Submitter : Dr. Michael Perry **Date & Time:** 09/22/2004 05:09:16

Organization : FHN

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

This would eliminate the physicians ability to provide extended services. Athletic trainers are vital to extending care to our schools and athlets.
This is less expensive care than seeing the drs.
Please reconsider "incident to".
MP

Submitter : Mr. Jonathan Howe **Date & Time:** 09/22/2004 05:09:53

Organization : Clear Channel Radio

Category : Media Industry

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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

Submitter : Mrs. Paula Brooks,NCMT **Date & Time:** 09/22/2004 05:09:09

Organization : AMTA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am writing to request that you not pass the policy whereby a physician can only refer "incident to" services to physical therapist. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Ms. Sabrena Lary **Date & Time:** 09/22/2004 05:09:53

Organization : The College of the Holy Cross

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attatchment.

CMS-1429-P-2703-Attach-1.txt

Attachment #2703

September 22, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician 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:

Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have at least a bachelor's degree from and accredited college or university. 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). Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. ATCs also receive advanced course-work in the areas of musculoskeletal assessment and evaluation, physical rehabilitation, therapeutic treatment or modalities, neurology, and general medical conditions across the life span, including those impacting the Medicare population.

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers accompanied the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes

injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

Athletic trainers are recognized by the American Medical Association as allied health care professionals and have been granted Correct Procedural Terminology (CPT) codes that are specific to this field. These codes are 97005 Athletic Training Evaluation and 97006 Athletic Training Re-evaluation. In addition, we are authorized to use physical medicine (97000 series) codes among others. The services we provide physically active and injured patients include, but are not limited to, emergency care, rehabilitation, and case management. We are licensed in many states to provide this type of care.

Athletic trainers licensed in the commonwealth of Massachusetts have long been providing the immediate care and intervention necessary to triage and facilitate appropriate medical care of the physically active and athletic patients. We have often provided rehabilitation of these patients as an "incident to billing" or for no fee, secondary to our employment in the educational or professional athletic settings. In the interest of public safety as well as patient care, athletic trainers are now working in many settings in which they have established associations with injured athletes and physically active individuals. Unfortunately, the continued resistance to recognize and credential the athletic trainer as providers of rehabilitative services for the medically necessary care they provide severely limits the overall quality of care available to patients.

Please refer to Common Procedural Terminology (CPT) code guidelines for the following:
"A practitioner may provide services if they are licensed and use the appropriate code(s). The term provider, as found in the physical medicine section of the CPT code book, is a general term used to define the individual providing the services described in the code. The provider can be anyone who is licensed to perform the service. Thus, the provider does not have to be a physician but can be, and in most cases is a physical therapist, occupational therapist or athletic trainer. Therefore, when the CPT manual refers to "provider", it is referring to the individual, such as a physician, chiropractor, athletic trainer, therapist, etc. who will be rendering the service described in the code."
American Medical Association – Frequently asked questions about CPT coding – CPT companion. Pg. 58.

Under the current Massachusetts regulations pertaining to Certified/Licensed Athletic Trainers, "services" are defined as and may be provided in the following:
Massachusetts General Law (M.G.L.) – Chapter 112, Section 23A
"Athletic Training", the application of principles, methods and procedures of evaluation and treatment of athletic injuries, preconditioning, conditioning and reconditioning of the athlete through the use of appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, massage, water, electrical stimulation, sound, exercise and exercise equipment under the direction of a physician. Athletic Training includes instruction to coaches, athletes, parents, medical personnel and communities in the area of care and prevention of athletic injuries.

“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 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, 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 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 providers 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.

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,

Sabrena D. Lary, ATC/L

CMS-1429-P-2704

Submitter : Mr. Jaime Rojas **Date & Time:** 09/22/2004 05:09:23

Organization : The Athletic & Therapeutic Institute

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I feel that this legislature undermines the importance of Certified Athletic Trainers in the outpatient physical therapy setting. As the co-director of my own clinic, I hire Certified Athletic Trainers because I feel that they, in general, are more proficient with orthopeadic injuries then the physical therapists. Athletic Trainers spend a minimum of 4 years concentrating on the prevention, evaluation, treatment and rehabilitation of orthopaedic injuries while Physical Therapists might spend a semester. The Athletic Trainers and Physical Therapists here at the Athletic and Therapeutic Institute work very close together to ensure that our patients get the best care available to them. There is no reason why a Certified Athletic Trainer should not be able to work in an orthopeadic therapy clinic and bill for the services he or she has rendered. I feel very strongly about this issue and will continue voicing my opinion.

Jaime A. Rojas, MS, ATC/L
The Athletic and Therapeutic Institute
635 Executive Dr.
Willowbrook, IL. 60527
(630) 455-6630

CMS-1429-P-2705

Submitter : Mrs. Leta WoloshukLMT **Date & Time:** 09/22/2004 05:09:09

Organization : FSMTA

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I oppose Medicares proposal to eliminate any provider except PT's providing "Incedent To" From medical proffesionals services to Patients

Submitter : Angel Chesimet **Date & Time:** 09/22/2004 05:09:50

Organization : NCIHCP

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please reconsider passing this policy on restricting physicians referals to only PTs. A physician should be able to refer to many types of intergrative health-care professionals who are qualified to work patients as needed. The recovery of a patient can be greatly enhanced with many types of modalities like massage and chiropractic practitioners working as a team towards the goal of recovery and comfort.

Submitter : Ms. Sally NeSmith **Date & Time:** 09/22/2004 05:09:03

Organization : HICAP - Health Insurance Counseling

Category : Consumer Group

Issue Areas/Comments

Issues 1-9

GPCI

Please consider changing the rural designation of Santa Cruz County in California. Santa Clara County, just a few miles away, has an urban designation. Santa Cruz County has mushroomed in the last 20 years and is now very urban. Some of the highest priced real estate in the nation is right here in Santa Cruz!!
We are losing doctors who take Medicare assignment. It is increasingly difficult to find Medicare doctors taking new patients. As a SHIP Program Manager (HICAP, I am daily made aware of how difficult it is for new Medicare enrollees to find a physician.
Thank yo for considering this change.
Sincerely,
Sally NeSmith
HICAP Program Manager
Santa Cruz & San Beniot Counties

Submitter : Dr. Andrew Nevitt **Date & Time:** 09/22/2004 05:09:07

Organization : Santa Cruz Emergency Physicians

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

9/20/04

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

Re: File Code CMS-1429-P
GPCI

I strongly object to the proposed rules governing the Physician Fee Schedule for 2005 as printed in the Federal Register of 8/5/04. Santa Cruz County has some of the highest housing prices in the country and one of the highest costs of living. It is unjust that it is trapped within locality 99, listed as a rural county. Our cost of living is comparable or even higher than adjoining counties of San Mateo and Santa Clara, which receive reimbursement 24% higher for the same services. We often care for the same patients! I have lived and worked in this county for the past 23 years and have watched the spiraling cost to live here severely undermine our medical community as we can no longer consistently recruit and retain physicians. This imbalance in reimbursement needs immediate correction.

Sincerely,

Andrew K. Nevitt M.D.
Santa Cruz Emergency Physicians
Vice Chief of Staff-Dominican Hospital
197 Pine Forest Drive
Aptos, CA 95003

CMS-1429-P-2709

Submitter : Mrs. Claudia Gazsi **Date & Time:** 09/22/2004 05:09:19

Organization : Lebanon Valley College

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I strongly support CMS's proposed requirement that physical therapy services provided in a physician's office incident to a physician's office visit, only be provided by a physical therapist or a physical therapist assistant, under the supervision and direction of a licensed physical therapist. Licensed physical therapists must be graduates of an accredited PT or PTA program, which then ensures a standard level of knowledge, critical decision making skills, and demonstrated clinical competence to provide effective, efficient, and evidence-based care. Physical therapists and physical therapist assistants are the only practitioners with the education and training to provide physical therapy services.

When services are billed as physical therapy, using the 97000 series of CPT codes, the patient and the insurer should feel confident that the services were actually provided by the appropriate qualified individual - physical therapists or physical therapist assistants, under the direction of the physical therapist. The extensive education in anatomy, physiology and pathophysiology, as well as the indications and contraindications for therapeutic modalities and interventions and their impact on various body systems places the physical therapist and the physical therapist assistant in the position to be the most appropriate provider of physical therapy services. If services are provided by unlicensed providers in the physician's office and billed as physical therapy, the entire cap for therapy services may be exhausted before the patient is ever referred for physical therapy. A subsequent catastrophic event, where significant physical and speech therapy services are required, will place the patient in the position of either assuming the entire cost of services or forgoing therapy services all together and risking significant loss of function and independence.

Patients who have received therapeutic modalities incident to physician services but provided by unlicensed providers have frequently reported excessive heat and pain with the application of therapeutic ultrasound and subsequent reluctance to the application when provided by a licensed physical therapist or physical therapist assistant as part of the comprehensive treatment plan. Patients have presented with ill-fitting 'off the shelf' orthotic or supportive devices which they have purchased through the physicians office only to have to repurchase the correct appliance after being referred to physical therapy. Patients have also demonstrated incorrect performance of exercises after being 'provided with a home program' from an unlicensed provider, to the extent that the exercises have exacerbated the patients symptoms and have had a negative impact on their overall health and wellness.

Thank you for your time and consideration of these comments

Sincerely,
Claudia C. Gazsi, PT, MHA
DCE, Asst Professor,
Lebanon Valley College
Annville, PA 17003-1400

Submitter : Mr. Carl Byron **Date & Time:** 09/22/2004 05:09:45

Organization : Health Care Consulting Services, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

The Incident To guidelines as they immediately stand are more than sufficient. Physicians, as the true diagnosing authorities in this country are in the best position to determine who may adequately treat patients, Medicare or commercial insurance. The decision on who treats under their professional supervision MUST be left to them.
The Federal Register proposal would allow supervised therapist assistants to treat patients: however, they only have two-year Associate degrees. Certified and licensed athletic trainers have four year degrees AT A MINIMUM, and most practicing ATCs have advanced degrees, and the predominant didactic portion of their rehabilitation training is taught by physicians and THERAPISTS. To say that an Associate level para-professional is more skilled than a four or six year educated professional is outrageous. Physicians hire certified and licensed athletic trainers and kinesiotherapists because they are much more highly skilled than assistants.
In addition,keep in mind that this proposal, if passed, will impact the insurance industry on a very wide scale. National organizations whose members perform physical medicine, and most commercial insurers look to CMS for guidance on how to best approach reimbursement and compliance. A decision so thoroughly restricting Incident To would make effective cost containment far too difficult. To only be able to employ therapists Incident To would automatically take overhead costs up excessively. In addition it must not be forgotten that there are state therapy Boards who have standing orders that only therapists can supervise assistants, whereas the Incident To guidelines restrict supervision to the physician. With professionals like certified and licensed athletic trainers and kinesiotherapists this issue does not arise. There is no mistaking whose orders must be followed. If one looks at the training between the physical medicine practitioners there will be little difference found; and in many states where athletic trainers practice they must have approval from their state's physical and occupational therapy Boards as well.

CMS-1429-P-2711

Submitter : **Date & Time:** 09/22/2004 05:09:49

Organization : The College of the Holy Cross

Category : Academic

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attatchment.

CMS-1429-P-2711-Attach-1.txt

Attachment #2711

Holy Cross Sports Medicine
The College of the Holy Cross
1 College Street
Worcester, MA 01610

September 22, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

We are writing to express our 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:

Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have at least a bachelor's degree from and accredited college or university. 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). Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. ATCs also receive advanced course-work in the areas of musculoskeletal assessment and evaluation, physical rehabilitation, therapeutic treatment or modalities, neurology, and general medical conditions across the life span, including those impacting the Medicare population.

Athletic trainers are employed by almost every U.S. post-secondary educational

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

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Please refer to Common Procedural Terminology (CPT) code guidelines for the following:
“A practitioner may provide services if they are licensed and use the appropriate code(s). The term provider, as found in the physical medicine section of the CPT code book, is a general term used to define the individual providing the services described in the code. The provider can be anyone who is licensed to perform the service. Thus, the provider does not have to be a physician but can be, and in most cases is a physical therapist, occupational therapist or athletic trainer. Therefore, when the CPT manual refers to “provider”, it is referring to the individual, such as a physician, chiropractor, athletic trainer, therapist, etc. who will be rendering the service described in the code.”
American Medical Association – Frequently asked questions about CPT coding – CPT companion. Pg. 58.

Under the current Massachusetts regulations pertaining to Certified/Licensed Athletic Trainers, “services” are defined as and may be provided in the following:
Massachusetts General Law (M.G.L.) – Chapter 112, Section 23A
“Athletic Training”, the application of principles, methods and procedures of evaluation and treatment of athletic injuries, preconditioning, conditioning and reconditioning of the

athlete through the use of appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, massage, water, electrical stimulation, sound, exercise and exercise equipment under the direction of a physician. Athletic Training includes instruction to coaches, athletes, parents, medical personnel and communities in the area of care and prevention of athletic injuries.

"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 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, 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 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 providers 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.

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,

Holy Cross Sports Medicine Department

CMS-1429-P-2712

Submitter : Mr. Gary Vigeant **Date & Time:** 09/22/2004 05:09:22

Organization : Florida State Massage Therapy association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I ask you to reconsider and NOT pass this policy whereby a physician can ONLY refer "ncident to" services to Physical Therapists. This will creat a monopoly for PT's, and exclude all other qualified Health care providers from giving service to those in nedd with a physician's prescription or under their supervision. This will also set a horrible precident for commercial heath ins. carriers to follow.

Submitter : Ms. Kathy Meyer **Date & Time:** 09/22/2004 05:09:42

Organization : Carle Sports Medicine

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

The following is an adendum to a previously submitted response due to lack of remaining characters:

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 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 beneficialry 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,

Kathy Tate Meyer, MS, ATC, NCMT

Submitter : Mrs. Jennifer Hess **Date & Time:** 09/22/2004 05:09:17

Organization : University of Illinois - SportWell Center

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam:

I am writing to voice my concern of proposal CMS-1429-P. As a certified/licensed Athletic Trainer, I am worried that the acceptance of this proposal would significantly affect our profession. Athletic Training is a health care profession that specializes in the prevention, assessment, treatment and rehabilitation of injuries caused by exercise or sport. Athletic Trainers have an extensive educational background, are certified by the National Athletic Trainers? Association and are recognized as an allied health care profession by the American Medical Association.

Limiting services we provide to Medicare and Medicaid patients will create higher customer dissatisfaction, with less qualified health care providers available for appointments, and reduce the overall quality of health care. I believe proposal CMS-1429-P should be rejected in order to support the current level of quality health care and to utilize trained professionals in an area of their expertise.

Sincerely,

Jennifer Hess, MS, ATC/L
ACSM Exercise Specialist certified
Fitness/Injury Prevention Specialist
University of Illinois
SportWell Center
201 E. Peabody Dr.
100 IMPE Bldg.
Champaign, IL 61820

Submitter : Dr. Jim Hawthorne **Date & Time:** 09/22/2004 05:09:41

Organization : Urology Associates of San Luis Obispo

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The abrupt change in reimbursement by Medicare for urology practices which we expect to decrease our revenues by 13-16%, will be very disruptive to provision of urologic care in our area. We have had difficulty in recruiting urologists at the current reimbursement rates due to the high cost of living here. That problem will become worse with the significant decrease in reimbursement. As I am anticipating retiring in the near future I am concerned about finding someone who will practice here.

