the scope of the athletic training profession but it would force physicians to increase their workload which in turn will take away from their ability to provide the best possible patient care. As physicians and allied medical professionals we are here to provide the best possible care to patients, not to try to make professional and financial gains at their expense.

Sincerely,
Sara Ebel, MS, ATC
Performance One Athletic Development
6124 Busch Blvd.
Columbus, OH 43229

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please consider the detrimental effects this revision will have on our profession, livelihood, and the economy.

Dustin Hardin, ATC, LAT
70276 Thames Ct. W.
Indianapolis, IN 46229

8-27-04

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.
- 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,

Dustin M. Hardin ATC/L
Assistant Program Manager
Community Health Network
Allison Transmission Rehabilitation Services
317-242-5014
dustin.hardin@gm.com

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter.

CMS-1429-P-518-Attach-1.doc

Alan Daniels,ATC
858 South 1660 West
Lehi, UT 84043

August 27, 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

To Whom It May Concern:

The purpose of my letter is to express my concern over a proposal that would limit providers of “incident to” services in physician clinics and offices. If CMS adopts such proposal, the ability of qualified health care professionals would be eliminated, thus increasing cost and reducing the quality of health care given to Medicare patients within our country. I would ask that you reconsider the proposal at hand. I have cited several of my own concerns below for you to take into account.

Since the physician accepts legal responsibility for the individual working under his/her supervision, Medicare relies upon the professional judgment of the physician to determine who is qualified to provide the services needed. This being the case, there have not and should not be any restrictions placed on the physician as to who can provide care for “incident to” services. It is important that physicians continue to have the right to make decisions in the best interest of the patients.

If physicians are no longer allowed to utilize a variety of qualified healthcare professionals working “incident to” the physician, patients in rural areas will experience delays when it comes to receiving quality treatment. These patients may also incur greater cost, including travel expenses, and time. In return, these delays would extend the patient’s recovery time, ultimately increasing the cost for Medicare.

All Certified Athletic Trainers (ATC) have earned at minimum a Bachelors Degree, and passed a rigorous board certified examination. Certified Athletic Trainers are caring individuals that have entered the profession, not for the money, but to aid in the well being of others. From my experience, Certified Athletic Trainers are dedicated individuals that are very capable of working under a physician in a “incident to” manner, and every bit as capable of providing the same level of service as a Physical Therapist.

It appears that this proposal is being done to satisfy the interest of a single professional group, which would like to be the one and only provider of therapy services. No support is given as to a problem with the standard as presently set.

These issues may lead to more physician practices eliminating or reducing the number of Medicare patients they accept. I do not feel that it is necessary or beneficial for CMS to institute the changes proposed. Doing so would be detriment to the overall healthcare picture.

Sincerely,

Alan Daniels, ATC

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

TO: Mark B. McClellan, MD, PhD
 Administrator
 Centers for Medicare and Medicaid Services
 U.S. Department of HHS
 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.

As a Physical Therapist specialist with 30 years of experience working with physicians and consumers I wish to comment on the issue 'Therapy-Incident to' in the August 5 proposed rule. CMS proposes that qualifications of individuals providing physical therapy services 'incident to' a physician should meet personnel qualifications for physical therapy in 42 CFR 484.4, with the exception of licensure.

Although I view the concept of 'Therapy-incident to' a physician practice as grossly inappropriate for '21st century' physical therapy services I urge CMS to support the proposed requirements for individuals who furnish outpatient physical therapy services in physician's offices.

In order to assure quality outcomes and cost effective use of resources if 'Therapy -incident to' practice is to exist it is most appropriate individuals providing physical therapy would be Physical therapists and graduates of an accredited professional physical therapist program or meet certain grandfathering clauses or educational requirements. Furthermore only those Therapy services provided by or under the supervision of a PT with these qualifications should be billable.

Overall I feel a Physician billing for services provided by another licensed professional, like a physical therapist, should instead be discourag, curtailed and eventually disallowed. According to commonly trends in health care reforms payors have progressively and intentionally curtailing physicians from providing and billing for questionable 'incident to items' such as durable medical goods, pharmacy, Lab and other diagnostic tests . The reason is simple payor audits found this practice encourages overutilization ,lower quality and higher costs. Do we not wish to continue prudent practices across all areas in CMS ? If so it is obvious physician billing for services of a physical therapist cannot be allowed to go unchecked as this is one last door still open for physician abuse as a profitable form of unchecked and sanctioned self referral. Based on bleak fiscal projections I believe PT 'incident to' a physician service is a gross over patronization of the physician community that Medicare beneficiaries can no longer afford.

Physicians make PT a profitable side practice as few other options exist. For example the physician that also provides PT controls the extent of income derived from such a 'medically needed service'. The hazard for abuse arises from the fact that the treating physician can determine 'medical need' and can knowingly write the request or prescription for 'Therapy -incident to' services with profit as a motive. How would one know if this is not a beneficial service to the patient or society? . There is no question 'therapy-incident to' practice is outdated as licenced Physical Therapy professionals universally may obtain MC provider status to perform services on refferal from any physician, bill CMS and other insurers directly and be accountable for services rendered. Use of the independent PT model cuts the risks of allowing the referring provider and rendering provider be one and the same and bill for the services.

Worse yet is the current 'incident to' clause which allows physicians to bill for PT services provided by any subordinate. If 'Therapy-incident to' is to continue it should do so as described in the proposed rules. Services should be medically needed and provided by or supervised by qualified PT and not the physician.

I support CMS's proposal in the rule that establish these standards for personnel providing physical therapy services in physicians offices.

Thank You

John Palazzo DSc(can)PT,ECS
248 342 3224
Waterford ,MI



Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

re.: reimbursement for vein mapping:

Dear Sir/Madam,

It is a simply distorted belief that limiting the reimbursement of vein mapping to the surgeon "will increase the creation of fistulas"!!. This is a complete misunderstanding to what real life is all about. The credit for increasing fistula placement should go primarily to the Nephrologist who have have been fighting over the last several years for the increase in placement of fistula and trying to improve the standard of care for dialysis patients. In our large practice of more than 20 nephrologists and more than 1300 dialysis patients, it took us a lot to educate and encourage the vascular surgeons to place fistula through an aggressive program including interventional suite and introduction of vein mapping to the surgeons. The ability of our local surgeons to do mapping is fairly limited and is only done in some practices by ultrasound technique. This can miss some of the important anatomic findings especially in the chest veins and the better way to do it is angiographically.. In summary, if it was not for the aggressive measures taken by the nephrologists nationwide to improve the prevalence of fistulas we would have been in an "afistulized" patient population. The reimbursement SHOULD NOT be limited to the surgeons (due to their limited abilities in several geographic areas) and it should include all specialists that have a knowledge of what they are doing!!

Antoine Samaha, MD
alsamaha@pol.net

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see the following attachment

CMS-1429-P-521-Attach-1.doc



American Kinesiotherapy Association

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

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

Debbie Berven
P.O. Box 1576
Huntington Beach, Ca. 92647

September 15, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

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

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

Sincerely,

Debbie Berven, RKT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached letter concerning Therapy-incident to

John Storsved HSD, ATC
Instructor, Department of Kinesiology
University of Illinois
Freer 216 D
906 S. Goodwin
Urbana IL 61801-3895

August 27, 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.

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

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

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- 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.
- I ask that you strongly consider this before deciding. Many individuals would be disadvantaged by any changes

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,

John Storsved HSD, ATC

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please reconsider the revisions made in regards to dis-allowing a licensed and certified athletic trainer to work under my supervision and bill for services he/she is more than qualified to provide.

James Mozzillo, M.D., M.P.H.
Allison Transmission
4700 W. 10th Street
Indianapolis, IN 46222

August 27, 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 a physician writing to express my concern over the recent proposal that would limit providers of “Therapy-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. 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, 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 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 patients with comprehensive health care. The patient would be forced to see the physician and separately seek therapy, causing significant inconvenience and additional expense.
- 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 care, greater cost and a lack of local, 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 also cost time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which 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 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.
 - CMS 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. This action could be construed as an unprecedented attempt by CMS 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.
 - These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

It is not necessary or advantageous for CMS to institute the changes proposed, and I request that the change not be implemented. This CMS recommendation is a health care access deterrent.

Sincerely,

James Mozzillo, M.D., M.P.H.
Medical Director
Allison Transmission
Division of General Motors
Mail Stop M-17
PO Box 894
Indianapolis, IN 46206

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I am delighted that CMS has established billing codes for venous mapping for hemodialysis access placement. At UAB we have used routine preoperative ultrasound mapping prior to every vascular access surgery, and this has doubled the proportion of our patients using fistulas.

I have a few specific suggestions:

1. It would be more accurate to use the term 'arteriovenous access', rather than 'autogenous graft' The former term would encompass both fistulas and grafts. With preoperative mapping, a proportion of patients are found to have no suitable vessels for an A-V fistula, but can still get an A-V graft.
2. At our program (as in many other programs) the vascular mapping is performed by Radiologists, who provide the information to the surgeons, to assist them in planning the optimal access surgery. It is too restrictive to limit the reimbursement to the operating surgeon. Rather, it should apply to whoever performs the mapping (Radiologist, Nephrologist, or Surgeon).
3. The success of a vascular access requires suitable dimensions of both the vein AND the artery. For this reason, the term 'vascular mapping' should be substituted for 'vein mapping'.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I strongly support the proposal that individuals who furnish outpatient physical therapy services in physician's offices must be graduates of an accredited professional physical therapy program. Just as I want a legitimate physician graduate or nurse graduate treating me or my family, I want a legitimate physical therapist. If I want an athletic trainer treating me, I will seek one out. If I want a massage therapist, I will go to one. But I do not want someone who is not a licensed physical therapist 'applying' physical therapy techniques to me!

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

<Your Name>
<Your Address>
<Your City, State, ZIP>

<DATE>

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.