I would encourage CMS to phase in the changes more gradually.

Thank you for your consideration of this view.

Submitter : Ms. Tanya Hecox **Date & Time:** 09/22/2004 06:09:38

Organization : Alexandria City Public Schools

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Tanya M. Hecox
4901 Seminary Rd, #1327
Alexandria, VA 22311

September 22, 2004

Center 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 in regards to the recent proposal concerning "incident to" billing of outpatient therapy services that was issued by the Centers for Medicare nad Medicaid Services (CMS). It is my understanding that this proposal, if adopted, would limit providers of "incident to" services in physician offices and clinics. This would ultimately reduce the quality of health care for Medicare patients by eliminating the ability of qualified health care professionals to care for these patients.

"Incindent to" has been utilized by physicians to allow other trained individuals (including certified athletic trainers) to provide services under the supervision of the physician. A physician has the right to delegate the care of his or her patients to individuals whom the physician deems knowledgeable and trained in the protocols to be administered as an adjunct to the physician's professional services. Because the physician accepts legal responsibility for the individuals under his or her supervision, Medicare and other private payers have relied on the professional judgement of the physician to determine who is or is not qualifed to provide a particular service. It is imperative that physicians continue to make the decisions in the best interest of their patients.

Athletic trainers are highly qualified and educated professionals. All certified or licensed athletic trainers must have a bachelor's degree from an accredited college or university. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational prgrams in Athletic Training (JRC-AT). Many certified athletic trainers hold advanced degrees comparable to other health care professionals, including physical therapists, occupational therapists, registerd nurses, and speech therapists. For CMS to suggest the athletic trainers are unqualified to provide services to Medicare patients is unjustified. Based on independent research the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incidence to" the physicians it will increase the workload of physicians who are already overworked and reduce the physician's ability to provide the best possible patient care. It is likely that the pateint will suffer delays in health care, greater cost, and a lack of local and immediate treatment. The physician would not be able to provide the patient with comprehensive, quick accessible health care. This will potentially force the patient to see the physician and separately seek therapy treatment elsewhere, causing significant convenience and an additional expense to the patient.

Athletic trainers have been a benefit to the current health care system. As a certified athletic trainer and a member of the National Athletic Trainers' Association (NATA), I believe it would be disadvantagous and unjustified for the CMS to institute this proposal.

Sincerey,

Tanya M. Hecox, A.T.C.

Submitter : Mr. Ronald Bodary **Date & Time:** 09/22/2004 06:09:33

Organization : Cumberland Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Comments on Proposed Rules Federal Register/ Vol. 69 No. 150/ August 5, 2004

File Code: CMS-1429-P

We would like to offer the following comments on the proposed rule, which would change the way physicians are paid for chemotherapy drugs.

1. We are a rural non-profit hospital located in Tennessee approximately 70 and 110 miles respectively from the nearest urban cancer center. The hospital provides radiation therapy services for cancer patients to avoid patients traveling long distances for cancer treatment. We also have on our medical staff, two medical oncologists who are providing cancer care and chemotherapy infusion services in their offices, again with the mission to help patients receive care close to home. The two medical oncologist have expressed grave concerns about the impact of the proposed rule on their ability to continue providing chemotherapy in their offices and have suggested sending their patients to the hospital for chemotherapy infusion. The only other recourse is to have patients travel 70-100 miles to an urban center.
2. We reviewed the proposed change with the idea of providing care for patients at the hospital rather than see patients having to travel long distances. This would have involved a significant undertaking because it would require finding space, infrastructure and employing chemo nurses, which are in great demand. This would have been a costly undertaking to bring this significant new service on line if physicians ceased providing the service in their offices.
3. We reviewed the sample list of chemotherapy drugs in the proposed rule and were able to obtain our invoice price for 24 of the drugs listed. We use a major buying group to purchase our drugs. We then compared our rural APC reimbursement for those 24 drugs. For 21 of the 24 drugs, we are paying more money for the drugs than we would receive from Medicare and copay!
4. As a rural hospital we do not receive the Federal rate that is published. We receive a much lower rate. This is an inequity for rural hospitals to receive lower reimbursement for drugs. The amount Medicare reimburses for drugs, supplies, etc. should not be less for rural areas and wage indexing should not apply to these areas.
5. We do not see how we can provide chemotherapy services to patients at a loss. This would result in patients having to travel 70 to 100 miles to urban centers, which have more favorable urban rates (wage index).
Recommendations:
1. We request you modify the proposed rule to reduce the loss the physicians are facing. This would avoid a major shift in the way chemotherapy is delivered especially in rural areas.
2. Review of this proposed rule has brought to our attention again the need for equitable payments, to rural hospitals especially for drugs and supplies, which should not be adjusted by a wage index.

Submitter : Dr. Alan Philippi **Date & Time:** 09/22/2004 06:09:22

Organization : Navy Environmental Health Center

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

CMS-1429-P-2718-Attach-1.pdf

September 21, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing, as a sports and occupational medicine physician, to express my concern over the recent proposal that would limit providers of "incident to" services in my office and clinics. If adopted, this would eliminate the ability of qualified health care professionals, such as certified athletic trainers (ATCs) to provide vital services. In turn, this ruling would reduce the quality of health care for many Medicare patients, ultimately increase the costs associated with these services, and place an undue burden on the health care system.

I strongly urge you to consider the following points as you proceed in the decision-making process:

- "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. I have the right to delegate the care of my patients to trained individuals, including ATCs whom I deem knowledgeable and trained in the protocols to be administered. My choice of qualified therapy providers is inherent to the type of medical practice, medical subspecialty and individual needs of the patient.

- There have never been any limitations or restrictions placed upon me in terms of who I can utilize to provide ANY "incident to" service. Because I accept legal responsibility for the individual under my 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 I and all other 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 and insurer.

- 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.

- I have worked for many years with athletic trainers at the collegiate level and within the Naval Special Warfare (SEAL) community. ATCs are highly educated and experienced professions who deserve reimbursement for the valuable services they provide. 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, 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.***

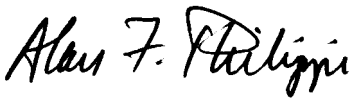
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program, every professional sports team in America and many corporations, including the U.S. military to work with athletes and physically active people to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition and the physical activity of daily life. In addition, dozens of athletic trainers have 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 a fall or illness is outrageous and unjustified.

- These issues may lead more physicians to eliminate or severely limit 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 deterrent to health care access and establishes a dangerous, and perhaps illegal, precedent in restricting the right of physicians to determine the most appropriate and cost effective treatment for their patients.

Sincerely,



Alan F. Philippi, DO
Commander, United States Navy
Navy Environmental Health Center
620 John Paul Jones Circle, Suite 1100
Portsmouth, VA 23708
(757) 953-0778

CMS-1429-P-2719

Submitter : Ms. Laura Brown **Date & Time:** 09/22/2004 06:09:49

Organization : Ms. Laura Brown

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Subject: Re-designation of Santa Cruz County, California as "Urban"

CMS's proposed rules for 2005 not only fail to address a long-standing issue for Santa Cruz County, California. This county is among the most expensive areas to live in the nation, yet it retains its rural designation from the 1967 Medicare map of California. To exacerbate the problem, under the current CMS proposal, our immediate neighbor, Santa Clara County, would become the highest-paid county in the U.S. This differential in physician payments would become 25 percent under proposed CMS policy!

The welfare of Santa Cruz County residents depends upon attracting and retaining capable local physicians. Our coastal County is geographically isolated from the bordering counties by the Coastal Mountains and the Pajaro River. Over the past 25 years, there have been numerous natural disasters including earthquakes, fires, and storms resulting in massive landslides and flooding, which have completely cut off roads outside of the area and rendered the county an isolated island for days at a time. The magnitude of this problem is illustrated by the fact that in the decade of the 1980's, Santa Cruz County held the record for the most Federally declared disasters. Access to health care is always essential, and the need is greatly magnified during disasters.

Santa Cruz County is among the smallest land areas in the state and, when dedicated park land is removed from consideration, the quarter million people who live here form a moderately high density, clearly urban environment.

I urge CMS to redraw the California map to designate Santa Cruz County, California as urban and within the same payment structure as Santa Clara County.

Thank you for your consideration.

Laura D. Brown
815 Vista Del Mar Dr.
Aptos, CA 95003

CMS-1429-P-2720

Submitter : Mr. John Eaton **Date & Time:** 09/22/2004 06:09:37

Organization : Charles Cole Memorial Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam:

I am an ATC 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 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.
It is not necessary or advantageous for CMS to institute the changes proposed.

Submitter : Dr. Donald Miller **Date & Time:** 09/22/2004 06:09:44

Organization : Bryn Mawr Medical Specialists

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sirs,
I am writing this comment to ensure that my medicare patients will continue to have acccess to their care. I am a practicing Rheumatologist in Bryn Mawr Pennsylvania. I have been in practice for 18 years. We perform in-office IV Remicade treatments for our patients with Rheumatoid arthritis,and for some patienmts with Crohn's disease. We have been perfroming these infusions since the initial medicare approval was given for these indications. Remicade has proved to be a remarkable drug and has truly changed the lives of hundreds of patients in our practice. The proposed change in reimbursement has some merit, but I belive needs to be changed in several ways. I do believe that we should be paid for our services. Remicade represents a complex biologic drug that often has severe side effects that have to be managed. These include hypotension, hives, chest pain shortness of breathe,and anaphylaxis. It is a Physician supervised infusion and we are always asked to comment on the dose given or whether the patient can receive the drug that day in terms of any infection or blood abnormality. Therefore there is a lot of physician work involved with administering this drug.

The current proposed ASP + 6% clearly does not use real numbers that we can obtain the drug for. The ASP cannot be a 'wholesale' number that physicians cannot in reality obtain the drug. The 6% also would need to be raised to at least 10% to be a 'fair' number. Unfortunately if these changes are not made it would be extremely unlikely we would continue to provide this service for our medicare patients. We would be forced to send these patients to the hospital, which would grealty increase the cost to medicare and would not provide a physician supervised environment.

Submitter : Mrs. Sandi Estes **Date & Time:** 09/22/2004 06:09:34

Organization : Tattnall Square Academy

Category : Nurse

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Centers for Medicare & Medicaid Services
Department of Health and Human Resources
Attn: CMS-1429-P
Post Office Box 8012
Baltimore, MD 2144-8012

Re: "Therapy--Incident To"

Dear Sir/Madam:

I am a nurse 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 healthcare system.

As a school nurse at Tattnall Square Academy, I work very closely with the school's Certified Athletic Trainer, Jody Burnett. I can personally attest to the quality of care Mr. Burnett provides to the school's athletes. Mr. Burnett's expertise in acute care of injury and illness is second to none. His knowledge of human anatomy and physiology, nutrition and excerise physiology makes him very profient in strength training and reconditioning of the school's athletes. I have seen first hand Mr. Burnett rehabiliate injuried athletes in a timely, yet absolutely safe manner. Mr. Burnett is an asset to this school and the athletic program. Mr. Burnett's educational background is a medical-based education model. This model focusses on education to serve as physician extenders, with emphasis on clinical reasoning skills. I have seen Mr. Burnett's clinical reasoning skills used on the field with acute injuries, as well as off the field in rehabiliation training.

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, at the unfortunate exclusion of a highly qualified group of certified athletic trainers.

From first hand experience, I can attest that the quality of service provided by Mr. Burnett is equal to or better than the quality of services provided by physical therapists.

It is not necessary for CMS to institute the changes proposed and I request that the change not be implemented, as this recommendation is a healthcare access deterrent.

Sincerely,

Sandi Estes, RN, FNPS

Submitter : Ms. Cara Ross **Date & Time:** 09/22/2004 06:09:07

Organization : Blue Heron Healing Arts

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do not limit patient access to licensed healthcare providers. This policy would allow doctors to refer only to Physical Therapists and not Massage Therapists. We massage therapists are soft tissue experts and can give excellent treatment to people with soft tissue injuries.

Submitter : Mrs. Roxanne Dingman **Date & Time:** 09/22/2004 06:09:29

Organization : Orthopedic Specialties

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-2724-Attach-1.doc

Attachment #2724

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.

- **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.**

- 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.

- 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.

There is no evidence to even suggest there is a problem with the care given to current patients, in fact this proposal is stemmed from a single professional group who would like to be the sole provider of therapy services. In a country of freedom it would be preposterous to let one group of professionals who have seen the unbelievable talents of getting "Athletes Back in the Game" whether old or young start year after year debates on this topic when the research shows and proves we are just as equal as a Physical Therapist. If the Collegiate and Professional world of sports has had exceptional treatment for many years than why take that treatment away from the Medicare population? 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,

Roxanne Dingman, ATC

Jan H. Postma, M.D. John E. Keith, Jr., M.D. Anthony A. Sanchez, M.D.
Mark D. Visk, M.D. Stephen M. Kana, M.D.
Peter J. Buchanan, Administrator
303 East Wood Street Spartanburg, SC 29303 Phone: 864-560-4282 Fax: 864-560-4568

CMS-1429-P-2725

Submitter : **Date & Time:** 09/22/2004 06:09:11

Organization :

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Hello,
I am a doctor of physical therapy student and registered voter who will be graduating May 2005. I am very concerned about the issue of ?incident to.? Currently ?incident to? allows a physician to bill for physical therapy services in his/her office regardless of if the person providing the therapy is a secretary, athletic trainer, or licensed physical therapist. This is extremely dangerous and contributes to inefficiency of the healthcare system.
I would like to express my strong support of CMS?s proposal to establish standards for personnel providing physical therapy services in physicians? offices, and that those standards be licensed physical therapists or licensed physical therapy assistants only. There are many reasons why this is necessary but I would like to concentrate on what I feel are the two most pertinent.
The first and perhaps most important is the issue of safety for the patient and quality of patient care. Physicians are very skilled at their profession but they are not educated or skilled in physical therapy to the extent that physical therapists are. Physical therapists and physical therapy assistants are the most qualified professionals to administer physical therapy services to patients based on education, experience, and licensure standards. If others who are not licensed in physical therapy are allowed to perform physical therapy services the quality of care, cost effectiveness of care, and patient safety will be diminished.
The second issue is that of cost effectiveness. Physical therapy services are currently being billed to payers regardless of who is providing the therapy. This is grossly inefficient because the quality of therapy is not controlled while the cost to the payer is the same. Physical therapists are educated in the most current standards of care that are the most effective and most efficient. This ensures that the patient is not only getting the most effective treatments but the most cost efficient as well.
I trust that you will see the need for this proposal to ensure quality healthcare that is efficiently managed by the most qualified professionals which are physical therapists and physical therapist assistants.
Thank you for your time!

CMS-1429-P-2726

Submitter : Mr. Dan Brown **Date & Time:** 09/22/2004 06:09:48

Organization : UMDNJ

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 22, 2004
To Whom It May Concern at the CMS:
My name is Dan Brown and I am a physical therapy graduate student at the University of Medicine and Dentistry of New Jersey (UMDNJ). I am currently in my second year of studies, working toward a Doctorate in Physical Therapy (DPT). I am writing concerning the proposed 2005 Medicare physician fee schedule rule, published on August 5, 2004. In specific, the part which addresses requiring physical therapy services provided in a physician?s office to be provided by an individual who is a graduate of an accredited professional physical therapist education program, or one who has met certain grandfathering clauses, or an individual who has met educational requirements for foreign trained physical therapists.
I strongly support this proposal and hope to see it implemented. My interest in this proposal is on a personal, professional, and societal level. It is grown out of the possible benefits such a policy may reap as well as the possible mishaps and injury it may prevent. Personally, I do not want to be bumped out of a job by a lesser competent practitioner, who may work for slightly less compensation. On a professional level, the role of physical therapy in the sector of health care has been developing over the years. Our education and practice have been more demanding and responsible to ensure the safety and successful rehabilitation of our patients. The providing of physical therapy services by another other than those listed above puts patients at risk. In my education, both in the classroom as well as in the clinic, I am taught precautions, contraindications, signs and symptoms, procedures, interventions, the latest evidence-based medicine studies, as well as the psycho-social aspects of illness. Lastly, for society if patients were mistreated by someone who was assumed to be a physical therapist, there would be lawsuits of epic proportions.
This proposal is an excellent one which will ensure the best and safest treatment of patients. It makes sense medically, socially, and economically. Please put it into effect.
Thank you,
Dan Brown SPT

Submitter : Ms. Debra Halperin **Date & Time:** 09/22/2004 06:09:56

Organization : Florida State Massage Therapy Assoc

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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

CMS-1429-P-2728

Submitter : Mr. William Durand **Date & Time:** 09/22/2004 06:09:57

Organization : Geneva High Schoool

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

As a Certified Athletic Trainer (ATC) and possible future patient, I feel compelled to write this letter in opposition of proposal CMS-1429-P. I am concerned that this proposal would limit patient access to qualified health care providers of a??incident toa?? services, such as ATCs, in physician offices and clinics; thereby, reducing the quality of health care for physically active patients. Furthermore, limiting access to qualified health care providers will cause delays in the delivery of health care, which in turn will increase health care costs and tax an already heavily burdened health care system.

Athletic trainers are multi-skilled health care professionals who can, and are, making significant contributions to health care. Athletic trainers are highly educated and fully qualified health care providers, evident in their recognition by the American Medical Association as an allied health care profession. If this proposal would pass, it would threaten the employment of many athletic trainers who are employed as physician extenders in clinics and physician offices. Therefore this proposal threatens my future employment in those settings and the value of my degree in Athletic Training. With this type of limitation artificially placed on the provision of a??incident toa?? services by qualified (through accredited academic programs in athletic training, a national board examination, and state practice acts) health care providers the CMS will only add to the skyrocketing health care costs, put qualified people out of work, and reduce the overall quality of health care in the United States.

Submitter : Mr. Blake Hardy **Date & Time:** 09/22/2004 06:09:29

Organization : Mr. Blake Hardy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Date : 9-22-04
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:
Blake Hardy, PT, MS, OCS, CSCS
MMSC Rehabilitation Center
1902 S. Center St.
Marshalltown, IA 50158

As a physical therapist I would like to comment on the "therapy-incident to" issue contained in this proposal. Medicare is the largest consumer of health care in this country and its policies pervade all other health care payor entities. As a result its policies must demand the utmost of quality and safety for its beneficiaries.

This measure is a step in the right direction to acheive both of these goals. In no other circumstance does Medicare turn its back on the requirement of having highly qualified professionals perform services. This current exclusion allows unlicensed individuals to perform care that in other settings only a licensed physical therapist or physical therapist assistant would be able to perform. It is wrong to allow unqualified personnel to carry out the tasks that in other settings requires highly trained professioanls to carry out. Consistency in the professionals carrying out care is a cornerstone of quality management and should not be given a pass just because the care is supposedly under the eye of a physician, when in fact we all know this is not occuring. Additionally, this would bring this practice into line with the rules contained in Section 1862(a)(20) in the Social Security Act that requires all professionals practicing within the physician office setting to have the same qualifications as is required in other settings, i. e. licensed physical therapist who is a graduate of an accredited program.

Thank you for your consideration of this matter.

Blake Hardy, PT, MS, OCS, CSCS
MMSC Rehabilitation Center
1902 S. Center St.
Marshalltown, IA 50158

Submitter : Mr. Gary Waller **Date & Time:** 09/22/2004 06:09:27

Organization : TDIC

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Pleae see attachment

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

The attachment to this document is not provided because:

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

CMS-1429-P-2731

Submitter : Daniel Holman **Date & Time:** 09/22/2004 06:09:52

Organization : National Athletic Trainers Association

Category : Health Care Professional or Association

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 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.

CMS-1429-P-2731-Attach-1.doc

SPRING-FORD SENIOR HIGH SCHOOL

ATHLETIC DEPARTMENT

Daniel Holman MEd, ATC, Athletic Trainer
350 South Lewis Road
Royersford, PA 19468

Training Room: 610-705-6001
Fax: 610-705-6257
dholm@spring-ford.k12.pa.us

Attachment #2731

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,

Daniel J. HolmaN

Submitter : James W. Richards **Date & Time:** 09/22/2004 06:09:52

Organization : Athletic Trainer Certified

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the position of the NATA with regard to this issue. I am urging you to include Certified Athletic Trainers in your listing of approved providers.

James W. Richards
M.S., A.T.C.
Head Athletic Trainer
Northwest University, Kirkland, Washington

CMS-1429-P-2733

Submitter : Mr. Frank Markett **Date & Time:** 09/22/2004 06:09:57

Organization : Hinsdale Orthopaedic Associates, S.C.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam,
I am writing to inform you of myu concerns against a provision to limit incident-to billing to Physical Therapist and Physical Therapist Assistants. As a Certified Athletic Trainer, licensed by the state of Illinois, I have worked in the clinical setting for over ten years. Throughout those ten years I have treated thousands of patients in need of Athletic Training services. I feel that limiting the care that people can receive in the clinical setting would not be advantageous to their recovery. There are many, many times that a patient benefits from the care given to them by a Certified Athletic Trainer.
All Certified Athletic Trainers have received, at minumum, a Bachelor's degree from an accredited four-year college or university. Most have gone on to earn a Master of Arts or Master of Science degree. The curriculum is heavily science based and includes Human Physiology, Anatomy, Kinesiology, Biomechanics, Physics, Nutrition, and the Biology's, Chemistry's, etc.
Therefore, I am in favor of CMS recognizing Athletic Trainers as licensed health care providers in all states. In addition, I am against limiting incident-to billing to PT's and PTA's.
Thank you for your consideration,

Frank Markett, MA,ATC/L,CSCS
HOTC-Therapy Administrator
Illinois Committee on Revenue

Submitter : Dr. Barbara Crane **Date & Time:** 09/22/2004 06:09:38

Organization : Clinician Task Force

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attached document for specific comments

CMS-1429-P-2734-Attach-1.doc

Attachment #2734

September 22, 2004

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P Section 302
P.O. Box 8012
Baltimore, Maryland 21244-8012

Dear Sirs,

The Coalition to Modernize Medicare's Coverage of Mobility Products (CMMCMP) Clinician Task Force (referred to in the rest of this document as the "Clinician Task Force") is providing the following comments regarding the proposed DME coverage rules described in Section 302 of the file referenced above. The Clinician Task Force is made up of 30 physical and occupational therapists and other practitioners with years of experience and expertise in functional evaluation and assessment of patients for the purpose of selection and provision of appropriate durable medical equipment.

We are providing both general and specific comments as noted below since we believe the clinical conditions, as described in the proposed rule would adversely affect provision of durable medical equipment and the quality of care for Medicare beneficiaries. Furthermore, the task force believes the clinical conditions noted do not accurately reflect current practice in providing durable medical equipment, prosthetic and orthotic supplies (DMEPOS).

GENERAL COMMENTS

The Clinician Task Force agrees with CMS that beneficiaries of DMEPOS should be under the care of a physician. Furthermore, those beneficiaries, whose care is coordinated by a primary physician, and who are referred for appropriate evaluations by other skilled and knowledgeable clinicians (e.g. physical and occupational therapists) often receive the most appropriate items of durable medical equipment; thereby reducing waste to the Medicare program due to abandoned or inappropriate equipment. Appropriately prescribed and fitted items of DMEPOS can greatly enhance the quality of health of beneficiaries, prevent the development of secondary conditions that greatly increase the health care costs (such as hip fractures due to falls, pain syndromes, or pressure ulcers), and ultimately lead to the most cost effective care.

The Clinician Task Force recognizes the problems associated with inappropriate proliferation of use regarding certain categories of DMEPOS and applauds the goals of

enhancing quality of health care delivery and reducing waste and abuse in the system. In order to achieve these goals, the Clinician Task Force recommends in our specific comments procedures, involving the use of a team process which is initiated and coordinated by a physician but involves other skilled and knowledgeable clinicians whose responsibilities include: carrying out specialty examinations as needed and providing the physician with information, in the form of a written medical report, thus allowing the physician to make the best decisions when ordering DMEPOS.

Along these lines, it is important for CMS to take into consideration the following quote from Schwartzberg, J.G., Kakavas, V.K., & Malkind, S. (Eds.) 1994. *Guidelines for the Use of Assistive Technology: Evaluation, Referral, Prescription*. Chicago, IL: Department of Geriatric Health, American Medical Association, which form the basis of many of our comments:

"Physicians need to be aware of other disciplines and consultants who can provide more in-depth assessment and training and assist with prescription of assistive technology. Physicians treating persons with disabilities should understand that an interdisciplinary team approach is often necessary to deal with the multifaceted problems facing these patients. Primary physicians should make sure that knowledgeable consultants, providers, and technology suppliers are readily available to help them meet their patients' needs."

Physical and occupational therapists are trained in performing functional assessments and routinely perform both physical and functional examinations that lead to technology assessments and ultimately result in the recommendation of an appropriate item of durable medical equipment. We believe that this process, if applied effectively, will meet the stated goals of CMS, will minimize the burden on the physician, lead to appropriate DMEPOS recommendations, and allow the health care team to work effectively and efficiently.

SPECIFIC COMMENTS AND RECOMMENDATIONS

We state below elements of the proposed rule in Section 302 and then our specific comments and recommendations.

- The proposed rule currently states: "*Establish a requirement for a face-to-face examination by a physician, physician assistant (PA), clinical nurse specialist (CNS), or nurse practitioner (NP), as they are defined in the Act (the prescribing physician or practitioner) to determine the medical necessity of durable medical equipment, orthotics and prosthetics"*

  Recommendation: The Clinician Task Force proposes the following alternative clinical conditions, which we believe will meet the stated goals of enhancing quality and reducing waste and abuse in the provision of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

- A face-to-face examination by the ordering physician **or**
- A prescription by a physician with an established relationship with the patient **if** the need for the item prescribed is appropriate for the conditions for which the physician has previously treated the patient (i.e. not a new condition)

An established patient is defined by the American Academy of Family Physicians and for the purposes of CPT billing as a patient who "has received professional services from the physician or another physician in the same group and the same specialty within the prior 3 years". The Clinician Task Force believes that either of these two conditions would meet the stated goal of controlling quality provision of DMEPOS.

- The proposed rule states: *Require that the order be dated and signed within 30 days after the face-to-face examination and include verification of the examination. We are soliciting comments on the appropriate verification process.*

  The Clinician Task Force disagrees with this since the outcome of a face-to-face examination by a primary care physician often includes, as an essential component of the treatment plan, referral to a specialist for a functional evaluation or technology assessment (for example – a physical or occupational therapist or an assistive technology specialty clinic). The 30 day window will not allow for adequate time for these evaluations and determination of appropriate equipment. This is especially true with more complex patients who require an extensive evaluation and in home trials with specific devices.

  *Recommendation :*If a face-to-face examination is required (i.e. the equipment specification and prescription is not generated by a physician with an established relationship with the patient), the Clinician Task Force proposes an appropriate window of time, during which all consultations may be completed, of **120 days.** This would allow for referral to a skilled and knowledgeable clinician, a functional assessment by the clinician, reporting the results of this functional assessment back to the referring physician and the generation of appropriate DMEPOS orders.

- The proposed rule states: *Establish a requirement that the face-to-face examination should be for the purpose of evaluating and treating the patient's medical condition and not for the sole purpose of obtaining the prescribing physician's or practitioner's order for the DMEPOS. We expect the prescribing physician or practitioner to conduct a sufficient examination of the patient's medical condition to ascertain the appropriate overall treatment plan and to order the DMEPOS as only one aspect of that treatment plan.*

  The Clinician Task Force disagrees with this since the requirement of a face-to-face examination by a physician for prescription of many items of durable medical equipment or for routine supplies would be cost prohibitive and severely restrict access to basic health care supplies (e.g. walkers, crutches, canes, bath benches,

toileting equipment, basic rental wheelchairs, self care items such as catheterization kits, adult diapers, dressing materials, etc.)

Recommendation: The Clinician Task Force proposes that the requirement of a face-to-face examination, in the absence of an established relationship with the physician, only be required for all purchased wheelchairs (i.e. non-rental items) and for items of DMEPOS that exceed $1200 in charges. We also agree that for those individuals with on-going needs due to stable disabling conditions, a face-to-face examination is not necessary for replacement of an item of DMEPOS – even if the item exceeds the proposed $1200 limit. Requiring face-to-face examination of these beneficiaries would place an undue burden on both the physician and the beneficiary and would result in no cost savings to Medicare.

- The proposed rule states: *Require the prescribing physician or practitioner to maintain appropriate and timely documentation in the medical records that support the need for all DMEPOS ordered.*

  We believe that documentation of specific need for durable medical equipment in the physicians' medical records is another element of this proposed regulation that is potentially problematic. Current clinical practice often relies on extensive documentation provided by skilled and knowledgeable clinicians (e.g. physical or occupational therapists) for specific and detailed reporting of a patient's functional skills and abilities and for specific documentation of medical need for durable medical equipment. Physicians' notes do not typically encompass this detailed explanation of a patient's functional assessment.

  Recommendation: The Clinician Task Force believes it is important that the treating physician document the need for an item of DMEPOS and the medical conditions being addressed by the application of the item of DMEPOS. According to the American Medical Association (1994) "Written prescription and recommendations [should] include evaluation and clinical condition, treatment, general rehabilitation goals, expected length of treatment, and precautions or limitations." If referral is made to another clinician for specific evaluation and recommendation, the results of this evaluation should be reported back to the ordering physician and an acknowledgement noted in the physician's notes. The report generated as a result of any specialty evaluation should be used as additional supporting documentation for the medical necessity of the item of DMEPOS.

- The proposed rule states: *Require that the prescribing physician or practitioner be independent from the DMEPOS supplier and may not be a contractor or an employee of the supplier.*

  Recommendation: The Clinician Task Force also concurs that it is critical to the ethical outcome of this process that not only the prescribing physician be independent of the DMEPOS supplier, but also that the skilled and knowledgeable clinician responsible for performing the functional assessment and equipment matching

process be independent of the DMEPOS supplier and should not be a contractor or an employee of the supplier.

Recommendation: It is also critical that the services provided by the skilled and knowledgeable clinician be appropriately reimbursed by Medicare. Without appropriate reimbursement, this critical process resulting in the highest quality of care and preventing over or under utilization of durable medical equipment will not be possible and CMS will not be able to achieve the goals of delivering the highest quality of care and preventing waste and abuse in the system.

Thank you for your consideration of these comments. Please feel free to contact us for clarification or further discussion.