Sincerely, Jeff Sullivan PhDc, ATC

Jeff Sullivan
Point Loma Nazarene
University
San Diego, CA 92106

8/27/04

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:

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- 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,

Jeff Sullivan, PhDc, ATC

Assistant Professor/Assistant Athletic Trainer

Point Loma Nazarene University

Submitter : Mrs. Amy Mihm Date & Time: 08/27/2004 06:08:13

Organization : UW Health Sports Medicine Clinic

Category : Health Care Professional or Association

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.

Please see attachment provided.

Amy L. Mihm
UW Health Hospital and Clinics
621 Science Drive
Madison, WI 53711

August 27, 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, such as certified athletic trainers, 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 expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor’s or master’s degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

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

Sincerely,

Amy L. Mihm, MS, RD, LAT
Registered Dietitian
Licensed Athletic Trainer
al.mihm@hosp.wisc.edu
608-265-8886

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attached letter.

CMS-1429-P-528-Attach-1.txt

Attachment #0528

<http://www.cms.hhs.gov/regulations/ecomments>

John Smith
Shifting Sands Medical Association
123 Main Street
Springfield, MO 56789

September 15, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

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

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

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

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

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

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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.

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

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

Sincerely,

John Smith

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the "Incident To" provision and request that it be included in the final rule. Only licensed physical therapists with proper training in evaluation, assessment, and treatment in physical therapy services are qualified to provide and bill for those services in my opinion. Treatment by those without the proper training will not only harm the profession of physical therapy, but patients as well.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

August 27, 2004

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

RE: Medicare Programs; Revisions to Payment Policies Under the Physician Fee Schedule Calendar Year 2005
'Therapy-Incident-To'

Dear Dr. McClellan:

I am physical therapist writing in support of the August 5 proposed rule on 'Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005.' I have 25 years of experience as a physical therapist. I am currently a physical therapist at a hospital in the MetroWest suburban Boston area. I am licensed to practice as a physical therapist and as an athletic trainer.

As you are aware this proposed rule requires that the qualifications of individuals who provide physical therapy services 'Incident-To' a physician should meet the same qualifications for physical therapy as detailed in 42CFR 484.4 with the exception of licensure. Section 1862(a)(20) of the Social Security Act clearly requires that in order for a physician to bill 'Incident-To' for physical therapy services, those services must meet the same requirements for outpatient therapy in all settings. Thus, provisions of physical therapy services by individuals other than physical therapists would violate this section of the Social Security Act. Therefore, I strongly support this proposed requirement.

The proposed requirement will require that an individual who has graduated from an accredited physical therapy education program provide these services. Educational preparation as a physical therapist, is paramount to insure appropriate and safe delivery of services, whether they are delivered, whether that is in a private office, hospital based department, or in a physicians office. The only practitioners educationally and professionally qualified to provide these services are physical therapists and physical therapist assistants, working under the supervision of physical therapists. The educational preparation for physical therapists currently requires a minimum of a master's degree. The majority of physical therapy education programs will offer the doctor of physical therapy (DPT) degree by 2005. Licensed in the states that they practice, physical therapists are professionally accountable for all of their actions.

Delivery of the broad scope of 'physical therapy services' by unqualified personnel may be potentially harmful to patients. Unqualified personnel have varied degrees of education and competence to provide these types of services. This lack of training and competence may place the Medicare or Medicaid recipient at risk for harm or care that is ineffective and inefficient from a clinical and fiscal perspective. These concerns are especially critical considering the financial limitations on beneficiaries that will be imposed due to the 'Therapy Cap' that becomes effective on January 1, 2006.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please, see the following attachment.

CMS-1429-P-531-Attach-1.doc



American Kinesiotherapy Association

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

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

Marinna Skye Edwards
1750 West Citracado Pkwy #47
Escondido, Ca 92029

September 15, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

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

Sincerely,

Marinna Skye Edwards, RKT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am glad that CMS is proposing to recognize licensed psychologists as being qualified to supervise technicians to provide diagnostic and therapeutic services. I am convinced that Medicare beneficiaries would benefit from having psychologists supervise the administration of psychological and neuropsychological testing. There is a documented shortage of geriatric psychologists and neuropsychologists available to the older adult population, and allowing them to supervise technicians would allow these clinicians to positively impact a greater number of Medicare beneficiaries in facilitating the diagnosis and planning for cognitive and psychological disorders. This would also benefit the field of psychology and indirectly benefit Medicare beneficiaries, by offering options for psychologists in training to obtain needed hands-on experience by practicing as technicians to ensure quality training and quality clinicians.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

MANAGING PATIENTS ON DIALYSIS

Venous mapping has become a standard in the care of the patient with chronic kidney disease and the institution of reimbursement for this procedure is a positive step forward. However, the current draft rule limits reimbursement for this procedure to the operating surgeon. This practitioner-specific restriction should be revised to permit reimbursement for this procedure based solely on the indication and requirement that this G-code only be used for assessment for AVF placement, and not based on which specialist or facility performs the procedure. With increasing frequency, mapping is being performed by practitioners and licensed providers other than surgeons, including: radiologists, interventional nephrologists, diagnostic vascular laboratories, and mobile diagnostic units. Limiting reimbursement for this G-code exclusively to the surgeon would serve as a barrier to increasing the AVF rate in this country, as it would prevent the majority of incident hemodialysis patients from being evaluated for AVF placement where this service is not provided by a surgeon.

Also, since mapping also usually requires limited assessment of the arteries, it is suggested that 'vein' mapping be replaced by 'vessel' mapping.

Consideration should be given to replacing 'graft' with 'fistula' in the G-code description, as the latter would cover all autogenous procedures, whereas 'graft' may confuse the issue by implying that only certain types of planned AVF procedures would qualify for reimbursement under this G-code.

Thank you for your attention to this critical step in the care of our patients who require renal replacement therapy.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Mr McC.ellan,

I am a physical therapist who practices in an outpatient clinic setting. I treat mainly orthopedic problems and and I treat a significant number of Medicare patients. I have 23 years of experience.

I strongly support CMS's proposed personnel requirements for physical therapy provided "incident to" physician services in the physician's office and that reimbursement for physical therapy only occur when provided by a physical therapist (PT) or directly supervised physical therapy assistant (PTA). PT's and PTA's are the only practitioners who have the education to provide these services. PT's and PTA's are professionally educated at the college or university level (accredited by the Commission on Accreditation of Physical Therapy recognized by the US Dept. of Education) and physical therapists must be licensed in the states where they practice. PT and PTA's have the background and training to provide good functional outcomes for individuals with disabilities and other medical conditions. Delivery of "physical therapy services" by less qualified practitioners is inappropriate as would be the reimbursement for those services. In my practice, I have treated Medicare patients that received inappropriate instruction for exercise programs from trainers and massage therapists that (at worse) exacerbated a condition or (at best) did not help them. This situation would become worse if financial reimbursement under a financial cap situation (as is slated to happen in 2006) prevented the Medicare patient from getting appropriate treatment.

Thank you for the opportunity to comment.

Sincerely,
Jeff Ray, PT
970.207.1500

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

8/27/04

Dear CMS:

As a practicing nephrologist, I would like to provide my comments to you regarding the proposed rule for venous mapping. I treat numerous end stage renal patients and I am continually concerned by the poor vascular access that these patients are subjected to. I believe that the proposed change will be instrumental in ensuring more patients receive a fistula.

It is well documented and accepted that vessel mapping is critical to both optimizing the identification of patients who are candidates for an autologous arterio-venous fistula (AVF), as well as to increasing the rate and success of AVF placement.

The current draft rule limits reimbursement for this procedure to the operating surgeon. This practitioner-specific restriction should be revised to permit reimbursement for this procedure based solely on the indication and requirement that this G-code only be used for assessment for AVF placement, and not based on which specialist or facility performs the procedure. With increasing frequency, mapping is being performed well by practitioners and licensed providers other than surgeons, including: radiologists, interventional nephrologists, diagnostic vascular laboratories, and mobile diagnostic units. Limiting reimbursement for this G-code exclusively to the surgeon would serve as a barrier to increasing the AVF rate in this country, as it would prevent the majority of incident hemodialysis patients from being evaluated for AVF placement where this service is not provided by a surgeon.

Since mapping also usually requires limited assessment of the arteries, I suggest that "vein" mapping be replaced by "vessel" mapping.

Although it may not need to be addressed in the proposed G-code language, reimbursement should not be restricted to Doppler mapping, as circumstances often require use of contrast or other mapping methods (which, incidentally, are not performed by surgeons).

Consideration should be given to replacing "graft" with "fistula" in the G-code description, as the latter would cover all autogenous procedures, whereas "graft" may confuse the issue by implying that only certain types of planned AVF procedures would qualify for reimbursement under this G-code.

I believe that these changes will result in a more proactive approach to creation fistula which will result in higher frequency of fistula, better clinical care and ultimately a lower cost to CMS. It is rare that a few simple changes will impact patient care as significantly as this rule change could. I hope that you agree with my suggestions.

Sincerely,
 Katafan Achkar , M.D
 1415 La Concha Lane
 Houston, Tx 77054

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see the following attachment.



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

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

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

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

Submitter : Date & Time:
Organization :
Category :

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

THERAPY - INCIDENT TO

To: 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

From: Drew Bossen, PT, MBA
4191 Westcott Drive NE
Iowa City, IA 52240

Re: ?Therapy- Incident To?

The purpose of my letter today is to comment on the August 5th proposed rule on ?Revision to the Payment Policies Under the Physician Fee Schedule for Calendar Year 2005.? I strongly support CMS?s proposed requirement that physical therapists working in physician offices be graduates of accredited professional physical therapist programs. The licensure of our profession ensures that the public is receiving the highest level of care. Without the requirement of licensure, virtually anyone can provide services ?Incident to? the care of a physician. I can assure you that unlicensed individuals do not have the needed skill-set nor the educational background to be considered a viable provider. Licensure has been established as a standard in every state of the nation for a reason. It is critical, for the safety of the public, that licensure be the foundation of every facility providing services.