Sincerely,

Co-coordinators of the CMMCMP Clinical Task Force

Laura Cohen PT, PhD, ATP
Clinical Research Scientist
Shepherd Center
Atlanta, GA
Lauracohen2004@yahoo.com
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Barbara Crane, PhD, PT, ATP
Private Consultant
Wethersfield, CT
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CMS-1429-P-2735

Submitter : **Date & Time:** 09/22/2004 06:09:48

Organization :

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

All health care practitoners including occupational therapists and massage therapists should be covered where physical therapy is covered.

CMS-1429-P-2736

Submitter : Mr. Eric Schneider **Date & Time:** 09/22/2004 06:09:14

Organization : OrthoMotion

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am certified athletic trainer (ATC) and I believe that limiting my profession to be nothing more then a "whipping-boy" for a physical therapist is preposterous. I have a Master's degree and several years of hands on experience that even the highest trained physical therapist may not have. The primary focus and intention of physical therapists is to crush my profession and let them create a monopoly in dealing with rehabilitation. DO NOT LET THIS HAPPEN!!! We have be accepted as a healthcare (Accredited) provider without any problems in the past so do not create any now. Do the right thing and do not give in to the power of physical therapists lobbyers.
Sincerely,
Eric Schneider, MS, ATC

CMS-1429-P-2736-Attach-1.doc

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

The attachment to this document is not provided because:

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

Submitter : Mr. Stephen Kana **Date & Time:** 09/22/2004 06:09:52

Organization : Orthopedic Specialties

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached document

CMS-1429-P-2737-Attach-1.doc

Attachment #2737

September 22, 2004

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

Dear Sir/Madam:

I am 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.

- 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.

As a physician who relies on the services performed by Athletic Trainers in our area, I believe this is an uncanny way for one profession who feels the pressure to limit the services to patients. Why deny the Medicare/Medicaid population from such great resources to get back into their active life. I have found that the active adult population is better served by those who understand the mechanics, and total body involvement in each of the sports/activities that patients are involved in. 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,

Dr. Stephen Kana

Jan H. Postma, M.D. John E. Keith, Jr., M.D. Anthony A. Sanchez, M.D.
Mark D. Visk, M.D. Stephen M. Kana, M.D.
Peter J. Buchanan, Administrator
303 East Wood Street Spartanburg, SC 29303 Phone: 864-560-4282 Fax: 864-560-4568

Submitter : Mr. Thomas Walker, B.A., LMT **Date & Time:** 09/22/2004 06:09:02

Organization : Mr. Thomas Walker, B.A., LMT

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I oppose the restriction of allowing only PT's to provide medically related care in a physician's office. This would eliminate the beneficial care now being provided by Licensed Massage Therapists.

CMS-1429-P-2739

Submitter : Mr. Christopher Zinn **Date & Time:** 09/22/2004 06:09:41

Organization : Mr. Christopher Zinn

Category : Other Health Care Professional

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 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, increase the costs associated with these services and place an undue burden on the entire health care system.

PLEASE READ LETTER ATTATCHED TO THIS COMMENT!

CMS-1429-P-2739-Attach-1.doc

Attachment #2739

September 22, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

Physicians should have the right to select the health care professional (including the Certified Athletic Trainer) who they deem is most qualified to treat the patient's condition. Physicians should be allowed to select the provider of care based on the best interests of the patient. By allowing the Physician to select from a variety of health care providers, the patient receives the benefits of quicker, more accessible health care. Additionally, no single group of individuals should receive exclusive rights to provide Medicare services for 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. Research has demonstrated that the quality of care provided by Certified Athletic Trainers in the provision of rehabilitation services is equal to that of Physical Therapists. Physical and Occupational Therapists do not "own" the right to provide rehabilitation services. Limiting the ability of Certified Athletic Trainers to provide care to Medicare patients, will mean that physically active individuals who qualify for Medicare will no longer be able to select the most qualified professional for care of athletic related injuries.

In summary, I feel it is neither necessary nor advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Christopher R. Zinn, ME.d., ATC

CMS-1429-P-2740

Submitter : **Date & Time:** **09/22/2004 06:09:15**

Organization : **Cancer Therapy and Research Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Issues 1-9

GPCI

Please see attachment for our comments.

CMS-1429-P-2740-Attach-1.doc

Attachment #2740

September 22, 2004

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

Re: GPCI

Dear Dr. McClellan:

On behalf of the Cancer Therapy and Research Center (CTRC), a multidisciplinary, freestanding, community cancer clinic and research center located in San Antonio, Texas, we are pleased to comment on the proposed Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2005 contained in the Federal Register of August 5, 2004. We are writing to comment on Section 1848 (e)(1)(C) of the Social Security Act that requires that payments made using the physician fee schedule must be adjusted in each geographic area to reflect variation in local resource costs as measured by the Geographic Practice Cost Indices (GPCIs) and this adjustment is to be reevaluated every three years.

Our comments reflect ongoing analysis of what we consider to be disparities in the formula-driven GPCIs, and we urge your reconsideration of the formulas and data used to set these resource costs for our area in Texas.

Historically, there have been eight payment areas (localities) in the state of Texas (Austin, Beaumont, Brazoria, Dallas, Fort Worth, Galveston, Houston, and Rest of Texas). The San Antonio metropolitan area, currently the second largest city in the state and eighth largest in the nation, has been included in the "Rest of Texas" category since 1997.

The U.S. Census Bureau has indicated that in 2004, San Antonio, in fact, surpassed the Dallas metropolitan area in population, yet the GPCI values assigned to San Antonio are far below those of the Dallas metropolitan area values. As presented in Attachment 1, moreover, the latest American Chamber of Commerce Researchers Association (ACCRA) tabulation of cost of living indices places San Antonio's cost of living index on par with or above the other major metropolitan areas in Texas, Dallas, Houston and Austin. A more comprehensive comparison is included in Attachment 2.

Since the formulas and data used by the Centers for Medicare and Medicaid Services (CMS) to calculate the GPCIs may be the root cause of this difference in GPCI values between the San Antonio area and other similar areas in Texas, we have attempted to understand the specific data and methodology used to calculate the costs for regions such as ours. This could explain the very low Practice Expense GPCI assigned to the San Antonio metropolitan area. Our analysis shows a significant, unwarranted disparity between San Antonio and the seven distinct Texas metropolitan localities in CMS' consideration of practice expense costs.

We attempted to discern the nature of the data and understand CMS' formula calculations in a discussion with agency staff. In that conversation, we were told that, because of technical issues, it would be methodologically unsound to use CMS' own formulas to compute accurate GPCIs for our area and subsequently draw conclusions from any such calculations. CMS, furthermore, could not offer alternative approaches for us to use in formulating San Antonio-specific GPCIs. All that could be discussed about the GPCI formulas and data, we were told, had already been presented in the Federal Register discussion of the proposed rule.

While we appreciate that CMS must be consistent in its intent and interpretation of such complex formulas, we believe precisely because these formulas are so complex, CMS may not be able to account for relevant new data or facts that would, if considered, change the outcome of the GPCIs for distinct localities. However, a hesitance to discuss the formula or alternatives, and thus potentially ignoring the possibility of miscalculation or the need for reinterpretation of data, is an unacceptable position when so much is at stake for patients in our locality. We bring this to your attention and urge that there be an opportunity to discuss the CMS GPCI formulas and data in detail before the final rule is determined.

The practice of medicine in San Antonio is among the best in the nation as evidenced by awards to many of our major health care organizations. San Antonio uses the same expensive, state-of-the-art medical equipment as other large Texas cities. San Antonio competes with those large Texas cities, especially Austin, for medical professionals, as well. Reimbursing healthcare providers in San Antonio at a lower rate than other equivalent cities severely taxes the ability of current providers in San Antonio to meet local needs.

We respectfully request that CMS designate San Antonio as a separate payment area (distinct locality) and recalculate the artificially low GPCI values for this locality using current statistical and demographic data in order to bring San Antonio to a payment level comparable to the payment levels of other equivalent metropolitan areas in Texas.

Thank you for your attention to this matter.

Sincerely,

Gerald Z. Dubinski
Executive Vice-President
Director of Government Relations
Cancer Therapy & Research Center

cc: Congressman Henry Bonilla, 2458 Rayburn House Office Building
Washington, DC 20515 www.house.gov/writerep
U.S. Senator Kay Bailey Hutchison, 284 Russell Senate Office Building,
Washington, DC 20510 casework@hutchison.senate.gov

Attachment 1: Practice Expense and Cost of Living Comparison
Attachment 2: ACCRA data

Attachment 1.

TEXAS PRACTICE EXPENSE CALCULATION
2004

Practice Location	Work GPCI	Practice Expense GPCI	% diff from "Rest of TX"	Malpractice GPCI	Carrier / Loc#
Austin, TX	1	**0.996**	**113%**	0.922	00900 / 31
Beaumont, TX	1	**0.89**	**101%**	1.318	00900 / 20
Brazoria, TX	1	**0.978**	**111%**	1.318	00900 / 09
Dallas, TX	1.01	**1.065**	**121%**	0.996	00900 / 11
Fort Worth, TX	1	**0.981**	**111%**	0.996	00900 / 28
Galveston, TX	1	**0.969**	**110%**	1.318	00900 / 15
Houston, TX	1.02	**1.007**	**114%**	1.316	00900 / 18
Rest of Texas *(includes San Antonio)*	**1**	**0.88**		**1.047**	**00900 / 99**

	COST OF LIVING INDEX	*% difference*	*AVG RENT*	*% difference*
SAN ANTONIO	**97.0**		**$ 967.00**	
AUSTIN	97.5	1%	$ 748.00	-23%
BEAUMONT	87.8	-9%	$ 742.00	-23%
BRAZORIA	91.1	-6%	$ 730.00	-25%
DALLAS	95.5	-2%	$ 844.00	-13%
FORT WORTH	91.7	-5%	$ 718.00	-26%
GALVESTON	N/A		N/A	
HOUSTON	91.1	-6%	$ 771.00	-20%
Examples of Rest of TX				
SAN ANGELO	88.7	-9%	$ 545.00	-44%
EL PASO	92.2	-5%	$ 669.00	-31%
LAREDO	85.5	-12%	$ 634.00	-33%
ABILENE	90.6	-7%	$ 582.00	-40%

Source: ACCRA Cost of Living Index sample data. Data represent the index calculated for 2004 Second Quarter.

Attachment 2.

ACCRA Cost Of Living Index

Location	Total(100%)*	Grocery (14%)*	Housing (29%)*	Utilities (10%)*	Trans. (10%)*	Health (4%)*	Misc. (33%)*	Avg Rent**	Avg Home Price***
From (Origin)									
Austin	97.5	88.1	95.4	91.8	95.2	112.7	103.1	$748.00	$245,692.00
To (Destination)									
San Antonio	97.0	91.0	100.5	77.0	86.3	102.7	103.5	$967.00	$238,737.00
Percent Difference	-0.5%	+3.3%	+5.3%	-16.1%	-9.3%	-8.9%	+0.4%	+29.3%	-2.8%
Based on the Current Income that you entered, if you are earning $0.00 after tax dollars in Austin , the comparable after-tax income in San Antonio is $ 0.00									

Location	Total(100%)*	Grocery (14%)*	Housing (29%)*	Utilities (10%)*	Trans. (10%)*	Health (4%)*	Misc. (33%)*	Avg Rent**	Avg Home Price***
From (Origin)									
Beaumont	87.8	92.5	77.9	89.4	97.5	85.1	91.8	$742.00	$183,000.00
To (Destination)									
San Antonio	97.0	91.0	100.5	77.0	86.3	102.7	103.5	$967.00	$238,737.00
Percent Difference	+10.5%	-1.6%	+29.0%	-13.9%	-11.5%	+20.7%	+12.7%	+30.3%	+30.5%
Based on the Current Income that you entered, if you are earning $0.00 after tax dollars in Beaumont , the comparable after-tax income in San Antonio is $ 0.00									

Location	Total(100%)*	Grocery (14%)*	Housing (29%)*	Utilities (10%)*	Trans. (10%)*	Health (4%)*	Misc. (33%)*	Avg Rent**	Avg Home Price***
From (Origin)									
Dallas	95.5	91.1	85.2	99.8	102.4	102.8	102.4	$844.00	$200,900.00
To (Destination)									
San Antonio	97.0	91.0	100.5	77.0	86.3	102.7	103.5	$967.00	$238,737.00
Percent Difference	+1.6%	-0.1%	+18.0%	-22.8%	-15.7%	-0.1%	+1.1%	+14.6%	+18.8%
Based on the Current Income that you entered, if you are earning $0.00 after tax dollars in Dallas , the comparable after-tax income in San Antonio is $ 0.00									

Location	Total(100%)*	Grocery (14%)*	Housing (29%)*	Utilities (10%)*	Trans. (10%)*	Health (4%)*	Misc. (33%)*	Avg Rent**	Avg Home Price***
From (Origin)									
Fort Worth	91.7	99.5	79.1	85.5	97.0	100.7	98.8	$718.00	$193,173.00
To (Destination)									
San Antonio	97.0	91.0	100.5	77.0	86.3	102.7	103.5	$967.00	$238,737.00
Percent Difference	+5.8%	-8.5%	+27.1%	-9.9%	-11.0%	+2.0%	+4.8%	+34.7%	+23.6%

Based on the Current Income that you entered, if you are earning $0.00 after tax dollars in Fort Worth , the comparable after-tax income in San Antonio is $ 0.00

Location	Total(100%)*	Grocery (14%)*	Housing (29%)*	Utilities (10%)*	Trans. (10%)*	Health (4%)*	Misc. (33%)*	Avg Rent**	Avg Home Price***
From (Origin)									
Brazoria	91.1	92.3	83.3	97.3	96.0	96.6	93.8	$730.00	$201,363.00
To (Destination)									
San Antonio	97.0	91.0	100.5	77.0	86.3	102.7	103.5	$967.00	$238,737.00
Percent Difference	+6.5%	-1.4%	+20.6%	-20.9%	-10.1%	+6.3%	+10.3%	+32.5%	+18.6%

Based on the Current Income that you entered, if you are earning $0.00 after tax dollars in Brazoria , the comparable after-tax income in San Antonio is $ 0.00

Location	Total(100%)*	Grocery (14%)*	Housing (29%)*	Utilities (10%)*	Trans. (10%)*	Health (4%)*	Misc. (33%)*	Avg Rent**	Avg Home Price***
From (Origin)									
Houston	91.1	85.9	79.3	101.4	101.9	104.1	96.1	$771.00	$193,560.00
To (Destination)									
San Antonio	97.0	91.0	100.5	77.0	86.3	102.7	103.5	$967.00	$238,737.00
Percent Difference	+6.5%	+5.9%	+26.7%	-24.1%	-15.3%	-1.3%	+7.7%	+25.4%	+23.3%

Based on the Current Income that you entered, if you are earning $0.00 after tax dollars in Houston , the comparable after-tax income in San Antonio is $ 0.00

Location	Total(100%)*	Grocery (14%)*	Housing (29%)*	Utilities (10%)*	Trans. (10%)*	Health (4%)*	Misc. (33%)*	Avg Rent**	Avg Home Price***
From (Origin)									
San Angelo	88.7	86.7	75.6	87.9	94.4	93.2	99.0	$545.00	$195,750.00
To (Destination)									
San Antonio	97.0	91.0	100.5	77.0	86.3	102.7	103.5	$967.00	$238,737.00
Percent Difference	+9.4%	+5.0%	+32.9%	-12.4%	-8.6%	+10.2%	+4.5%	+77.4%	+22.0%

Based on the Current Income that you entered, if you are earning $0.00 after tax dollars in San Angelo , the comparable after-tax income in San Antonio is $ 0.00

Location	Total(100%)*	Grocery (14%)*	Housing (29%)*	Utilities (10%)*	Trans. (10%)*	Health (4%)*	Misc. (33%)*	Avg Rent**	Avg Home Price***
From (Origin)									
El Paso	92.2	108.9	79.8	99.8	95.0	108.5	92.1	$669.00	$199,180.00
To (Destination)									
San Antonio	97.0	91.0	100.5	77.0	86.3	102.7	103.5	$967.00	$238,737.00
Percent	+5.2%	-16.4%	+25.9%	-22.8%	-9.2%	-5.3%	+12.4%	+44.5%	+19.9%

Difference									

Based on the Current Income that you entered, if you are earning $0.00 after tax dollars in El Paso , the comparable after-tax income in San Antonio is $ 0.00

Location	Total(100%)*	Grocery (14%)*	Housing (29%)*	Utilities (10%)*	Trans. (10%)*	Health (4%)*	Misc. (33%)*	Avg Rent**	Avg Home Price***
From (Origin)									
Laredo	85.5	78.4	83.4	87.5	107.2	101.1	82.1	$634.00	$217,060.00
To (Destination)									
San Antonio	97.0	91.0	100.5	77.0	86.3	102.7	103.5	$967.00	$238,737.00
Percent Difference	+13.5%	+16.1%	+20.5%	-12.0%	-19.5%	+1.6%	+26.1%	+52.5%	+10.0%

Based on the Current Income that you entered, if you are earning $0.00 after tax dollars in Laredo , the comparable after-tax income in San Antonio is $ 0.00

Location	Total(100%)*	Grocery (14%)*	Housing (29%)*	Utilities (10%)*	Trans. (10%)*	Health (4%)*	Misc. (33%)*	Avg Rent**	Avg Home Price***
From (Origin)									
Abilene	90.6	92.5	83.3	95.0	94.2	93.0	93.7	$582.00	$219,600.00
To (Destination)									
San Antonio	97.0	91.0	100.5	77.0	86.3	102.7	103.5	$967.00	$238,737.00
Percent Difference	+7.1%	-1.6%	+20.6%	-18.9%	-8.4%	+10.4%	+10.5%	+66.2%	+8.7%

Based on the Current Income that you entered, if you are earning $0.00 after tax dollars in Abilene , the comparable after-tax income in San Antonio is $ 0.00

Source: ACCRA Cost of Living Index sample data. Data represent the index calculated for...

2004 Second Quarter

Thanks for choosing the ACCRA Cost of Living Index!

*The national average cost for each index area is set at "100", and the indices for each place are then calculated based upon their relation to that average. In addition, the total cost of living index does not include taxes. For more information please refer to the Methodology & Data Interpretation area.

**Avg Rent - two bedrooms, unfurnished, excluding all utilities except water, 1 1/2 or 2 baths, 950 sq ft.

***Avg Home Price - 2,400 sq ft. living area, new house, 8,000 sq ft. lot, 4 bedrooms, 2 baths.

CMS-1429-P-2741

Submitter : Mr. Benjamin Widder **Date & Time:** 09/22/2004 07:09:47

Organization : South Middleton School District

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached letter. Thank You kindly!

CMS-1429-P-2741-Attach-1.txt

Attachment #2741

Benjamin L Widder, ATC
293 Kauffman Road East
Chambersburg, PA 17201

September 22, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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.

Athletic Trainers are highly educated health care professionals. All Certified Athletic Trainers have at least a bachelor's or master's degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, therapeutic exercise, therapeutic modalities, nutrition, exercise physiology, acute care of injury and illness, statistics and research design. 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 education programs in Athletic Training (JRC-AT.)
Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
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,

Benjamin L. Widder, ATC
293 Kauffman Road East
Chambersburg, PA 17201

CMS-1429-P-2742

Submitter : **Date & Time:** **09/22/2004 07:09:19**

Organization : **Cancer Healthcare Associates**

Category : **Physician**

Issue Areas/Comments

Issues 1-9

SECTION 303

Please see attachment for comments.

CMS-1429-P-2742-Attach-1.doc

Attachment #2742

CHA

CANCER HEALTHCARE ASSOCIATES

7979 Wurzbach, Suite 330 San Antonio Texas 78229

ELECTRONIC LETTER
www.cms.hhs.gov/regulations/ecomments
Mark B. McClellan, MD, PhD
Administrator, Centers for Medicare and Medicaid Services
Centers for Medicare & Medicaid Services
Department of Health and Human Services

September 22, 2004

Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2005
File Code CMS-1429-P

Dear Dr. McClellan:

On behalf of the Cancer Healthcare Associates (CHA), a community physician group practicing in San Antonio, Texas, we are pleased to comment on the proposed Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2005 contained in the Federal Register of August 5, 2004. Our group embodies the wide range of specialty care often required for effective cancer treatment: medical oncology, hematology, and surgical oncology. In addition to providing this specialized care, we also engage in medical education and clinical research through affiliations with the Cancer Therapy and Research Center and the University of Texas Health Science Center in San Antonio. The broad spectrum of our activities in cancer therapy—from providing conventional treatment, to participating in innovative Phase I clinical trials, and to educating the next generation of oncologists—gives us unique insight into how the proposed physician fee schedule revisions impact cancer communities such as ours in San Antonio.

CHA commends the ongoing efforts of the Centers for Medicare and Medicaid Services (CMS) to address longstanding, complex issues with the Medicare reimbursement rates for the administration of Part B drugs. We particularly support the changes made to the relative value units (RVUs) for chemotherapy administration codes. These important changes produce more appropriate payment for historically underpaid chemotherapy services, thereby, permitting CHA and other community cancer care providers to maintain patient access to life-saving chemotherapy. Allowing different chemotherapy administration codes to be separately billed in the same day without “bundling” further corrects some of the reimbursement and billing problems that have complicated cancer care delivery in the past. We strongly urge CMS to continue to ensure that payments for furnishing chemotherapy services are aligned with the costs incurred by oncologists.

Furthermore, we encourage the agency to continue its approach of implementing appropriate payment for chemotherapy administration in combination with implementing appropriate

payment for cancer drugs. Increases in payments for drug administration should not be considered as a substitute for adequate drug reimbursement. Each is critically important. The evaluation of and payment for providing services must be kept separate from the evaluation of and payment for drugs. CHA and other community cancer care providers require adequate payment for both the costs of oncology drugs and the costs of administering them. Cancer patients can only receive the care they deserve if both are appropriately reimbursed.

Section 303—Payment Reform for Covered Outpatient Drugs and Biologicals, Average Sales Price Methodology

Despite the positive steps made by CMS in reforming Medicare payment for drug administration services, the issue of Medicare payment for the drugs themselves remains a significant concern for CHA. Beginning in 2005, CMS proposes to utilize a new payment methodology based on a drug's average sales price (ASP). With some exceptions, most providers would receive Medicare reimbursement for drugs equal to ASP plus 6%.

In implementing the 106% ASP methodology, we urge CMS to re-consider the widely varying effects that the new methodology imposes on different-sized physician groups. Larger oncology groups and physician practices have a greater ability to leverage substantial discounts and competitive prices in their procurement of drugs. Consequently, Medicare payment set at 106% of ASP would more likely be commensurate with their drug acquisition costs and not harm their ability to provide care.

Medium-sized groups, small physician practices, and individual practitioners, in contrast, have substantially more difficulty in leveraging the same market discounts and prices available to the larger physician groups. For medium and small community oncology groups, in particular, drug payments set at 106% of ASP probably would be wholly inadequate to cover their costs to purchase and make available many expensive specialized cancer drugs. According to our analysis, CHA, as a mid-sized oncology group, would confront notable numbers of drug cases in which the new Medicare reimbursement amounts would not cover our procurement costs, placing us in the difficult position of continuing to make these drugs available only at a financial loss.

Medications Costing CHA > 106% of ASP

Medication	J-Code	CTRC Cost per Billing Unit	CY 2004 Pay Allow Limit per billing Unit	CY 2005 Allow Limit per billing unit	Amount Lost in drug purchase with proposed 2005 allowable
PROCRIT 1000U	Q0136	$11	$12	$10	($1.0)
GOSERELIN 3.6 MG IMPLANT	J9202	$387	$376	$234	($152.7)
LEUPROLIDE 7.5 MG IMPLANT	J9217	$590	$501	$234	($355.5)

Numerous other medium and small-sized cancer care facilities, especially rural entities, simply would not be able to absorb such losses. These potential unintended consequences of the 106%

ASP methodology would deprive sick cancer patients of access to care in community physician offices, forcing them to travel longer distances to receive treatment from unfamiliar doctors.

CMS recommends in the proposed rule that small purchasers of Part B drugs join group purchasing organizations (GPOs) to obtain price discounts comparable to those obtained by larger purchasers. CHA has and will continue to participate in a GPO. However, even a group of our size with membership in a GPO has been unable to negotiate successfully or consistently for discounted prices for all drugs. While membership in a GPO may yield some advantages, it is not an across-the-board solution effective for all physician groups in the achievement of major discounts for drugs. Moreover, from our experience, GPOs entail considerable administrative requirements. These administrative requirements, in conjunction with the costs of meeting them, could deter physician practices already facing heavy administrative burdens from joining GPOs.

We believe it is imperative that CMS implement a mechanism that ensures that drug payments based on 106% of ASP are **acceptable for physician groups of all sizes—not just large, corporate-sized practices**. In order to make the new reimbursement methodology workable for medium, small, and individual physician groups, we urge CMS to create a mechanism through which payment could be adjusted for drugs with acquisition costs exceeding their Medicare payment amounts. Specifically, CHA recommends that a code modifier be developed to distinguish drug claims for which the Medicare payment amounts would be insufficient to cover the physician's drug costs. Physicians then should be given the opportunity to document the costs of drugs "flagged" by the code modifier and have the Medicare reimbursement amounts appropriately adjusted to at least meet their acquisition costs for these drugs. The code modifier and subsequent payment adjustments would provide an immediate remedy for smaller providers who are more sensitive than larger groups to inadequate drug payments over even a limited amount of time. Establishing such a mechanism would preserve the ability of small and medium oncology practices such as CHA to provide the most appropriate drugs and the highest standards of care for their patients.

Section 303—Payment Reform for Covered Outpatient Drugs and Biologicals, Provisions for Appropriate Reporting and Billing for Physicians' Services Associated with the Administration of Covered Outpatient Drugs

The proposed rule indicates that CMS is reviewing coding issues related to drug administration raised by the American Medical Association's Current Procedural Terminology (CPT) Editorial Panel. Among the questions addressed by the CPT Editorial Panel are: 1) whether or not the current coding for chemotherapy administration recognizes all of the resources utilized in administering chemotherapy and 2) whether or not there is a need for code revisions or new codes specifically for support services unique to oncology. CHA would like to comment and bring to CMS' attention two issues in the area of chemotherapy resource coding.

First, CPT code 96412, the code for the second and subsequent hour(s) of chemotherapy, currently is undervalued, resulting in chemotherapy furnished beyond the initial hour to be significantly underpaid by Medicare. Payment rate decreases for CPT code 96412 planned for 2005 and 2006 will further worsen the already inadequate payment amount. While it is clear that the Practice Expense RVU for subsequent hours of chemotherapy should be lower than for the initial hour, it is excessively low under the current formula. Although the initial hour is more

time and work intensive than subsequent hours, the nursing time required for subsequent hours of chemotherapy does not decline nearly as much as is presently reflected in the reduction to the Practice Expense RVU. Continuing the practice of inadequate payment for CPT code 96412 provides a perverse incentive for oncology facilities to ration nursing time with cancer patients, a medically unsafe practice that would put patients at risk. While no conscientious cancer care provider would hook patients up and leave them sitting alone, insufficient payment for administering chemotherapy would certainly affect decisionmaking as to how to allocate limited nurse resources. This would be to the inevitable detriment of all cancer patients. From a clinical perspective, many experience side effects during subsequent hours of chemotherapy. In fact, some of the most effective cancer drugs have the worst side effects, thus, all but necessitating that a nurse be present during the administration. From a psychological perspective, the majority of patients simply need interaction with nursing staff in order to allay their anxiety about a frightening process. As stated by our Nurse Manager, Leslie Smetzer, RN, BSN,

> "*Sure, we give them Ativan, but we have to hold their hand and talk to them sometimes too. Are you telling me I can only afford to give time and attention during the first hour of their chemo? Why would we be reimbursed at a rate to cover a chemo certified nurse for the first hour and not the second? I'm just a nurse and not a finance person, but that doesn't make sense to me.*"

CHA urges CMS to revise the Practice Expense RVU calculation and payment rate for CPT code 96412 such that it better reflects the nurse time and other resources used in administering subsequent hours of chemotherapy.

Second, oncology practice groups are insufficiently reimbursed for the cost of certain oncology-specific supplies. Our own operational standards, as well as those of the Occupational Safety and Health Administration, require CHA to provide the safest working environment possible. Most recently, this consists of deploying supplies such as intricate safety needle systems and expensive ventilation hoods costing thousands of dollars to acquire and maintain. Furthermore, there are numerous items involved in the daily treatment of oncology patients, including wheelchairs, IV poles, patient scales to ensure adequate dosing, and nebulizers. Practices such as ours also incur large overhead costs for hazardous waste management, utilities, ancillary staff, educational materials, linen management and sanitation, and post-treatment patient monitoring for new drugs (*e.g.*, Erbitux). While seemingly inconsequential, these all contribute to effective patient care.

Many of these supplies are more expensive than even surgical supplies and cannot be recycled. However, there is no direct reimbursement from Medicare for us to procure and use these critical supplies, especially the safety supplies required by law. We understand that their costs are "bundled" into the chemotherapy administration codes for the sake of administrative simplicity. Our analysis, nevertheless, reveals that the costs we incur for them are insufficiently covered by the reimbursement for the chemotherapy administration codes. The table below presents important supplies that are required to maintain safety for patients as well as for the technicians, nurses, and doctors involved in delivering cancer care. When reimbursement for these supplies is bundled into the payment amounts for chemotherapy administration, it results in financial losses for oncology practices. We recommend that CMS "unbundle" these supplies from chemotherapy administration and establish separate payment for them in the physician fee schedule. For those supplies currently without CPT codes, we recommend that the agency also assign codes to them.

Supplies with existing CPT codes which should be unbundled from Chemotherapy Administration payment	**Supplies without CPT codes which should be given CPT codes and also not be bundled with payment for Chemotherapy administration payment**
91105 Needle, 19g - 25g, butterfly, $1.67 each, per blood draw for pre-chemo labs	IV tubing, cost $8 and $12 per infusion.
91109 IV tubing (extension) $1.04 - 4.59	Huber needles which cost $12 to $15 a piece
91106 Angiocatheter 14g – 24g $1.81 - 3.22	Syringe w/needle, OSHA $0.44 - 0.87
53062 Sodium chloride .9% injection bacteriostatic (30ml uou) $0.38 - 0.80	Water, sterile injection 50ml $0.71 - 1.69
52305 Povidone swabstick (3 pack uou) $0.12	
52304 Silver nitrate applicator $.07 - 0.1	
75038 Sodium Chloride, .9% mm $0.5	

CHA appreciates the opportunity to comment on the payment revisions contained in the proposed rule. Again, we fully support CMS' approach of reforming the payment methodology both for Part B drugs and for their administration. Providing appropriate payments for one and not the other only jeopardizes our ability to deliver cancer care and, by extension, our patients. We look forward to an improved system in which all individuals have timely access to the best care that we and other community cancer care facilities have made it our mission to deliver.