To those ends, I believe that individuals providing services in physicians offices must be a graduate of an accredited professional physical therapist programs. In addition, 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. Unqualified personnel should NOT be providing physical therapy services.

So why does this issue interest me? I have been a practicing physical therapist for the past 25 years. I am an owner of Progressive Rehabilitation Associates in Iowa City, Iowa. Progressive Rehab provides needed rehab services to the East-Central region of Iowa. We employ nearly 100 individuals in our nine clinics. We continually see unqualified individuals providing services to Medicare participants via the ?Incident To? clause. Be clear, the physician may be in the office but is essentially removed from the day to day care as he sees and treats new patients coming into his practice. Virtually all decision of care are left to unlicensed, uneducated individuals. The lack of assessment skills and treatment progression within these practices leads to excessive utilization of the Medicare dollars which in turn reflects on all of us.

I would ask for your support in proceeding with the proposed changes. It will provide a higher level of service and care to Medicare participants across the country.

With regards,

Drew Bossen, PT, MBA
4191 Westcott Drive NE
Iowa City, IA 52240

P: 319-337-9252
C: 319-430-3382

Email: bosspt@mchsi.com

CMS-1429-P-537-Attach-1.doc

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

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With regards,



Drew Bossen, PT, MBA
4191 Westcott Drive NE
Iowa City, IA 52240

P: 319-337-9252
C: 319-430-3382
Email: bosspt@mchsi.com

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

Eric McCutchan
1101 Spruce St., Apt. 108
Terre Haute, IN 47807

27 August 2004

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

Re: Therapy – Incident To

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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,

Eric D. McCutchan, LAT, ATC
Graduate Athletic Trainer
Indiana State University

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Chevonne Goff
University of Charleston
2300 MacCorkle Ave S.E.
Charleston, WV 25304

August 16,2004

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 unease about the recent proposal that would limit providers of "incident to" services in the physical offices and clinics. If implemented, this would eradicate the ability of qualified health care professionals to provide these important services. It would also reduce the quality of health for Medicare patients and increase the costs associated with this service; causing an unwarranted burden on the health care system.

When making your decision, 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.

Due to a shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas, it is likely that the patient would have delays in health care, increased costs, 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. As a student in an accredited university, I have taken essential courses to enhance and strengthen my knowledge and skills that are vital to the health care profession. These courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute and care of injury and illness, therapeutic modalities, therapeutic rehabilitation, statistics and research design, and exercise physiology. During these classes I am assessed fervently and meticulously on my skills to ensure that I could properly maintain the health care of both athletes and non-athletes.

"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).

"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.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached document. Thank you for your time in this matter that is very important to the athletic training profession.

Aaron Galpert ATC/L
1340 Harmony Drive
Wadsworth, OH 44281

September 1, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician 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.
- 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.

- 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.
- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor's or master's degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide "incident to" outpatient therapy in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- As a professional athletic trainer, I have worked with the high level athlete as well as the Medicare patient. I have also been named to the US National Paralympics soccer team staff as an athletic trainer. It is obvious to me that our profession has become very reliable in various aspects of the health care domain. Throughout my years of serving in the health care field and dealing with the clinical patient both young and old, I feel that the older population feels better when they are treated as a younger athlete. Too many times I have seen a Medicare patient being treated by a physical therapist only to see that person doing his/her home program in the presence of the PT. Yet still billing Medicare for watching the patient do in-house what they should be doing at home in the first place. No aggressive rehab and no urgency to return the patient to a functional lifestyle. To me, competition has always been good. If the PT's have a monopoly over the health care field then the health care field is certainly in trouble.

In summary, it is not necessary for CMS to institute the changes proposed. Please reconsider redefining the role of healthcare professionals.

Sincerely,

Aaron Galpert ATC/L

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

see attached letter

Jessica Walter
P. O. Box 313
Marion, MD 21838

August 20, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P. O. Box 8012
Baltimore, MD 21244-8102

Re: Therapy – Incident to

Dear Sir/Madam:

I am writing to express my concern and anger over the recent proposal that would limit providers of “incident to” services in physician’s offices and clinics. I am a senior athletic training student at Salisbury University. I have worked very hard to achieve good grades and to develop my skills. When I become a certified athletic trainer this coming year, I want the opportunity to serve Medicare patients. It offends me that my skills are being questioned, and that I am being judged unqualified to provide therapy services under the supervision of a physician.

Please take into consideration that physicians have the right to delegate the care of the patients under his/her care to qualified individuals whom the physician feels is knowledgeable and trained in the protocols to be administered. The physician is legally responsible for individuals under his/her supervision. Therefore, the professional judgment of the physician on who is or is not qualified to provide a service has been respected. Changing the “incident to” services reimbursement would not allow the physician to offer comprehensive, quickly accessible care. Patients would be forced to seek separate therapy treatments, causing the patient increased expense and inconvenience. There is an increasing shortage of health care professionals. If physicians were not able to utilize a variety of health care professionals working “incident to” the physician, patients will ultimately suffer a decreased quality of health care.

Athletic trainers prevent, assess, treat, and rehabilitate injuries in the universities, professional teams, and the United States Olympic teams. I am dismayed that athletic trainers are being deemed unqualified to provide these same services to Medicare beneficiaries who may become injured during physical activity and seek treatment from their local physician.

Sincerely,

Jessica Walter

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir/Madam:

Please read the attached commentary on the proposed rule change.

Thank you for the time,

Jason Vian
MS, ATC, CSCS

Jason Vian MS, ATC, CSCS
Alvernia College
400 Saint Bernardine Street
Reading, PA 19607

August 28, 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. This rule would cut down on patient and physician choice by limiting the number of options that a physician and patient can utilize. 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:

I find it very offensive that in reading the language of the proposed rule change that my skills and background are considered to be inferior for reimbursement. There are many athletic trainers that currently service individuals in various settings from hospitals to professional sports. The profession of athletic training is based on sound medical principles and continuing research that is done by individuals within our own profession as well as the outstanding research that is done by other various health care related groups.

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).

Please remember that 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. It is a matter of physicians being able to utilize health care providers that they feel are the most appropriate to that individual patient.

Finally, every single profession needs to work together for the health care system to work and improve its ability to provide for our nation’s citizens. This rule would effectively ignore a large group of individuals whose compassion for others combined with their education and abilities would leave the healthcare system with a void that could not be appropriately filled.

Sincerely,

Jason Vian MS, ATC, CSCS

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

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.

Personally, I have worked with a variety of Medicare patients in both recreational and clinical settings. I have been involved with the Silver Sneaker fitness program, the YMCA, and part of the medical staff for the National Senior Games. The National Senior Games Association (NSGA) is a not-for-profit organization that is dedicated to promoting healthy lifestyles for active adults 50 and over through education, fitness and sport. As a community-based member of the United States Olympic Committee since 1988, the NSGA spearheads the Senior Games movement, sanctioning and coordinating the efforts of 50 member state organizations across the country. The City of Pittsburgh is proud to host the 2005 National Senior Games and I will be proud to be a part of the 750+ health professionals, most of whom are Certified Athletic Trainers, Emergency Medical Technicians or Physicians, working to provide a safe and healthy environment for these games to take place.

I have also had the opportunity to work with active people of all ages and athletic levels, ranging from peewee softball to the elite level athlete. Throughout my career, athletes, coaches, administrators, headmasters, and parents just to name a few, have believed in my skills and education level. They have entrusted their children, their bodies, their teams, and in many cases, their livelihood in me and my skill set. I find it difficult to believe that now CMS may be considering my professional skills inadequate and my overall profession unqualified to provide services to Medicare beneficiaries.

Please see attached document for additional information to be considered during your decision-making process.

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,
Stephany Lang

Stephany N. Lang
Point Park University
201 Wood Street
Pittsburgh, PA 15222

August 28, 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.

Personally, I have worked with a variety of Medicare patients in both recreational and clinical settings. I have been involved with the Silver Sneaker fitness program, the YMCA, and part of the medical staff for the National Senior Games. The National Senior Games Association (NSGA) is a not-for-profit organization that is dedicated to promoting healthy lifestyles for active adults 50 and over through education, fitness and sport. As a community-based member of the United States Olympic Committee since 1988, the NSGA spearheads the Senior Games movement, sanctioning and coordinating the efforts of 50 member state organizations across the country. The City of Pittsburgh is proud to host the 2005 National Senior Games and I will be proud to be a part of the 750+ health professionals, most of whom are Certified Athletic Trainers, Emergency Medical Technicians or Physicians, working to provide a safe and healthy environment for these games to take place.

I have also had the opportunity to work with active people of all ages and athletic levels, ranging from peewee softball to the elite level athlete. Throughout my career, athletes, coaches, administrators, headmasters, and parents have believed in my skills and education level. They have entrusted their children, their bodies, their teams, and in many cases, their livelihood in me **and** my skill set. I find it difficult to believe that now CMS may be considering my professional skills inadequate and my overall profession unqualified to provide services to Medicare beneficiaries.

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,

Stephany N. Lang

Pittsburgh, PA 15222

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I strongly support Cms'proposal that individuals who furnish outpatient physical therapy in physicians's offices must be graduates of an accredited professional physical therapist program. There are physicians in my area who are currently providing "Physical Therapy" by individuals who have no more than on the job training. This is substandard care and could lead to potential harm to patients because of lack of proper training.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Many Physicians, especially chiropractic physicians, have unqualified personnel performing "physical therapy" services like massage therapists and general office staff with no education. This behavior markedly tarnishes the physical therapy profession and most importantly can potentially harm the patients receiving care.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached document

Aikane Belez
9052 First View St, Apt. B106
Norfolk, VA 23503

August 30, 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.
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- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
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- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

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

Sincerely,

Aikane Belez, ATC, LMT
9052 First View St, Apt. B106
Norfolk, VA 23503

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see following attachment.



American Kinesiotherapy Association

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

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

Craig D. Ing, RKT
405 Circle Drive
Addison, IL 60101

August 28, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

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

Sincerely,

Craig D. Ing, RKT

Submitter : Joy Crouse, ATC/L Date & Time: 08/29/2004 03:08:32

Organization : Joy Crouse, ATC/L

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 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.

Joy Crouse, ATC/L
Alabama Orthopaedic Clinic, P.C.
3610 Springhill Memorial Dr. N.
Mobile, AL 36608

8/28/2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

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

Sincerely,

Joy Crouse, ATC/L

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a Certified Athletic Trainer and I have had 6 years of education in anatomy/physiology, rehabilitation, modalities, administration and education in learning about injuries and how to treat them. I have more education then a Physical Therapy Assistant and they are qualified to bill for their services. I am just asking that I be treated the same. The following letter describes in more detail about Certified Athletic Trianers' knowledge in the health field.

CMS-1429-P-549-Attach-1.txt

Attachment #0549

Shaunna Olson
57 E. Langdon Rd.
Walla Walla, WA 99362
August 28, 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:

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- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor’s or master’s degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education

Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

- To allow only physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.
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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.

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,

Shaunna Olson, ATC

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Athletic Training is a vital part of the medical field. Please ensure it stays this way. These individuals have sacrificed a lot of time, energy et effort to receive degrees.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Please read the attached email exchange with the editor of the National Athletic Trainers Association News and make your own decision. I have recently become a physical therapist this past June. Before finishing PT school I was an Athletic Trainer for six years. This is an email exchange so please start with the letter at the bottom and work your way up. This letter was never published!!

From: Valerie Hunt [valerieh@nata.org]
Sent: Wednesday, August 20, 2003 8:17 AM
To: Sean P. Riley
Subject: RE: Letter to NATA News

Hi, Sean!

Your letter will appear in the October NATA News, with no accompanying feedback from the education experts. Thanks for writing! Valerie

-----Original Message-----

From: Sean P. Riley [mailto:phystherapysr@snet.net]
Sent: Mon 8/4/2003 7:44 AM
To: Valerie Hunt
Cc:
Subject: RE: Letter to NATA News

Valerie:

Thank you for your timely response and I look forward to hearing from you in the future.

Thanks again,

Sean

-----Original Message-----

From: Valerie Hunt [mailto:Valerieh@nata.org]
Sent: Monday, August 04, 2003 8:09 AM
To: 'Sean P. Riley '
Cc: Eve Becker-Doyle; Teresa Foster Welch; Larry Commons
Subject: RE: Letter to NATA News

Dear Sean,

Thank you for your letter to the editor regarding athletic training education. It's easy to see you care deeply about the issue, and that is always welcome.

I'll send your letter through our review process and let you know which edition will contain it. (I expect it will be either the October or November edition.) Although you might see an accompanying editor's note or a follow-up letter from our education reform experts discussing the points you made, I would be quite surprised if your letter is rejected from print. In the years I've been with NATA, only one letter to the editor has been withheld, and that was due to incorrect statements bordering on libel. Hot opinions aren't banned just because they're hot. We try to encourage as much discussion as possible.

Sean, please let me know if you've got any questions. I'll keep you posted regarding the publication date of your letter to the editor.

Best regards,
Valerie Hunt
NATA News
valerieh@nata.org
800-879-6282, ext.146

-----Original Message-----

From: Sean P. Riley
To: valerieh@nata.org
Cc: ebd@nata.org; teresa@nata.org; larryc@nata.org
Sent: 8/3/2003 8:46 PM
Subject: Letter to NATA News

Sean P. Riley, MS, ATC, EMT
1800 Silas Deane Hwy
Rocky Hill, CT 06067

August 3, 2003

Dear Editor:

I am doubtful that this letter will ever see print secondary to its inflammatory nature. I write this letter in response to the numerous letters written in response to issues that do not, have not, and will not make a difference in employment opportunities, wages, and quality of life for athletic trainers. To follow is a story and example of exactly what I mean.

I recently had a friend who was receiving physical therapy services at a large physical therapy company. She reported that she received approximately 90% of her care from an athletic trainer, who was a recent graduate from a local accredited athletic training curriculum. The question that she posed to me knowing that I was an athletic trainer and a graduate of the program was: "What is the athletic training curriculum like?" I simply looked up the information on the internet which was presented as follows:

Required General Education Courses:

BIO 111, CHEM 111, ENG 110, HIST 261, HIST 262, STAT 104, CS 115, PHYS 111,
PSY 236 and COMM 140.

Major in Athletic Training, B.S

62 credits as follows

Lecture Courses (48 credits)

PE 110 Concepts in Fitness
PE 112 Introduction to Athletic Training
PE 210 Personal and Community Health
PE 213 Anatomy in Physical Education
PE 214 Physiology in Physical Education
PE 216 Kinesiology
PE 217 Care and Treatment of Athletic Injuries
PE 218 Scientific Basis for Athletic Training
PE 307 Human Nutrition
PE 317 Therapeutics in Athletic Training
PE 332 Psychological Aspects of Sport
PE 410 Exercise Physiology
PE 413* Organization and Administration in Athletic Training
PE 415* Fitness Assessment and Exercise Prescription
PE 421* Pharmacology in Sports Medicine and Special Populations
PE 440 Therapeutic Modalities in Athletic Training
IT 380 Emergency Medical Technician

Skill and Practicum Courses (14 credits)

PE 315* Practicum in Athletic Training I
PE 316* Practicum in Athletic Training II
PE 319* Practicum in Athletic Training III
PE 375 Training for Fitness
PE 445* Internship in Athletic Training

Require admission to the Professional Program prior to enrollment.

Clinical Experience

All students in the Athletic Training Education Program are required to complete four semesters of clinical experience in the Athletic Training facility and a fifth semester in an off-campus affiliation. The student will be under the direct supervision of a certified athletic trainer while obtaining the minimum of 800-clock hours required by the NATABOC to become eligible to sit for the certification exam. While the program maintains the minimum standard of 800-clock hours of clinical experience under the direct supervision of a NATABOC certified athletic trainer, emphasis is placed on mastery of the educational competencies over the five semesters of clinical experience.

My friend took one look at the curriculum, looked at me and stated, "You have a degree in gym." She thought it was the funniest thing and I was offended. On reflection, she was absolutely right. Does this look like the curriculum of an allied health care professional?

If it is, why is the program housed in the school of Physical Education and Health Fitness Studies? Where is the coursework in the general sciences required by all allied health care professional curricula? Is the 3 semester hours in anatomy in physical education and 3 semester hours in physiology in physical education the same as their counterparts in the biology department?

The problem is that athletic training curriculum has not evolved as others have in the past 20 years. There are currently approximately 200 CAAHEP accredited entry level and 14 entry level graduate programs. There are also approximately 160 schools in candidacy for accreditation as I write this letter. <<http://www.cewl.com/jrc-at/elm.html>> There could conceivably be approximately 375 CAAHEP accredited programs in the United States within the next 5 years. Does anyone else see this as a problem? If this number of schools can attain the standard for accreditation maybe the standard is to low?

It is my opinion that athletic trainers will not get the respect and money that they deserve until they can stand up to other allied health care professionals with the objective educational documentation that says they know what they know. Until then the profession does not have a good argument in many states when it comes to issues such as direct access and third part reimbursement.

Sincerely,

Sean P. Riley, MS, ATC, EMT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear CMS,

As a physical therapist with over 20 years of experience in private practice, I am STRONGLY supporting CMS' proposal that individuals who furnish outpatient physical therapy services in physician's offices must be graduates of an accredited professional physical therapist program. In addition, physical therapists, under the supervision of physical therapist are the only caregivers who have the requisite training to provide physical therapy services. Physical therapists must undergo rigorous training and obtain their Masters degree before they are able to sit for the national board examination. In a few years, new therapists will have to obtain a doctoral degree prior to sitting for the exam. Not even chiropractors undergo such strict and rigorous training prior to providing rehabilitative services. The delivery of physical therapy services by anyone who is not a licensed physical therapist will harm patients in their current and future physical states. Currently, not only are unqualified services being provided by non-physical therapist in doctors offices, but they are also being provided by chiropractors, who are charging Medicare for services that can only be provided by a licensed physical therapist. They are telling their clients they are receiving "physical therapy" services, when in fact they are being provided chiropractic services. Medicare is footing the bill for these false and illegal services. It's time all those concerned with Medicare regulations and policy decisions to take a stand in favor of the American people and put an end, once and for all, to physical therapy services provided by other than licensed and credentialed physical therapists. Millions of dollars will be saved by Medicare by eliminating payment for services to non-physical therapist provided services, in any type of physicians' offices. Small business is what makes America great and Medicare must step to the forefront and protect and encourage business development in the private physical therapy practice sector and eliminate illegal charging of services by chiropractors, M.D.'s, nursing homes and hospitals by anyone other than licensed and credentialed physical therapists. Thank you in advance for supporting our cause!

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Certified athletic trainers are educated, trained and qualified to provide therapy under the supervision of a physician.