Sincerely,

Physician Members
Cancer Healthcare Associates

Signature Page-- All signatures on file, not attached to electronic version.

Eric Rowinsky, M.D.
CHA Staff Physician

Anthony Tolcher, M.D.
CHA Staff Physician

Amita Patnaik, M.D.
CHA Staff Physician

Samira Syed, M.D.
CHA Staff Physician

Geoffrey Weiss, M.D.
CHA Staff Physician

David Boldt, M.D.
CHA Staff Physician

William Knight III, M.D.
CHA Staff Physician

Robert Marciniak, M.D.
CHA Staff Physician

Christopher Takimoto, M.D.
CHA Staff Physician

Leslie Mathew, C-NP
Nurse Practitioner

Leslie Smetzer, RN, BSN, Nurse Manager

Theresa Mays, PharmD,
Director of Pharmacy

Kyri Papadopoulos, M.D.
CHA Staff Physician

John Sarantopoulos, M.D.
CHA Staff Physician

Jose L. Ochoa, M.D.
CHA Staff Physician

Murali Beeram, M.D.
CHA Staff Physician

Boris Darvosky, M.D., Ph.D.
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Anand Karnad, M.D.
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Oncology Fellow

Phoung Mai, M.D.
Oncology Fellow

Jayasree Rao, M.D.
Oncology Fellow

Carlos Taboada, M.D.
Oncology Fellow

Mazen Khalil, M.D.
Oncology Fellow

Albert Dekker, M.D.
Oncology Fellow

Nabeel Sarhill, M.D.
Oncology Fellow

Yue Guo, M.D.
Oncology Fellow

Sridhar Beeram, M.D.
Oncology Fellow

Duyen Nguyen, M.D.
Oncology Fellow

Lokesh Nagori, M.D.
Oncology Fellow

CMS-1429-P-2743

Submitter : Mr. James Nave **Date & Time:** 09/22/2004 06:09:32

Organization : Biomax Rehabilitation

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am writing in response to the recent proposal that would limit providers of ?incident to? services in physicians? offices and clinics. The adoption of this law would greatly reduce to quality of our health care system. A growing concern in our nation is the cost of health care. This proposal would eliminate the ability of qualified health care professionals to provide important ?incident to? services. Medicare patients? quality of care would decrease while the costs of services would increase

Physicians have the right to delegate the care of patients to individuals who they deem qualified (including certified athletic trainers). This proposal would take this power out of the physician?s hands and in turn decrease the quality of patient care. Already, insurance companies take too much power away from physicians. This proposal seeks to take even more of the decisions away from the physicians by dictating who is qualified to provide ?incident to? services.

The nation is already experiencing a shortage of credentialed allied health care professionals. By not allowing physicians to utilize these professionals to provide ?incident to? services, it is likely that patients will have greater delays in health care and greater costs. Not only would this increase delays, but costs due to increased travel. The rehabilitation duration would most likely be increased due to the above-mentioned delays in treatment time, increasing cost incurred by the patient.

Certified Athletic Trainers are highly educated and qualified. A Certified Athletic Trainer must obtain a bachelor?s degree from an accredited university, and 70% have obtained a master?s degree or higher. Courses for an Athletic Training degree include the following: human anatomy, human physiology, kinesiology, biomechanics, nutrition, acute care of injury and illness, statistics, therapeutic exercise, evaluation and rehabilitation of injuries, research and design, and exercise physiology. These classes are very comparable to other health care professionals, including Physical Therapists, Occupational Therapists, Registered Nurses, and many other mid-level health care practitioners. Athletic Trainers must also pass a national examination and maintain continuing education credits The continuing education system for Athletic Trainers is much more stringent and structured than that for Physical Therapists.

The CMS has offered no evidence that there is a problem in need of fixing. It appears this change to ?incident to? is being done for the interests of a single professional group who seeks to establish themselves as the sole provider of therapy services. CMS does not have the authority to restrict who can and cannot provide these services, especially when it could be construed that the changes are being made to benefit one specific type of health care professionals.

The American Physical Therapy Association has taken a very hypocritical stand on this issue. On one hand, the APTA wants to eliminate all physician owned outpatient therapy clinics, as well as treat patients without a physician?s prescription. On the other hand, the APTA wants to be the only profession allowed to provide ?incident to? services.

As a Certified Athletic Trainer working in an outpatient clinic, I find that each day the Head Athletic Trainer and myself are performing tasks that we take care of exclusively: brace measurement and isokinetic testing. The Head Athletic Trainer is considered our shoulder specialist. I handle the ACL reconstructions because the style of rehabilitation is aggressive in such an injury. I find it comical that Athletic Trainers are considered ?unqualified,? when we can work along side Physical and Occupational Therapists in a clinical setting. Certified Athletic Trainers, should be utilized as part of the solution for the rising health care costs. This new proposal would be a step in the wrong direction for health care reform in our nation

Submitter : Mr. Brian Chavarin **Date & Time:** 09/22/2004 06:09:56

Organization : St. Vincent's Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please See Attached File

CMS-1429-P-2744-Attach-1.doc

Attachment #2744

September 18, 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

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.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive access to health care.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- To allow only physical therapists 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.
- 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.

Thank You

Brian Chavarin, MS, ATC, CSCS
Director, Sports Medicine
St. Vincent Medical Center
2131 W. 3rd Street
Los Angeles, CA 90057
(213) 207-5638

Submitter : Ms. Kirstin Davis **Date & Time:** 09/22/2004 07:09:39

Organization : Catnap Massage

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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

Submitter : Mrs. Susan Pitcher **Date & Time:** 09/22/2004 07:09:41

Organization : Sports Medicine Dept.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please See Attached File

CMS-1429-P-2746-Attach-1.doc

Attachment # 2746

September 22, 2004

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

Re: Therapy – Incident To

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.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive access to health care.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- To allow only physical therapists 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.
- 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.

Thank You

Susan Pitcher, MS, ATC
Supervisor, Sports Medicine Dept.
St. Vincent Medical Center
2131 W. 3rd Street
Los Angeles, CA 90057
(213) 207-5638

Submitter : Ms. Sharon Price **Date & Time:** 09/22/2004 07:09:25

Organization : LifeBridge Health and Sports Medicine

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please read this letter regarding ATC services in Maryland

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

The attachment to this document is not provided because:

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

Submitter : Mrs. Jeanne Buzzi **Date & Time:** 09/22/2004 07:09:14

Organization : Mrs. Jeanne Buzzi

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Address: Mark B. McClellan, MD,PhD
Administrator
Centers for Medicare and Medicaid
Attention: CMS-1429-P

Medicare Program: Revision to Payment policies under the physician for the schedule for calendar year, 2005.

Submitted by: Jeanne Buzzi, student physcial therapist assistant at Cuyahoga Community College, Cleveland, Ohio.

I'm writing in response to Aug 5 proposed rule on 'Revisions to payment policies under the physician fee schedule for the calendar year 2005.' I strongly agree with the proposed rule which states individuals providing physical therapy must be graduates of an accredited professional physical therapist program or meet certain grandfathering clause or educational requirements for foreign trained physical therapist.

As a student of a physical therapist assistant program, we are required to take core classes in which the main focus is human anatomy , physiology, and the body and it's functions. I believe the background I'm attaining will allow me to provide safe and effective care that meets the needs and goals for my patients, physical therapists, and the whole health care team. I believe if one does not have the proper education, one could possibly do harm to a patient. Every patient is different, and what therapy works for one individual, doesn't necessarily work on another. Physical therapists,and physical therapist assistants have an immense knowledge of different conditions and diseases which enables the physical therapists to choose a therapy program wisely for that particular individual while the assistant provides the proper intervention under the supervision of the therapist.

A financial limitation on the provision of therapy services (referred to as the therapy cap) is scheduled to become effective January 1, 2006. Under the current Medicare policy, a patient could exceed his/her cap on therapy without ever receiving services from a physical therapist. This will negatively impact patient outcomes because our goal is to make sure each patient reaches a functional level so they can become active members in the community, and this would greatly effect the ability for most patients reach this goal.

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 out patient therapy services in all settings. Thus, the services must be performed by individuals, who are graduates of accredited professional physical therapist education programs.

Thank you so much for reviewing my comments.

Sincerely,

Jeanne Buzzi

CMS-1429-P-2749

Submitter : Miss. Shelly Radtke **Date & Time:** 09/22/2004 07:09:21

Organization : Miss. Shelly Radtke

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

To Whom it May Concern:
I am a concerned citizen who would like to express my frustration regarding this proposal. I know several athletic trainers who are very intellegent, well refined individuals in the areas of orthopedic injuries and acute care. In addition, I have had the priviledge of working with an athletic trainer when I injured my shoulder. This individual was very professional and skilled in the areas of treatment and rehabilitation of my injury.
Athletic trainers have a place in our medical system. They serve a key role in acute care, treatment, and rehabilitation. I know I would not feel comfortable allowing my children to participate in sports at a school that does not employ an athletic trainer.
Sincerely,
Shelly Radtke

Submitter : Ms. Lisa Johnson **Date & Time:** 09/22/2004 07:09:20

Organization : Florida State Massage Therapy Assocation

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do not pass this policy where a physician can only refer services to physical therapist. we are also qualified health care providers as massage therapist we need to remain included.

CMS-1429-P-2751

Submitter : Ms. Sharon Baltmanis **Date & Time:** 09/22/2004 07:09:27

Organization : Grand Canyon University

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached

CMS-1429-P-2751-Attach-1.txt

Attachment # 2751

Sharon A Baltmanis
3300 W Camelback Rd
Phoenix, AZ 85017

September 21, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

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

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

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

To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services. CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

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

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

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

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

Sincerely,

Sharon A Baltmanis, M.S., ATC/L, CSCS
Clinical Education Coordinator
Athletic Training Education Program
Grand Canyon University
3300 W Camelback Rd

Phoenix, AZ 85017
602-589-2728
sbaltmanis@ashs.edu

CMS-1429-P-2752

Submitter : Dr. Carl Van Wey **Date & Time:** 09/22/2004 07:09:14

Organization : East Bay Radiation Oncology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir:

I appreciate the opportunity to comment on cms-1429-P, that deals with my specialty of Radiation Oncology.

For many years stereotactic radiosurgery and stereotactic radiotherapy have been accepted as very useful treatment for a variety of malignant and non-malignant conditions, but the G codes (eg G0173) have only been payable if place of service is hospital. These procedures are done on an outpatient basis and are routinely and safely delivered in free-standing radiation oncology centers as well, with place of service as Office. I request that cms rules be changed to eliminate this disparity, and allow G codes in the free-standing centers which currently make up 40% of all radiation therapy facilities.

I also request that cms rules be changed to allow Free-standing radiation oncology centers to bill medicare part B for the technical component of radiation therapy for medicare patients who are at a skilled nursing facility (SNF). Under current rules we can only seek payment from the SNF's, who are refusing to contract for radiation therapy, saying their cms reimbursement is not sufficient to cover the additional cost of radiation therapy.

I request that CMS clarify the rules for the proposed 90 day global period for code 77427 (weekly radiation therapy management) to apply only to 99XXX codes. As you know, radiation therapy can last 1 to 8 weeks and without clarification, there will be major problems with inapproriate denials of payment.

Thank you for your consideration.

Sincerely, Carl C. Van Wey, MD carlcvw@mindspring.com

Submitter : Mrs. Stacey Johnson **Date & Time:** 09/22/2004 07:09:45

Organization : Space Coast Health Institute

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do not pass this policy were a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians perscription or under thier supervision.

Submitter : Ms. Claire Heath, MA, CMT **Date & Time:** 09/22/2004 07:09:21

Organization : Maryland Chapter AMTA, NCTMB, AMTA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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

In many instances Massage Therapy has provided greater relief for many patients.

CMS-1429-P-2755

Submitter : Mr. Neil Anastasio **Date & Time:** 09/22/2004 07:09:08

Organization : Mr. Neil Anastasio

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

All Medicare beneficiaries should receive the same standard of care when CMS is paying for Physical Therapy services. Secretaries and clerical workers under the direction of a physician CAN NOT be allowed to continue rendering care to Medicare patients under the guise of a Physical Therapy treatment, simply because a physician is on the premesis. Patients are being short changed and CMS is being ripped off by paying for care by unlicensed personnel. Only a licensed Physical Therapist should be paid for Physical Therapy treatment.
In my community in New York City there are hundreds of so called phsical therapy centers where clerical staff apply modalities to patients, bill Medicare and are supposedly under the supervision of a physician. That is not Physical Therapy....it is the application of a modality without purpose or plan. That should not be paid for by Medicare. In fact the OIG should investigate these claims.

Physical Therapists are licensed and educated in the juristiction where they practice are the only practitioners who have the qualifications to provide P.T.

There should be only one standard for outpatient physical therapy services in all outpatient settings. The current laws allow medical practitioners to milk the system, by over treating and unnecessarily treating Medicare patients ....all for the means of generating another revenue source. You have the ability to stop this and you must act now!
Thank you.

CMS-1429-P-2756

Submitter : Ms. Tisha Hess **Date & Time:** 09/22/2004 07:09:44

Organization : Millikin University

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

The proposal put forth by the federal government stating that ONLY physical therapists are qualified to provide physical medicine services to Medicare patients is ludicrous. Perhaps, the individuals who developed this proposal should thoroughly research the situation before acting in such an impulsive, uneducated way. Upon researching, they will find an undergraduate education saturated with intense academic requirements coupled with a rigorous clinical schedule. Upon researching, they will find professionals with bone deep dedication to their patients. Upon researching, they will find a reservoir of knowledge and the talent to apply this knowledge in a humble, caring manner. Physical therapy and the public's view of the profession has been an established comfort zone for quite awhile. Athletic Training is the "new kid" on the block, and because of this lack of established comfort, there will be sour situations until the roles are clarified. When we peel away all of our opinions, our styles, our experiences, our pride, we, in the medical profession, are all on the same page and are equal--providing health care to those who are ill or disabled and helping them become functional human beings.

CMS-1429-P-2757

Submitter : Mrs. Jamy Jones **Date & Time:** 09/22/2004 07:09:42

Organization : Health Plus Physical Therapy, Inc

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I would like to express my support for the "Incident to" requirement in the final rule on CMS 1429-P. I hold duel creditials of physical therapist and athletic trainer. I progressed my education to a Masters of Physical Therapy because I found that as an athletic trainer I just did not know enough to effectively treat a wide range of patients. I was trained to treat "athletes" and young athletes at that. None of the athletes I treated in my training would have qualified to Medicate benefits-despite the NATA argument of the "Senior Athlete". Differential diagnosis is very important as we age and an athletic trainer is not trained in much beyond muscular injury. I do not feel that other avenues of education (kinesiotherapists, massage therapist,exercise physiologist, and athletic trainers), provide the depth of education and experiance that a PT program provides. Allowing people not educated in physical therapy to provide physical therapy services and get PAID for them does not make any sense to me. Why have any regualtions at all, because it opens up a "Pandora's Box" of people who think Medicare should pay for their services. If they want to get paid like a physical therapist, go back to school and get the education of a physical therapist, like the a "REAL" physical therapist has. I feel very strongly that physical therapy should be provided by or under the supervision of a physical therapist. I have found in my PT practice that when a physician or one of his staff instructs a patient the follow-up and progression is done poorly and not to the best benefit of the patient.
I support the "incident to" provision and ask it be maintained by the CMS. Sincerely, Jamy A. Jones PT, ATC

CMS-1429-P-2758

Submitter : Mr. Alfred E. Kritter, Jr. **Date & Time:** 09/22/2004 07:09:06

Organization : Hanger Prosthetics

Category : Device Industry

Issue Areas/Comments

Issues 10-19

SECTION 302

See attached comments regarding Section 302.