August 30, 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,

<Your name and address>

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I am a practicing PT in the state of NJ for the past 18 years. I am strongly committed to the concept that physical therapy services should be rendered to the consumer by a licensed PT or PTA. The concept that a physician can employ an un-licensed person, to administer physical modalities in their office, and call it, physical therapy, is really unethical. I was on the NJ State Board of PT Ecaminers for 8 years. It is my understanding that the laws exist to protect the health, safety, and welfare of the consumer. Supporting this Rule would be paramount to that protection of the consumer and would be appropriate, as unlicensed persons could harm the consumer. In addition, it is fraudulent to deliver physical therapy by anyone other than a licensed PT or PTA. In summary, I urge you to support this rule. Thank you for your time.
Professionally yours, Leslie K. Marcks, PT NJ License QA03996

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

This is a response to the recent government proposal that would mandate that ONLY physical therapists would be qualified to physical medicine to Medicare patients. Let me express that, as a certified athletic trainer, I am outraged that the CMS has taken a stand to judge our profession as unqualified to provide therapy services under the supervision of a physician. The purpose of this letter is to clarify any misconceptions that the CMS may have about the profession of athletic training.

Certified athletic trainers are allied health professional that specialize in the field of sports-related injuries. These injuries can occur from collision sports such as football and hockey, or they may occur from non-contact sports and leisure activities. As an allied health profession, our services are also kept under the direct supervision of a physician.

There are numerous instances where a certified athletic trainer would be more than qualified to see a Medicare patient. One example would be that a 65 year old may experience back pain while out on the golf course. Another would be if an elderly person experiences knee pain while running. These instances fall well within the scope of practices that certified athletic trainers provide. To not provide Medicare coverage in similar instances and by not allowing a certified athletic trainer to care for these instances would be a great injustice to the medical profession.

I would also like to take this time to respond to the following statement issued by the American Physical Therapy Association.

?It has been a long-standing concern of the APTA that personnel who are unlicensed and have not graduated from an accredited PT professional program furnish services in physicians' offices and those services are billed as therapy services under the Medicare program. Under current policy it is possible for a high school student or another individual with no training in anatomy, physiology, neuromuscular reeducation or other techniques to furnish services in a physicians' office without the physician actually observing the provision of these services.?

My first comment responds to the education of the certified athletic trainer. A student who pursues the field of athletic training must take didactic and clinical coursework in various subjects, including anatomy, physiology, therapeutic modalities, injury evaluation, biomechanics, therapeutic exercise (which includes muscle reeducation), and exercise physiology. To put it simply; there is very little a physical therapist can legally do that a certified athletic trainer can't! The major difference between the two professions is that certified athletic trainers are meant to see those injured in strenuous physical activity. Physical therapists, on the other hand, see a much wider patient population, such as those who are wheelchair bound, are suffering from systemic and neurological diseases, amongst other ailments.

My second comment from this statement refers to the legal aspects. The statement made by the APTA is inaccurate. In many states, it is against the law for certified athletic trainers to practice athletic training without a state issued license. Many other states are pursuing this for athletic trainers. Certified athletic trainers must take a national exam, and are licensed through either 1) acceptance of this national exam by the respective state, or 2) passing a state-administered exam for athletic trainers.

I hope that these comments help in influencing your decision to amend this proposal. I would consider it a great tragedy if the CMS decides to not utilize the expertise of the certified athletic trainer. Please do not cut a perfectly qualified provider out of the loop for providing quality therapy services to those who are eligible to receive it.

If you would like to respond, which I strongly encourage, please feel free to write me at this address

Michael S. McElroy, ATC/L
1601 N. Willow Rd. Apt. 208
Urbana, IL 61801

Dear Centers for Medicare and Medicaid Services,

This is a response to the recent government proposal that would mandate that ONLY physical therapists would be qualified to physical medicine to Medicare patients. Let me express that, as a certified athletic trainer, I am outraged that the CMS has taken a stand to judge our profession as unqualified to provide therapy services under the supervision of a physician. The purpose of this letter is to clarify any misconceptions that the CMS may have about the profession of athletic training.

Certified athletic trainers are allied health professional that specialize in the field of sports-related injuries. These injuries can occur from collision sports such as football and hockey, or they may occur from non-contact sports and leisure activities. As an allied health profession, our services are also kept under the direct supervision of a physician.

There are numerous instances where a certified athletic trainer would be more than qualified to see a Medicare patient. One example would be that a 65 year old may experience back pain while out on the golf course. Another would be if an elderly person experiences knee pain while running.

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I would also like to take this time to respond to the following statement issued by the American Physical Therapy Association.

“It has been a long-standing concern of the APTA that personnel who are unlicensed and have not graduated from an accredited PT professional program furnish services in physicians’ offices and those services are billed as therapy services under the Medicare program. Under current policy it is possible for a high school student or another individual with no training in anatomy, physiology, neuromuscular reeducation or other techniques to furnish services in a physicians’ office without the physician actually observing the provision of these services.”

My first comment responds to the education of the certified athletic trainer. A student who pursues the field of athletic training must take didactic and clinical coursework in various subjects, including anatomy, physiology, therapeutic modalities, injury evaluation, biomechanics, therapeutic exercise (which includes muscle reeducation), and exercise physiology. To put it simply; *there is very little a physical therapist can legally do that a certified athletic trainer can't!* The major difference between the two professions is that certified athletic trainers are meant to see those injured in strenuous physical activity. Physical therapists, on the other hand, see a much wider patient population, such as those who are wheelchair bound, are suffering from systemic and neurological diseases, amongst other ailments.

My second comment from this statement refers to the legal aspects. The statement made by the APTA is inaccurate. In many states, it is against the law for certified athletic trainers to practice athletic training without a state issued license. Many other states are pursuing this for athletic trainers. Certified athletic trainers must take a national exam,

and are licensed through either 1) acceptance of this national exam by the respective state, or 2) passing a state-administered exam for athletic trainers.

I hope that these comments help in influencing your decision to amend this proposal. I would consider it a great tragedy if the CMS decides to not utilize the expertise of the certified athletic trainer. Please do not cut a perfectly qualified provider out of the loop for providing quality therapy services to those who are eligible to receive it.

If you would like to respond, which I strongly encourage, please feel free to write me at the address below

Thank you,

Michael S. McElroy, ATC/L
1601 N. Willow Rd. Apt. 208
Urbana, IL 61801
E-mail: msmcelro@uiuc.edu

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY STANDARDS AND REQUIREMENTS

I feel that it is extremely important to protect the health and well being of medicare beneficiaries from harm. That means that no one should perform physical therapy on any patients except a licensed physical therapist. Furthermore, doctors should not be allowed to higher physical therapist in their offices due to the unethical abuse of referrals.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY STANDARDS AND REQUIREMENTS

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

August 29, 2004

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

Dr. McClellan:

I am a licensed physical therapist practicing in Michigan for the last 31 years, 24 years as a Physical Therapist in Private Practice (PTPP) under the Medicare program. I am also the physical therapist member of our local Carrier Advisory Committee (CAC), with Wisconsin Physician Services. As a CAC member I meet many physicians practicing in their own private offices. In light of the above, I would like to comment on the "Therapy Standards and Requirements" section of the proposed rule.

I strongly support CMS's proposal to eliminate the requirement that physical therapists provide personal supervision (in the room) of physical therapist assistants in the physical therapist private practice office, and replace it with a direct supervision requirement. Physical therapist assistants are recognized practitioners under Medicare and are defined in the regulations at 42 CFR 484.4, and have the education and training to safely and effectively deliver services without the physical therapist being in the same room as the physical therapist assistant. No state requires personal (in the room) supervision of the physical therapist assistant.

Requiring direct supervision would be consistent with the previous Medicare supervision requirement for assistants that physical therapists in independent practice (PTIP) were required to meet prior to 1999. This would also standardize supervision requirements of physical therapy assistants with Rehabilitation Agencies and Hospitals. I can see no adverse effect on patient care, and a removal of a burdensome redundancy in the Medicare program.

Thank you for your consideration of my comments.

Sincerely,

Mark D. Beissel, DPT, OCS, FAAOMPT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 10-19

THERAPY ASSISTANTS IN PRIVATE PRACTICE

Physical Therapist Assistant's in PTIP's have the same license and qualifications as those in Hospitals or SNFs. And if there could be an effective method to review their CEUs, I am sure those in a PTIP have many more hours of advanced training. To hold them to a more restricted level of supervision (line of sight) is unfair.

Issues 20-29

THERAPY - INCIDENT TO

This is the most abused tactic to bilk the Medicare system. A physician in our area approached me about providing services because his X-Ray tech was leaving. This person was doing hot pack & ultra sound, and they were calling that Physical Therapy. That's not Physical Therapy! That's ineffetive use of a modality that is strictly a revenue stream, and only effective if it is part of a plan of care based on objective information gathered through a physical therapy evaluation. Every bill submitted should have the license number of the therapist who is providing the care.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached letter.

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

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

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

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

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

MANAGING PATIENTS ON DIALYSIS

Dear CMS:

As a practicing radiographer, I would like to provide my comments to you regarding the proposed rule for venous mapping. I treat numerous end stage renal patients and I am continually concerned by the poor vascular access that these patients are subjected to. I believe that the proposed change will be instrumental in ensuring more patients receive a fistula.

It is well documented and accepted that vessel mapping is critical to both optimizing the identification of patients who are candidates for an autologous arterio-venous fistula (AVF), as well as to increasing the rate and success of AVF placement.

The current draft rule limits reimbursement for this procedure to the operating surgeon. This practitioner-specific restriction should be revised to permit reimbursement for this procedure based solely on the indication and requirement that this G-code only be used for assessment for AVF placement, and not based on which specialist or facility performs the procedure. With increasing frequency, mapping is being performed well by practitioners and licensed providers other than surgeons, including: radiologists, interventional nephrologists, diagnostic vascular laboratories, and mobile diagnostic units. Limiting reimbursement for this G-code exclusively to the surgeon would serve as a barrier to increasing the AVF rate in this country, as it would prevent the majority of incident hemodialysis patients from being evaluated for AVF placement where this service is not provided by a surgeon.

Since mapping also usually requires limited assessment of the arteries, I suggest that "vein" mapping be replaced by "vessel" mapping.

Although it may not need to be addressed in the proposed G-code language, reimbursement should not be restricted to Doppler mapping, as circumstances often require use of contrast or other mapping methods (which, incidentally, are not performed by surgeons).

Consideration should be given to replacing "graft" with "fistula" in the G-code description, as the latter would cover all autogenous procedures, whereas "graft" may confuse the issue by implying that only certain types of planned AVF procedures would qualify for reimbursement under this G-code.

I believe that these changes will result in a more proactive approach to creation fistula which will result in higher frequency of fistula, better clinical care and ultimately a lower cost to CMS. It is rare that a few simple changes will impact patient care as significantly as this rule change could. I hope that you agree with my suggestions.

Sincerely,

Henry Cotar

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Only a PT has the education to provide PT. Physical modalities alone are NOT PT. It isn't fair to allow an unlicensed person provide these medical services to consumers, nor is it fair to the PT profession.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

i am very concerned that the reduction in fees for

g0166,external counterpulsation(ecp)rvu reduced by 10% will result in further limiting this valuable therapy and its availability to patients who need and benefit from it. the equipment is expensive but more importantly even if fees were DOUBLED it would represent a very cost competitive and cost effective form of therapy.. ecp is very safe and is part of medical therapy which is competitive with much more expensive angioplasty/stenting/coronary bypass surgery. as a cardiologist offering this therapy i am pleading with you to actually increase the reimbursement for this therapy as it will lead to considerable cost savings to medicare relative to the invasive modalities and equivalent if not superior efficacy to ther invasive modalities..yes i know surgery and angioplasty are more in demand and more dramatic but look at the medical evidence,not consumer demand first..thanks for listening.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Many years ago I became active in health care regulation. These activities have consisted of participation in the regulation of physical therapists and physical therapist assistants in the Commonwealth of Virginia and as the founding president of the Federation of State Boards of Physical Therapy. It has been with particular interest that I have watched the standards of education for physical therapists and physical therapist assistants elevate. The physical therapist education program has progressed from a certificate/bachelor level to a masters degree to a clinical doctorate in the years since 1972. During this entire time I have been aware of individuals providing "licensed" activities within offices of medical practitioners and chiropractors. Frequently the individuals providing therapy "modalities" have no education in the application of the treatments and the patients treated have been subjected to a hoax.

In one incident, I employed a lady who left the employment of a local doctor. In her previous employment she treated as many as one hundred ten patients daily with modalities without physician participation. This can accurately be described as a "therapy mill" without benefit to the patient but with huge impact on the healthcare system.

I strongly recommend the application of physical medicine modalities and procedures be restricted to licensed individuals with appropriate education in the appropriate field of study. The patient and the costs of healthcare will be well served by the requirement.

Thank you for your consideration.

J. Scott Stephens, MS, PT
Licensed in Virginia and North Carolina

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly support the proposed rule change that will allow Clinical Psychologists to supervise ancillary personnel in the administration of psychological and neuropsychological tests. This will have a positive impact on delivery of diagnostic assessment services, making assessments more widely available and at a reasonable cost. It will also correct a logical inconsistency in the existing rule; currently Psychologists are not permitted to supervise administration of tests that are, for the most part, developed by and standardized by Psychologists. Furthermore, as noted in the proposed rule change, Psychologists generally have at least 7 years of advanced training which includes specific instruction in the administration, scoring and interpretation of psychological and neuropsychological tests.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Thank you for allowing my comments regarding Docket: CMS - 1429 -P.

This proposal would require that CMS only recognize PT, OT, and SLP to perform rehabilitation services for Medicare beneficiaries in physician offices, because no other profession is qualified to deliver services. I certainly hope that certified athletic trainers have voiced opposition to this proposal.

The state of South Carolina presents an interesting situation for consideration:

On March 30th, the South Carolina Attorney General's office issued an opinion interpreting the SC Physical Therapy Practice Act to prohibit PTs from working within a doctor's office(<http://www.capitolcounsel.us/ptagopinion.pdf>) A few days later, on April 8, the South Carolina Board of Physical Therapy abandoned its 1998 policy regarding POPT's (which specifically allowed therapists to work within a physician's office) and adopted the attorney general's opinion as its own policy. The Board also gave notice that in 90 days it would begin investigating complaints against therapists and could suspend or non-renew their licenses for violations of the new policy. (<http://www.scstatehouse.net/code/t40c045.htm>)

It's interesting that the SC Physical Therapy Association and the SC Physical Therapy Board are supporting that PTs not work in physician offices. What does this mean - if CMS adopts this policy, no Medicare beneficiaries will have access to rehabilitation services in physician offices in South Carolina.

This can only be interpreted as the Physical Therapist's attempt to eliminate competition in SC and nationwide with this CMS proposal. This would ELIMINATE any Medicare beneficiary from receiving rehabilitation services in a physician's office in SC.

Please DO NOT adopt this proposed policy change.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 10-19

THERAPY ASSISTANTS IN PRIVATE PRACTICE

?Therapy Standards and Requirements?

I strongly support CMS's proposal to replace the requirement that physical therapists provide personal supervision (in the room) of physical therapist assistants in the physical therapist private practice office with a direct supervision requirement. This change will not diminish the quality of physical therapy services.

Physical therapist assistants are recognized under state licensure laws as having the education and training to safely and effectively deliver services without the physical therapist being in the same room as the physical therapist assistant. No state requires personal (in the room) supervision of the physical therapist assistant.

Physical therapist assistants are recognized practitioners under Medicare and are defined in the regulations at 42 CFR 484.4. According to this provision, a physical therapist assistant is "a person who is licensed as a physical therapist assistant by the State in which he or she is practicing, if the State licenses such assistants, and has graduated from a 2-year college-level program approved by the American Physical Therapy Association.

Requiring direct supervision would be consistent with the previous Medicare supervision requirement for assistants that physical therapists in independent practice (PTIPs) were required to meet prior to 1999.

Changing the supervision standard from personal (in the room) to direct would protect the privacy of the patient's that receive services from physical therapists and physical therapist assistants. It will enhance protection to keep private conversations about a patient's care from being overheard.

This change in supervision standard will not cause physical therapists to change staffing patterns. As licensed health care providers in every jurisdiction in which they practice, physical therapists are fully accountable for the proper delegation and direction of services. The majority of states have physical therapist/physical therapist assistant supervision ratio limits in their state laws or Board rules.

I strongly support the proposed change from personal to direct supervision. This would be consistent with the supervision standard that applies to physicians who use other practitioners (e.g., nurses, physician assistants) in their offices. One can only imagine how inefficient a physician would become should they be required to provide "personal" supervision of nurses and physician assistants. This would then also be true of physical therapists should they be bound to a similar requirement.

Sincerely,
Lynn N. Schmitz, DPT, CEAS

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 10-19

THERAPY ASSISTANTS IN PRIVATE PRACTICE

I strongly support the change to the supervision of physical therapist assistants from personal to direct. As a physical therapist in Nevada, this is the same type of supervision required in our state practice act and I feel very confident that it would be appropriate for medicare patients. I have worked for over 11 years in a multitude of settings, including acute care and inpatient rehabilitation, and have always felt the knowledge and expertise of the physical therapist assistants I've worked with has been exceptional. They are well trained and direct supervision is appropriate in all settings.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I strongly endorse the "Incident To" provision and request that it be included in the final rule. Those providing physical therapy services should be licensed physical therapists educated through an APTA approved/accepted curriculum or a physical therapist assistant under the supervision of a licensed physical therapist.

Only PT's and PTA's have the training to provide PT services and monitor patient responses to these services. Unqualified persons delivering physical therapy services can harm patients.

Submitter :

Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam:

I am a physical therapist with 25 years of experience. I have been following with interest the issue of physician use of non-physical therapy personnel in their office, to provide "physical therapy" services. I have personally talked with several patients who have had physical therapy under these circumstances. Therapy is provided by on the job trained "aides" without the supervision of a physical therapist. Often the therapy provided is of a very simple nature, with canned exercise routines and modality protocols.

As an example, an orthoped in my community used such a non-skilled person to "treat" knee patients. All the patients received the same exercises, specifically exercises to strengthen the quadriceps and hamstrings. This non-skilled person had no idea what the purpose of the exercises were, how to select some exercises as higher priority, and most concerningly, what exercises might be contraindicated for certain problems. The exercise program given to ALL patients was very basic, reflecting a lack of understanding of how to benefit individual patients.

Licensure of PTs and PTAs is a minimum standard which should be attained before services which are labeled and billed as "PHYSICAL THERAPY" are given. To allow otherwise is to continue to expose the public to low quality services. Please stay the course on this proposed fee schedule rule.

I appreciate your consideration of this issue.

Sincerely,

Maureen Raffensperger, PT, OCS, MS
Director, PTA Program
Missouri Western State College
4525 Downs Drive - JGM 304
St. Joseph, MO 64507
816-271-4251

Submitter : Mrs. Christine Blakey Date & Time: 08/30/2004 06:08:40

Organization : National Athletic Trainers' Association

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Christine Blakey MS, ATC/L
Fitness First
9300 Weber Park Place
Skokie, Illinois 60077

August 30, 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.

We are facing a severe shortage of allied health care professionals in this country. Many hospitals are short staffed on every shift and patients need to wait weeks to get a physical therapy visit in the Chicagoland Area. Patient care will suffer in the long run if this trend continues. I am outraged that the Department of Health and Human Services would consider removing more health care providers knowing this situation exists. Certified Athletic Trainers are an integral part of the health care system. We are all highly educated health care providers who have received extensive training in the care of musculoskeletal injuries. We all have Bachelor?s Degrees, have passed a national board and most of us are licensed in the state we practice in. There are also a large percentage of us that have Master?s Degrees. We did not take a weekend course to get certified.

On behalf of myself and my peers, I urge you to reconsider this proposal. The abilities of Certified Athletic Trainers should not be considered inferior when providing care to Medicare or Medicaid patients. Considering our education, national certification and track record of providing care to the world?s best athletes, I think we are capable of treating these patients under the direction of a physician.