CMS-1429-P-2758-Attach-1.doc

PROSTHETICS & ORTHOTICS
Hanger Inc.

Attachment #2758

September 20, 2004

Ms. Karen Daily
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
PO Box 8012
Baltimore, MD 21244-8012

Comments regarding file code CMS-1429-P
Issue Identifier: 302

Dear Ms. Daily,

The purpose of this letter is to express the concerns of Hanger Prosthetics and Orthotics over the proposed regulations defining the "Clinical conditions for payment of covered items of durable medical equipment."

As discussed in the August 5, 2004 proposed rule entitled, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005", section 302(a)(2) of the Medicare Modernization Act (MMA) requires the Secretary of Health and Human Services to "establish clinical conditions for payment of covered items of durable medical equipment."

The proposed rule discusses CMS' intention to implement the law by requiring direct patient/physician interaction for covered DME items. In addition, the proposed rule discusses the expansion of the clinical conditions required for coverage to items and services not included in the initial legislation, specifically Orthotic and Prosthetic devices. We are concerned that CMS is operating outside of its authority by using the regulatory process to expand the scope of legislation to classes of devices that are legally separated from DME in the Social Security Act (see sections 1861(n), 1861(s)(8, 9,12)). We ask CMS to explain the legal authority it has to expand the scope of section 302(a)(2) of the MMA to include device that are not classified as DME.

In addition to our concern above, I believe that the inclusion of all Orthotic and Prosthetic (O&P) services in the list of devices requiring a face-to-face physician visit will create an unnecessary burden on Medicare beneficiaries, physicians, as well as O&P providers.

We understand and fully support the need for full involvement of the physician in all aspects of a patient's medical care. Orthotists and Prosthetists fit and fabricate devices that stabilize weak or replace missing body parts. Orthotic and Prosthetic professionals do not possess the skills required to diagnose and treat acute medical conditions, nor is it within the typical scope of an O&P practice. Proper Orthotic and Prosthetic care relies on a primary interaction between the patient and physician followed by a finite or infinite period of care by the Orthotist or Prosthetist. The intent of our comments is not to

request the elimination of a direct patient-physician interaction, but to better define when a face-to-face visit is appropriate, specifically when an orthotic or prosthetic service is provided.

There are two general categories of O&P devices: those necessary to treat an acute medical condition, and those necessary to treat a lifelong or chronic condition.

When discussing acute conditions such as limb fractures or post-surgical stabilization, we certainly agree that an in-person evaluation of the patient's needs by a physician is essential to proper treatment. For example, if a patient is referred to an orthotist for fitting of a tibial fracture orthosis, the initial referral must come from the physician who diagnosed the fracture. Subsequent replacement devices should also require a direct patient/physician interaction to determine the continued need to treat the fracture.

On the other hand, there are other orthotic and prosthetic devices used to treat chronic medical conditions are often "lifetime" items, meaning that the beneficiary will require the device and subsequent replacement of identical or similar devices for an indefinite period of time. Several examples of this lifetime need are illustrated below.

A patient who loses a limb requires a prosthesis for the remainder of their life. The proposed rule discusses the belief that "it is good clinical practice for the beneficiary to be seen by the physician for their medical condition and for the physician to decide whether or not an item of DMEPOS is appropriate during the face-to-face examination of the beneficiary." While physician management of medical conditions is obviously crucial to the patient's overall health, for many of our prosthetic patients, the medical condition that resulted in their amputation (e.g. juvenile cancer, trauma, etc.) no longer requires regular medical attention. These beneficiaries look to their prosthetist when they need adjustments or replacement of their ill-fitting prosthesis.

Prosthetists are trained allied health professionals who possess unique skills that enable them to adequately determine whether an existing prosthesis can be adjusted to meet the needs of their patient or if replacement of some or all of the prosthesis is required for a proper fit. The large majority of physicians do not possess the skills or training to make such an assessment.

The current Local Medical Review Policy for Lower Limb Prosthetics governing Medicare coverage of prosthetic devices requires a new prescription when the replacement of the prosthesis is necessary due to wear. The requirement of a new prescription ensures that the physician is aware of the need for a replacement, but does not require a face-to-face interaction between the physician and beneficiary. Instead, the prescription requirement creates a clinically based communication between the physician and the prosthetist regarding the prosthetic needs of the patient. More specifically, according to Lower Limb Prosthetics Local Medical Review Policy,

> "An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DMERC upon request."

Furthermore, the prescription must be detailed enough to meet the following requirements:

> "An order for the prosthesis including all components which is signed and dated by the treating physician must be kept on file by the prosthetist. Adjustments and repairs of prostheses and prosthetic components are covered under this original order. Claims involving replacement of a prosthesis or major component (foot, ankle, knee, socket) necessitated by wear or a change in the patient's condition must be supported by a new physician's order."

The process of the physician reviewing this very specific prescription will act to insure that only medically appropriate components/supplies are provided to the beneficiary.

In addition to requiring detailed prescriptions, the current Medicare requirements use functional levels in order to ensure that beneficiaries are receiving prosthetic components that are appropriate for their every day needs. Functional levels range from K0 (for patients who do not have the ability or potential to ambulate using a prosthesis), to K4 (for patients who are extremely active and require a prosthesis that will withstand continual stress typical of athletes or young children). All prosthetic components that replace a missing knee, ankle, or foot must be approved for the patient's specific functional level in order for Medicare to cover the component. A patient's functional level is assigned through direct coordination between the physician and the prosthetist and must be reconsidered every time a new prescription is required.

The addition of a requirement for a direct physician/patient interaction for the prosthetic patient with a lifelong need will result in redundant evaluation, financial hardship on the patient due to out-of-pocket payments for the physician visit, and may delay the delivery of the adjusted or replacement prosthesis. A delay of even a few days may result in a patient's continued use of a poorly-fitting prosthesis, possibly resulting in skin breakdown and infection. The proposed rule specifically states that the physician/patient interaction should not be for the sole purpose of obtaining a prescription, but it appears in many cases there may not be any other valid reason for the prosthetic patient with a lifetime need to see their physician.

A similar example of lifetime need for an orthotic device involves long leg orthoses (KAFOs) that are used to stabilize the lower limbs of patients who were stricken with acute paralytic poliomyelitis. In this instance, treatment of the acute viral medical condition is no longer necessary; however, the atrophy of the muscles in the lower extremities is permanent and requires the use of long leg braces in order for the patient to ambulate. Wearing these braces 12-18 hours a day eventually causes them to wear and they must be replaced in order to properly function. Much like the scenario above, the current AFO/KAFO Local Medical Review Policy requires a new prescription in order for Medicare to cover an orthosis that must be replaced due to wear. As written,

> "The order must list the unique features of the base code that is billed plus every addition that will be billed on a separate claim line. The medical record must

contain information which supports the medical necessity of the item and all additions that are ordered."

This detailed written order will confer the agreement of the physician with the patient's needs. While consultation between the physician and the orthotist should be and is required under current requirements, the additional requirement of direct physician/patient interaction will only serve to delay the provision of a safe replacement orthoses.

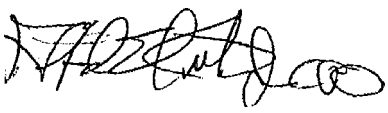
Requiring a direct patient/physician interaction for devices used to treat chronic medical conditions will have an unwarranted effect on a Medicare beneficiary's access to quality medical care. Under current Medicare guidelines, if a patient requires an emergency repair to their prosthesis, they can come directly to their prosthetist. The prosthetist in turn will consult with the patient's physician if they feel a new direction is necessary. If the repaired prosthesis is functionally equivalent to the original device, the original physician prescription remains valid for the repair. Under the proposed rule, the prosthetist would have no authority to repair the patient's prosthesis without a direct interaction between the patient and the physician. The patient would have to be turned away and advised to consult with their physician. It could feasibly be weeks or months in order for the beneficiary to secure an appointment with their physician. This time may be "lost" time for the beneficiary, especially if they are unable to ambulate due to the condition of their prosthesis.

We believe that the current prescription requirements, as outlined in the DMERC Local Medical Review Policy, adequately ensure direct physician involvement in the prosthetic or orthotic management of the patient.

While the above examples only highlight two scenarios where there is no true benefit to a direct interaction between the physician and the patient, they are representative of many other scenarios where an orthotist or prosthetist can provide medically necessary services under the guidance of the patient's physician. Requiring a face-to-face visit for the sole purpose of obtaining a new prescription will place undue hardship on Medicare beneficiaries, physicians, and O&P suppliers and in some case may limit the beneficiary's access to otherwise reasonable and timely healthcare treatment.

We appreciate the opportunity to submit my concerns prior to the publication of the final rule.

Sincerely,



Alfred E. Kritter, Jr., CPO FAAOP
Vice President, Clinical Services

Submitter : Mr. Jason Hall **Date & Time:** 09/22/2004 07:09:37

Organization : NATA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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

During the decision-making process, please consider the following:
? 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,
Jason Hall, ATC
Certified and Licensed Athletic Trainer

CMS-1429-P-2760

Submitter : Mr. Carlo Mastrangelo **Date & Time:** 09/22/2004 07:09:00

Organization : The Bullis School

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

"Please see atattched file"

CMS-1429-P-2760-Attach-2.doc

CMS-1429-P-2760-Attach-1.wpd

Attachment #2760 (1 of 2)

Carlo Mastrangelo MS, ATC

September 22, 2005

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:

- 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,

Carlo Mastrangelo MS, ATC
8505 Welbeck Way
Montgomery Village, MD 20886

Attachment #2760 (2 of 2)

Carlo Mastrangelo MS, ATC

September 22, 2005

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:

- 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,

Carlo Mastrangelo MS, ATC
8505 Welbeck Way
Montgomery Village, MD 20886

Submitter : Mr. Jonathan Glasberg **Date & Time:** 09/22/2004 07:09:24

Organization : Mr. Jonathan Glasberg

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

It is great to see progress in this area. Our public deserves to be TREATED by professionals trained to heal them- not just BILLED that way! Physicians billing for PT services provided by unlicensed personal should be called what it is- fraud. In fact, why would a physician EVER be compelled to bill for PT services? Hopefully that will be laid to rest next.
Physical Therapy has been proven to help improve function for musculoskeletal dysfunctions of varying causes. There is no place for physicians to bill for services they did not personally provide. Thank you-

CMS-1429-P-2762

Submitter : Mrs. Rebecca Price **Date & Time:** 09/22/2004 07:09:56

Organization : Mrs. Rebecca Price

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I would like to express my concern regarding restriction of medicare and medicaid support for athletic trainers. I worked as an equipment manager at a Division III college. During this time I got the priviledge of working with certified athletic trainers. I would first of all like to express my appreciation for their skill and knowledge of treatment and rehabilitation for athletic injuries. They were extremely capable of handling any medical situation. Secondly, I would like to express my discontent for the individuals who are trying to oppress this profession. Without athletic trainers at the institution I worked at, the athletics department could not run. How could a football team practice and participate in games without proper medical care. What would happen to the compound fractures, concussions, and spinal cord injuries if no one qualified to take care of these injuries is there. It would be catastrophic. Athletic trainers have a real nitch is the medical system. This should be recognized and celebrated, not shunned because some profession has too many schools and too many graduates without enough jobs!!!!
Please do not hesitate to contact me if you have any additional information.
Becky Price
715-752-3464

CMS-1429-P-2763

Submitter : Ms. Marybeth Hyer **Date & Time:** 09/22/2004 07:09:23

Organization : Center For Balance Massage

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I oppose changes to Medicare which enable only Physical Therapists to perform physician referred touch therapies to patients. I love my older clientele, and am able to help them. Dr.s like to send patients to well educated, caring, health professionals who they feel will help the patient the most. Physical Therapists are not the only professionals who train to work with soft tissue injuries and joint injuries and ROM training. Others that I can think of right off the top of my head are massage therapists, physical trainers, athletic trainers, chiropractic assistants. Thank you

CMS-1429-P-2764

Submitter : **Date & Time:** 09/22/2004 07:09:22

Organization :

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I?m writing to provide comments and express my support for the proposed ?revisions to payment policies under the physician fee schedule for calendar year 2005? and all related issues regarding ?therapy-incident to?. I am currently in my 3rd year of physical therapy school and will graduate with a doctor of physical therapy (DPT) in 2005. I?m a member of the American Physical Therapy Association (APTA) and our local Physical Therapy Student Association (PTSA). I feel very strongly that all providers of physical therapy services be accredited by a professional physical therapy program, regardless of their practice setting. Currently, all accredited education programs offer at least a master?s degree while the majority are transitioning to doctorate programs. This thorough education and knowledge of anatomy physiology enables therapists to provide comprehensive patient care by understanding the body?s functions and their interactions.
This extensive background facilitates positive rehabilitation outcomes in individuals experiencing neuromuscular impairments and functional limitations. Unqualified personnel attempting to administer physical therapy services are exposing individuals to unnecessary harm and compromising their safety. In order to practice and provide patient care, physical therapists must be licensed by their state and are thus held fully accountable for their professional actions. It is extremely important for individuals seeking health services that the providers of that care are recognized as an accredited profession and are responsible for their own actions. Thank you for considering my comments, I appreciate your time and attention.

Sincerely,

Robin Johanson, SPT

CMS-1429-P-2765

Submitter : Ms. Mary Murphy **Date & Time:** 09/22/2004 07:09:46

Organization : Center for Complementary Medicine

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

As a nationally certified massage therapist working in a multi-disciplinary clinic at a hospital, i urge you not to pass this policy whereby a physician can only refer "indcidnet to" services to physical therapists. All qualified health care providers should be allowed to provide services to a patient with a physician's prescription or under their supervision.

Submitter : Dr. Terry Nicola **Date & Time:** 09/22/2004 07:09:48

Organization : American Associan of PM

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attached document.

CMS-1429-P-2766-Attach-1.doc

Attachment #2766

Please accept this note of strong protest to the following damaging agenda of the political body representing physical therapists.

1. They are aggressively trying to block the vital role and access of certified athletic trainers to practice the very healthcare for which they are superbly trained to practice. They already have proven invaluable in the school institutional setting to initiate treatment and manage immediate (acute and hyperacute) injuries suffered by athletes in practice, in competition, and for illnesses that interfere with their ability to participate in sports. From this training they have proven invaluable in the industrial injury setting due to the similarity in injuries and illness which occur at the worksite. Their training has also proven invaluable that their immediate care training and team work attitude has allowed them to be vital assistants to physicians in the office setting. For these three institutional and clinical settings you will have a difficult time to find physical therapists providing immediate care treatment AT THE SITE of injury. By shear numbers, as well as training design in the college curriculum athletic trainers must be allowed to practice their career and life work in at least these settings. It is obvious that for any judge of athletic trainer competency physical therapists are simply unqualified to raise protest. .