Sincerely
Christine A Blakey MS, ATC/L

Attachment #570

Christine Blakey MS, ATC/L
Fitness First
9300 Weber Park Place
Skokie, Illinois 60077

August 30, 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.

We are facing a severe shortage of allied health care professionals in this country. Many hospitals are short staffed on every shift and patients need to wait weeks to get a physical therapy visit in the Chicagoland Area. Patient care will suffer in the long run if this trend continues. I am outraged that the Department of Health and Human Services would consider removing more health care providers knowing this situation exists. Certified Athletic Trainers are an integral part of the health care system. We are all highly educated health care providers who have received extensive training in the care of musculoskeletal injuries. We all have Bachelor’s Degrees, have passed a national board and most of us are licensed in the state we practice in. There are also a large percentage of us that have Master’s Degrees. We did not take a weekend course to get certified.

On behalf of myself and my peers, I urge you to reconsider this proposal. The abilities of Certified Athletic Trainers should not be considered inferior when providing care to Medicare or Medicaid patients. Considering our education, national certification and track record of providing care to the world’s best athletes, I think we are capable of treating these patients under the direction of a physician.

Sincerely
Christine A Blakey MS, ATC/L

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I believe this action will provide the best and most appropriate care for the individuals seeking such treatments. I would not want to receive health care, or a procedure from an unqualified individual. With good conscience, I do not see how you could provide a service that you are not qualified to give. I as a health care provider, and customer, would want the best care possible.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Looking realistically at the numbers, and with the idea that private industry will follow Medicare's lead on this issue, it is clear that a continued erosion in the reimbursement of biologics in office will result in our practice having to send these patients to the hospital for infusion- a scenario no one wants and one more likely to increase morbidity and to be more costly and more inconvenient to patients and to physicians in the long run.

Under the old model of 95% AWP, the total reimbursement for an infusion left an amount of profit reasonable to cover expenses and provide for a small profit margin.

With shift to 85% AWP, the overall impact to the practice's bottom line has caused us to begin charging patients for things we never had to before.

We expect the shift to ASP +6% will reduce the margin to such a slim amount that it may become impractical to continue to provide infusion services in our office. Especially given the difficulties, in some cases, in collecting copayments from patients on limited or fixed incomes. Multiple attempts are many times unsuccessful, but ethically it is unreasonable to withhold a treatment from these patients which we know improves their health.

We are still awaiting more information but are certain that the shift will cause a further net reduction in reimbursement.

We have accepted and approve of the idea that reimbursement for drugs should be commiserate with their cost with the caveat that reimbursement for the administration, storage, handling, and processing of drugs should also reflect true costs.

We applaud the decision to look at and re-evaluate drug administration costs. We hope that it is clear that administering biologics or bisphosphonates intravenously is a complex therapy on par with administering chemotherapy and reimbursement should reflect this. Reducing administration costs by 20-25% is, in essence, telling physicians that you do not wish them to do infusions in their office at all. Since it is more cost effective to do infusion here than in the hospital, this issue is not understood by the physician community at all.

As to the issue of ASP +6%, we hope it is well understood that as a small group practice, we are not able to purchase drugs with the same discount given to specialty pharmacies, hospitals, the VA, etc. It is our hope that the methodology to calculate ASP reflects this.

We urge you to consider these real world experiences and invite any interested parties to visit a rheumatologist's office in their district to see first hand the impact of biologic therapy on the lives of arthritis patients. Committee members are also welcome to visit our office here in Los Angeles.

We, as well as the entire rheumatology community, are interested in providing cost effective, comprehensive care for our patients. We pay premiums for our families and our employees as well and are not interested in irresponsibly driving up health care costs. We seek appropriate reimbursement to allow us to continue providing quality care- in our office- for our patient population.

James A. Jenkins
Executive Director
Pacific Arthritis Care & Research Center, Inc.

Gary R. Feldman, MD
Medical Director & CEO
Pacific Arthritis Care & Research Center, Inc.

5230 Pacific Concourse Drive, Suite 100
Los Angeles, CA 90045-6200

Submitter : Mrs. Fatima Hakeem Date & Time: 08/30/2004 08:08:18

Organization : Woman's Hospital of Texas

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I would strongly urge that CMS look into the issue of personnel providing services at physicians offices and being allowed to bill the same under PT codes. Any person who is billing physical therapy codes should have graduated from an accredited physical therapy program and have a license to practice in that State as a PT. The outcomes for these interventions are dubious, there is inadequate supervision and the lack of positive outcomes would then go into the general PT database for using up "PT dollars" that were ineffective.

I strongly urge that CMS MANDATE and no PT services will be provided by any person who is not a licensed PT or PTA
thanks.

Submitter : Lana Loken Date & Time: 08/30/2004 08:08:20

Organization : Lana Loken

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached letter.

Attachment #574

Lana M. Loken, MS, ATC
403 W. 10 th Ave
Mitchell, SD 57301

8-30-04

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.
- 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,

Lana M. Loken, MS, ATC

Clinical Education Coordinator

Dakota Wesleyan University

Mitchell, SD

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Please read and consider the attached statement. Thank-you.

Attachment #575

J. David Pilgrim, ATC, CSCS
Springfield High School
875 7th St.
Springfield, OR. 97477

August 30, 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. For example, I provide care and treatment for sports related injuries at Springfield High School in Springfield, Oregon. These injuries occur during high contact sports such as football and others, providing an essential service with my expertise that would not otherwise be provided. In turn, the proposal 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. I find it insulting that I will be deemed unqualified to provide care for sports related injuries, I have graduated from a 4 year CAAHEP accredited curriculum at San Diego State University, I am currently attending the University of Oregon to earn my Masters in Sports Medicine, and I have been certified by the National Athletic Trainers Association. These accomplishments were not easy and should be taken as credible evidence of my competence and ability to serve my patients/athletes. This is the career I have chosen to be in and plan to work with high profile athletes in the future. I know I am qualified and do not want my qualifications and career to be in jeopardy.

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,

J. David Pilgrim, ATC, CSCS
 Springfield High School
 875 7th St.
 Springfield, OR. 97477

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I would like to express concern with the proposal which would tie the hands of providers of 'incident to' services in physician offices and clinics. The ability of many qualified health care professionals would be eliminated if this proposal were adopted. We need to take a close hard look at the health care of our Medicare patients and cost reduction, not cost increase.

- '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.

- 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).

- 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 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.

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

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am in favor of having CMS change the current Medicare regulations. It only makes sense that clinical Psychologists be allowed to supervise technicians performing 96100 codes. Allowing only physicians to supervise them makes no sense. Most of the time the physicians are unfamiliar with the tests they are 'supervising' the technicians on, while the clinical psychologists are the ones trained on these tests. This will allow for less expensive and more efficient health care. The cost of delivery will be less because the cost associated with a technician doing the testing under the supervision of a psychologist is less expensive than if the psychologist has to administer the tests themselves.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

As a practicing physical therapist, in a physician's office setting, I am very disturbed when a physician bills "physical therapy" when a patient has not recieved services from a physical therapist. I am self employed in this setting, and fortunately, the doctors here, DO refer patients to physical therapy very readily. Physical therapy is a specific medical treatment and requires professional judgement and should not be misrepresented by persons other than physical therapists doing various kinds of treatments. Medical doctors are not the skilled specialists in physical therapy. Physical therapists are, by virtue of education, training, licensing, and experience.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

MANAGING PATIENTS ON DIALYSIS

Comments related to:

- II. Provision of the proposed regulation related to physician fee schedule
- D. coding issues
- 6. Venous mapping

I am glad to see the policy on venous mapping up for comment. There are a few important points to consider.

1. Mapping is done by specialties other than surgery. Physicians and radiologists may be involved in this procedure and should be included in the reimbursement schedule.
2. Mapping is not always done by duplex sonography. Contrast studies are sometimes required for adequate visualization of vessels and should be included in the schedule.
3. Mapping only veins gives only half the story. The arteries must also be mapped since the vein will be connected directly to an artery (for an AV fistula) or by a graft if a primary AV fistula cannot be constructed. The policy should read "vessel" mapping instead of venous mapping to avoid confusion with this issue.

Thank you for your attention.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY STANDARDS AND REQUIREMENTS

August 30, 2004,

Mr. McClellan,

I am a physical therapist practicing in the Baltimore, MD area since 1986. I am writing to you about the Medicare Program and the therapy standards and requirements regarding practice by physical therapist assistants.

I strongly support CMS's proposal to eliminate the requirement that physical therapists provide personal supervision (in the room) of physical therapist assistants in the physical therapist private practice office, and replace it with a direct supervision requirement.

? Physical Therapist Assistants have graduated from a 2-year college-level program approved by the American Physical Therapy Association.

? They are recognized practitioners under Medicare and are defined in the regulations at 42 CFR 484.4.

? Physical Therapist Assistants perform safely and effectively in the delivering of physical therapy services without the PT being in the same room as the PTA in the state of Maryland and indeed in every state, per state licensure laws.

? In Maryland, a very regulated and strict state for physical therapy practice, physical therapist assistants practice safely and effectively, off site from the physical therapist post evaluation.

I have had the opportunity to work with many physical therapist assistants in my 18 years of experience and have found them to exhibit all the qualities above. In addition they are skilled and committed health care professionals and are capable of practicing in a direct supervision situation versus via in the room supervision.

Thank you very much for consideration of my comments.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I strongly support CMS-1429-P, as it is imperative that individuals who provide outpatient physical therapy services in physician's offices be graduates of an accredited professional physical therapy program.

Physical therapists and P.T.A.'s under the supervision of P.T.s are the only caregivers who have the requisite training to provide physical therapy services. This training/education includes creditation from authorized P.T. schools, which includes four to five pre-graduate internships at various hospitals and clinics. Graduation then includes passing state boards for licensure.

Provision of physical therapy services by unqualified persons can be detrimental to patients in that untrained personnel may, in worst case scenario, do physical harm to patients, but more generally, overlook and neglect essential aspects of patient care, resulting in minimal or total lack of progress. The knowledge and experience required to prevent this comes with physical therapy training, education and accreditation from a professional school.

Thank you for taking the time to read my comments.

Best regards,

Joan Meservey-Dillon, P.T.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Any service billed under a physical therapy code should only be performed by a physical therapist or physical therapist assistant.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

See attached letter.

ATTACHMENT # 583

Toby J. Brooks, PhD, ATC, CSCS
Head Football Athletic Trainer
Liberty University
1971 University Blvd.
Lynchburg, VA 24502

8/30/2004

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 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 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,

Toby J. Brooks, PhD, ATC, CSCS

Head Football Athletic Trainer

Liberty University

1971 University Blvd.

Lynchburg, VA 24502

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the proposed regulation that restricts reimbursement for physical therapy to only those services provided by a physical therapist or physical therapy assistant. Physical therapists have a unique education and are the only caregivers qualified to provide quality services. Clearly the public is best served in receiving the best care by the best provider. To allow other less qualified practitioners to receive payment from cms is not the best buy for your dollar. Not only is this a misuse of funds but may lead to injury to the patient as an unqualified provider may be used to increase profits.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 10-19

THERAPY ASSISTANTS IN PRIVATE PRACTICE

I strongly recommend changing PTA supervision requirements to direct supervision from personal supervision. This will not adversely affect PT practice. PTAs are recognized as licensed therapy personnel, and have the training to perform therapy interventions without the personal supervision of a PT.

Submitter : Date & Time:

Organization :

Category :

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 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.

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

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

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

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

Submitter : Mrs. Susan Doty Date & Time: 08/31/2004 04:08:29

Organization : American Physical Therapy Association

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THErapy - INCIDENT TO

THErapy-INCIDENT TO...It is essential in the daily pursuit to retain some kind of quality of care that physical therapy services provided in physicians offices be delivered by personnel licensed to provide physical therapy....in other words a physical therapist or a physical therapist assistant under the supervision of a physical therapist. These are the only practitioners who have the education and training to deliver physical therapy services and have it be billed as such. Accredited physical therapy educational programs are masters level programs, and by 2005 most will be doctorate programs. There is a wealth of knowledge and insight that is needed to execute proper evaluation and sound physical therapy interventions for referred patients to accomplish positive outcomes. Uneducated personnel put the patient at risk, and robs them of the quality of service they deserve and the system pays for. The Social Security Act clearly requires the same requirements for physical therapy services in a physician's office be the same as outpatient services in all settings. "Physical Therapy" delivered by a trainer, an aide, an orthotist, a massage therapist, a reflexologist constitutes false billing practice. I don't think any other profession would appreciate an uneducated person portraying themselves as someone they most assuredly are not! Thank you for your consideration of this comment.

Sincerely, Susan Doty, PT
Dir. of Rehabilitation Services
Sullivan Co. Community Hospital
Sullivan IN 47882
PT since 1975

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support very strongly your change in this area that allows clinical and independently practicing psychologists to provide supervision to non-psychologists. In the practice of psychological testing, the psychologist rather than the physician has the most training and knowledge in this area and it makes much more sense that a psychologist should be able to supervise a non-psychologist rather than having a physician do it.

Thank you for your proposed revision and for listening to APA and related resource organizations in making this revision.

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

August 31, 2004

Good morning:

I write in reference to the 'Incident To' proposed change for physical therapy of August 5, 2004.

As a practicing physical therapist and a concerned citizen I support the change that requires physical therapists working in a physician's office to be graduates of an accredited physical therapy program. In all states PT's are licensed. We have the necessary training and skill to provide the highest-level care and ensure the best possible outcomes. Patients with injuries, impairments and disabilities deserve the best care possible. Services by unqualified personnel are harmful to the patient, exposing them to a greater likelihood of frustration, unnecessary suffering or further injury.

For the sake of patient safety and the effectiveness of treatment it is necessary to require that physical therapy services to all patients be provided by a professional physical therapist or a physical therapist assistant under the direction of a PT.

Thank you for the opportunity to comment on this important proposal.

Sincerely,

Arthur Veilleux, PT, OCS, CSCS

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I wish to express my strong support for CMS's proposed requirement that physical therapist working in physician's offices be graduates of an accredited professional physical therapy program and licensed in the state they practice in. Licensure is a sure way to achieve standards of practice and safety for patients. Unqualified personnel should not be providing physical therapy services. Staff that do not have the proper education can not possibly make the decisions and plan of care that is required to offer accurate, safe, and appropriate treatment for patients. In this age of specialization, physical therapists are trained specifically to evaluate and set up the treatment program for the patients as well as continually re-evaluate the success of that treatment and make modifications as necessary. A Personnel who are not sufficiently educated are unlikely to achieve the positive outcomes desired by patients.

As a licensed therapist practicing for nearly 20 years, I am fully accountable for my professional actions and patient care. Legally and ethically I am held to standards that unqualified unlicensed personnel are not. Allowing untrained, unqualified personnel perform patient care is a recipe for disaster in any health care arena and should be stopped immediately.

Under current Medicare policy, a patient could reach their financial limitation on the provision of therapy services and never see a qualified therapist!! To me this is ludicrous. Thank your time and consideration of my comments. Sincerely, Diane Bohn MSPT

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.

I am a Certified Licensed Athletic Trainer employed by an Orthopedic practice in Wilmington, NC as the Director of Sports Medicine. I feel like the physicians in our practice have the utmost confidence in my education, skills, and aptitude to assess, treat, and rehabilitate all of the patients they send to me, including Medicare patients. Please continue to allow the physician to delegate the care of his or her patients to trained individuals such as myself and other certified licensed athletic trainers.

Thank you for your consideration.

Stephen L. Bright Jr., ATC-L

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

please see the following attachment

CMS-1429-P-592-Attach-1.doc



American Kinesiotherapy Association

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

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

Chad Adams
119 SW Hummingbird Glen
Lake City, FL 32024

September 15, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel

expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

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

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

Sincerely,

Chad Adams, RKT

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached letter regarding CMS-1429-P.

CMS-1429-P-593-Attach-1.doc

ATTACHMENT # 593

Erin Vickers, ATC
1333 Eldridge Pkwy.
Houston, TX 77077

August 31, 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:

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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.
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- 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,

Erin Vickers, ATC

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached document regarding CMS-1429-P

CMS-1429-P-594-Attach-1.doc

ATTACHMENT # 594

Melissa Gattis, ATC
10225 Wortham Blvd.
#2213
Houston, TX 77065

August 31, 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.
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In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Melissa Gattis, ATC

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attachment.



Tasha Tjarks, MS, ATC, CSCS, PES
Calumet Medical Center
Rehabilitation Department
614 Memorial Drive
Chilton, WI 53014

August 31, 2004

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

Re: Therapy – Incident To

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- 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. This is especially important to me, as I work in a rural community hospital and treat many patients in the area, including covering three area high schools. Were I not here, the closest place for these patients and athletes to go would be 30 minutes away.

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

Sincerely,

Tasha Tjarks, MS, ATC, CSCS, PES
 Calumet Medical Center
 Rehabilitation Department
 614 Memorial Drive
 Chilton, WI 53014

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached letter regarding CMS-1429-P

CMS-1429-P-596-Attach-1.doc

ATTACHMENT # 596

Jessica Blakeney, ATC
701 TC Jester
#1302
Houston, TX 77008

August 31, 2004

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

Re: Therapy – Incident To

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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.

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

Sincerely,

Jessica Blakeney, ATC

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

please see attachment



American Kinesiotherapy Association

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

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

Your Name
Your Address

September 15, 2004

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

Re: Therapy – Incident To

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

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

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

expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

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

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

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

Sincerely,

Your Name, RKT

Submitter : Mrs. Shantelle Weichers Date & Time: 08/31/2004 06:08:39

Organization : Cedar Valley Medical Specialists--Department of PT

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

It is a disgrace to our public health care system that we are taking away the right and priveledge of a licensed physician's ability of making decisions that are correct for an individual patient. Athletic Trainers are unique health care providers who work under the direction of a physician with physically active patients. My grandmother, who is 81 yrs. old, still vigorously walks daily and would benefit tremendously from an Athletic Trainer after incurring an athletic related injury. Narrow-mindedness is a sad weakness of many lawmakers in this country.

Shantelle Weichers, ATC, LAT
Cedar Valley Medical Specialists
Department of Physical Therapy
1731 W Ridgeway Ave
Waterloo, IA 50701

September 15, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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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.
- 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.
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During the decision-making process, please consider the above statements.
Thank you for your time and consideration.

Sincerely,

Shantelle Weichers, ATC, LAT

Submitter :

Date & Time:

08/31/2004 06:08:00

Organization :

Category :

Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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.

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

Sincerely,
Brett Macklin

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

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

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

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

Submitter : Date & Time:

Organization :

Category :

Issue Areas/Comments

GENERAL

GENERAL

On behalf of my practice group, Champlain Valley Cardiovascular Associates, South Burlington, VT, and as administrator of external counterpulsation (ECP) services, I wish to express my opposition to further proposed reductions in fees for ECP. You are possibly unaware of the time-intensive requirement to verify the safety and efficacy of ECP for the subset of patients needing this treatment. They are characteristically individuals with the most advanced heart disease and symptoms who commonly possess a wide range of co-morbidities. A nurse, with physician available, has to be committed full-time to patient monitoring. With the additional consideration of costly outlays for equipment and associated servicing, the provision of ECP is a very costly undertaking. A further reduction in fees would probably require a discontinuation of this service for our patients. I urge that the fees be increased from their current level.

Sincerely, Walter Gundel, M.D., F.A.C.C.