2. They want to independently perform nerve conduction studies and electromyography, inclusive of needle insertion under the skin into muscle without any formal training in the diagnosis of neurological and related diseases.

2. While trying to impose themselves upon the above mentioned physician administered test the physical therapy political body somehow has declared an ability to stop physicians from the ability to administer exercises, stretching, joint mobility, and the use of heat and cold modalities in their offices. As a specialist in physical medicine and rehabilitation, I have received the extensive training to hold this highly responsible position for the welfare of my patients. Furthermore, I am board certified to practice these and other interventions to promote immediate and follow up patient care as needed. The insult to say that I would be in error in the practice of physical therapy by performing the above tasks is unforgivable. I am a physician. As such, I have a responsibility to my patients irregardless of physical therapist unqualified to pass judgment on my competency. There are

well organized healthcare organizations, not to mention my own patients, who see to my level of competent delivery of medical care.

I continue to work closely with a number of talented physical therapists. However, the political body representing physical therapists is demonstrating behavior that is blatantly unethical maybe illegal to block perceived competition by declaring incompetency on the part athletic trainers and physicians. This is also true for a number of vital allied health practitioners who are also proving their importance to medical care such as exercise physiologists with master's degrees in exercise science. It should also be realized that massage therapists are currently in a number of physical therapy practices, fully demonstrating that all this physical therapy political body wants to do is do a power play for control. In contrast, they are trying to infringe on the practice of physicians who are highly trained in the performance of electromyography and nerve conduction studies, without any formal training in the diagnosis of neurological and related diseases. They propose to stick needles into people without the vital safety training that comes with years of medical school and postgraduate training in residency programs, essential and required for medical practice as a physician with an MD or DO degree. All the while, the number of physical therapy centers increase at a rapid rate further evidence that they are simply trying to expand unchecked without any constraints from healthy competition, even physicians!

The behavior of this political body will stifle physician practice and destroy healthy well trained competition from certified athletics trainers, and other highly skilled providers, critical to the efficient and optimal delivery of healthcare in clinics and onsite in the community.

Sincerely,

Terry L. Nicola, MD, MS
Director Sports Medicine Rehabilitation
Assistant Professor Clinical Rehabilitation Medicine
Department of Orthopaedics
University of Illinois Medical Center
Chicago, Illinois

Submitter : Dr. LAWRENCE MENDELSOHN **Date & Time:** 09/22/2004 07:09:57

Organization : LITTLE ROCK HEMATOLOGY ONCOLOGY

Category : Physician

Issue Areas/Comments

Issues 1-9

SECTION 303

I am a medical oncologist in private practice since 1985 in Ark. When I began practice, most oncology patients were treated in the hospital in an expensive and inefficient manner. Over the last 20 years, most practices endeavored to improve the lives of people with cancer and their families by creating an outpatient environment grounded in family atmosphere, efficient administration of chemotherapy by professional nurses and less expensive care. These efforts were successful in improving oncology to its highest level ever. This includes large scale buying and delivery of chemotherapy drugs for outpatient treatment. The investment is great, meaning that securing, storing and administering these drugs involves a great deal of capital. In many practices, profits created by a small margin on some drugs were used to build cancer centers, improve nursing care and delivery of drugs and provide free care to thousands of uninsured. The last 3-4 years, the government, through Medicare changes, mostly by people who have never experienced cancer treatment either as a physician or as a patient, began to chip away at the world's greatest cancer care system. The first changes reduced drug reimbursement and made it illegal to deliver free care. In my practice, that eliminated $1.5 -$2 million a year in care for indigent patients who would have had inconvenient and poor access to treatment. These people are given services which are not reimbursed such as dietitian, social worker and prayer counselor. With MMA, drug reimbursement was slashed to historically low levels. Even with the modest increase in administration reimbursement (only for 2004), some patients with no co-insurance or no insurance are sent to the hospital. It is, of course, illegal to care for anyone without insisting they pay the co-pay, another government breakthrough. The 2004 changes impacted only 10%-15% of our patients who now must go to the hospital for chemotherapy. This is not because oncologists want to continue to make lots of money, but the failure to collect $2000-$3000 the patient is responsible for per month, on the 10,000 patients seen in our office each year would bankrupt anyone. The changes forecast for 2005 are a death sentence for oncology as we know it. Of the drugs we commonly give, 90% will be paid for at a price so low we will be unable to deliver these drugs in our office. In an effort to save this money, the government will bankrupt the Medicare system in a very short time. A typical bill from our office for Erbitux with Camptosar, for colon cancer would be $5000 a month. The patient's responsibility without co-insurance is $1000, which most people cannot afford. At a typical hospital center, the Camptosar-Erbitux combination for one month of treatment is $17,000. It is not difficult to do the math and see that this will not be a savings, but the mass destruction of the cancer care system and Medicare. Delivery of chemotherapy at the hospital is unfriendly, inefficient and more expensive. The hospitals will be unable to treat them either if hospital reimbursement decreases; they will simply refuse to treat these patients as well and you will have a huge number of predominately senior citizens who in effect will be handed a ticket to death because they will not be able to receive their cancer treatment. We understand that money is short and there are no areas left to squeeze by the government to pay for the defense of our country and other large budgetary items. Unfortunately, unless your wish is to destroy cancer treatment access for most Americans, you cannot squeeze the oncology community beyond 2004 levels. It is our hope that you will make 2005 a transition year where the shaky ASP-based chemotherapy sales will be studied and data gained that will enable us to create a fair system for everyone. We, like you, know the ASP system is not ready to go January 1, and it is unfair to put it into place unstudied and inefficient.

CMS-1429-P-2767-Attach-1.doc

Attachment #2767

Lawrence A. Mendelsohn, M.D.
9500 Lile Drive
Little Rock, AR 72205
Phone: 501-219-8777
Fax: 501-219-8680

September 21, 2004

RE: Comments to CMS regarding government changes for Medicare

To Whom It May Concern:

I have been a medical oncologist in private practice since 1985 in Arkansas. When I first came into practice, most oncology patients were given treatment in the hospital in a largely expensive and inefficient manner. Over the last 20 years, most oncology practices, ours included, have endeavored to improve the lives of people with cancer and their families by creating an environment in the outpatient setting, which is grounded in family atmosphere, efficient administration of chemotherapy by professional nurses and much less expensive overall care. These efforts have been successful across the country because we have met our goals in improving oncology to its highest level ever. This is including the large scale buying and delivery of chemotherapy drugs for treatment in the outpatient setting. The investment is great, meaning that the securing, storing and administration of these drugs involves a great deal of capital. In many practices, profits created by a small margin on some drugs has been used to build cancer centers, improve nursing care and the delivery of drugs and also provide free care to thousands of people who are uninsured. Unfortunately, within the last 3 to 4 years the government, through Medicare changes, mostly by people who have never experienced cancer treatment either as a physician or as a patient, have begun to chip away at the world's greatest cancer care system. The first changes reduced some drug reimbursement and it also made it illegal to deliver free care. In my practice, that eliminated $1.5 to 2 million dollars a year in care given to indigent patients who otherwise would have had inconvenient and poor access to cancer treatment. These people are also given services which are not reimbursed such as dietitian, social workers and prayer counselors.

With the Medicare Modernization Act, drug reimbursement has been slashed to historically low levels. Even with the modest increase in administration reimbursement (only for the year 2004), some patients are being sent to the hospital particularly those with no co-insurance and those with no insurance at all. It is, of course, illegal to take care of anyone without insisting they pay the co-pay, another government breakthrough. In 2004, the changes have impacted only 10-15% of our patients who now have to go to the hospital for their chemotherapy. This is not because oncologists want to continue to make lots of money, but the failure to collect $2000-3000 dollars the patient is

responsible for per month, on the 10,000 patients that we have run through our office each year would bankrupt anyone. The changes forecast for 2005 are a death sentence for oncology as we know it. Of the drugs that we commonly give, 90% will be paid for at a price so low that we will be unable to deliver these drugs in our office. In an effort to save this money, the government will bankrupt the Medicare system in a very short time. A typical bill from our office for the drug Erbitux with Camptosar, for colon cancer would be $5000 a month. The patient's responsibility without co-insurance of course would be about $1000, which most people cannot afford. At a typical hospital center, the Camptosar-Erbitux combination for one month of treatment is $17,000. It is not difficult to do the math and see that this will not be a savings, but the mass destruction of the cancer care system and the Medicare system. Delivery of chemotherapy at the hospital is unfriendly, inefficient and more expensive. The hospitals will not be able to treat them either if reimbursement decreases to the hospitals; they will simply refuse to treat these patients as well and you will have a huge number of predominately senior citizens who in effect will be handed a ticket to death because they will not be able to receive their cancer treatment.

We in the cancer-care community understand that money is short and that there are no areas left to squeeze by the government to pay for the defense of our country and other large budgetary items. Unfortunately, unless your wish is to destroy cancer treatment access for most Americans, you cannot squeeze the oncology community beyond 2004 levels. It is our hope that you will make 2005 a transition year where the shaky ASP-based chemotherapy sales will be studied and data will be gained that will enable us to create a system that is fair to everyone. We, like you, know full well that the ASP system is not ready to go January 1 and it is unfair to everyone to put it into place unstudied and inefficient.

I pray that cool heads and wisdom will prevail and the right decisions will be made.

Sincerely,

Lawrence A. Mendelsohn, MD
Hematology-Oncology

LAM:lm

Submitter : Mr. Daniel Henley **Date & Time:** 09/22/2004 07:09:37

Organization : Southeastern Orthopaedic Specialists

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please See Attached Word Document

CMS-1429-P-2768-Attach-1.doc

Attachment #2768

Daniel G. Henley M.A.Ed., B.S.Ed., B.A.., ATC-L
215 Green Valley Road
Greensboro, North Carolina 27403
dan.henley@sosbonedocs.com

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 **opposition** to the recent proposal that would **limit providers** of "incident to" services in physician offices and clinics. 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 **place an undue burden on the health care system**.

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 those professionals (including certified athletic trainers) whom the physician deems knowledgeable, trained and qualified to do so. The **physician's choice** of qualified therapy providers must be **respected**.

- 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 be allowed to continue to make decisions in the best interests of their 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** causing significant **inconvenience** and **additional expense** to the **patient**. These issues may also lead to more

physician practices **eliminating or severely limiting** the number of Medicare patients they **accept,** especially in rural practice settings.

- Certified Athletic Trainers are highly educated. **ALL** certified and state licensed athletic trainers must be **degreed** from an accredited college or university. **Seventy percent** of all athletic trainers have a **master's degree or higher**. Their **academic and clinical training is equal to or exceeds** that of other comparable health care professionals. **Academic programs are accredited** by the Commission on Accreditation of Allied Health Education Programs **(CAAHEP)**.

- **Independent research** has demonstrated that the **quality of services and outcomes** provided by certified athletic trainers are **equal to** the quality of services provided by physical therapists etc. **Patient satisfaction** ratings are very high.

- To mandate that only these practitioners (Physical Therapists, etc.) may provide "incident to" outpatient therapy in physicians' offices would **improperly remove the states' right** to license and regulate the allied health care professions they deem qualified, safe and appropriate to provide health care services to their citizens.

- 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, <u>at the behest</u> of a specific type of health professional, to seek exclusivity as a provider of therapy services.***

- Certified and State Licensed Athletic trainers are currently employed to **prevent, assess, treat and rehabilitate** injuries in **diverse practice settings** under the supervision of a physician. These include Interscholastic, Collegiate, Professional and Olympic Sports Teams, Industrial Settings, **Federal and State Law Enforcement Settings**, Municipal Service (Fire) Settings and many other critical service areas. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary is **unjustified and unfair to the patient, physician and competent health care providers**.

This CMS recommendation is a health care access deterrent and is discriminatory. This proposal must be rejected in the best interest of Medicare Patients.

Respectfully and Sincerely Submitted,

Daniel G. Henley M.A.Ed., B.S.Ed., B.A., ATC-L

CMS-1429-P-2769

Submitter : Mrs. Leeann Pearce-Woolley **Date & Time:** 09/22/2004 07:09:21

Organization : National Athletic Trainers Association

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Leeann Pearce-Woolley
38 Fisk Street
Manasquan,NJ,08736
September 22,2004

Dear Sirs/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 wuld 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:
1. "Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals(including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
2. There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professonal judgment of the physician to be able to determine who is or is not qualified to provide a particular service. IT IS IMPERATIVE THAT PHYSICIANS CONTINUE TO MAKE DECISIONS IN THE BEST INTERESTS OF THE PATIENTS.
3. In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
4. 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 athetes to PREVENT, ASSESS, TREAT AND REHABILITATE injuries sustained during athleti competition. In addition, dozens of athletic trainer accompanied the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athetes from 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 ina local 5k race and goes to their local physician for treatment of that injury is outrageous and unjustified.
5. 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.
6. To alow 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.
7. CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
In summary, it is not necessary or advantageous for CMS to institute the changes proposed. THIS IS A HEALTH CARE ACCESS DETERRENT.
Leeann Woolley

CMS-1429-P-2770

Submitter : Miss. Amy Clampitt-Holsenbeck **Date & Time:** 09/22/2004 07:09:24

Organization : Florida Southern College

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

CMS-1429-P-2770-Attach-1.doc

Attachment #2770

Sue Stanley-Green
Athletic Training Program Director
Florida Southern College
Lakeland, FL 33801

September 19, 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 will 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, 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, been utilized by physicians to allow others, under the physicians supervision, 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 they can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under their care, Medicare and private payers have always relied upon the professional judgment of the physician 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 their 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, it is likely the patient will suffer delays in health care, greater cost and a lack of access to immediate treatment.
- 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. 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 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.

- 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 this summer to provide these services to our top athletes. For CMS to even suggest athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured 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 recommendation is a health care access deterrent.

Sincerely,

Sue Stanley-Green, ATC

Submitter : Mr. Franklin Merillat **Date & Time:** 09/22/2004 07:09:27

Organization : A Center for Therapeutic Massage

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

All patients should be able, with the referral of their physician, to see the health care professional of their choice and not be limited to a single type of provider.

CMS-1429-P-2772

Submitter : Mr. Taum Sayers **Date & Time:** 09/22/2004 07:09:24

Organization : Mr. Taum Sayers

Category : Individual

Issue Areas/Comments

Issues 20-29

IMPACT

I do not want PTs to be the only health care professionals allowed to provide medically related care to physician's patients. Massage therapy is often the most efficient thgerapy....

Submitter : Dr. Jason Bennett **Date & Time:** 09/22/2004 07:09:56

Organization : National Athletic Trainers' Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-2773-Attach-1.doc

Dr. Jason Bennett, DA, ATC
10 Daffodil
Rancho Santa Margarita, CA 92688

Attachment #2773

2/1/2005

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.
- According to the federal government, the preparation of an athletic trainer is rated as equivalent to a PT's, and it is more significant than that of an OT, OTA or PTA. O*NET OnLine is a Web site (the web address is onetcenter.org) developed for and funded by the U.S. Department of Labor. It rates jobs according to level of education, preparation required, and duties. Athletic trainers (ATCs are code 29-9091.00) have a Specific Vocational Preparation (SVP) rating of 8+, versus a 7 to <8 for occupational therapists (code 29-1122.00), and a 4 for occupational therapy assistants (code 31-2011.00) and physical therapy assistants (code 31-2021.00). **See Table 1**

Table 1. Occupational Characteristics of Health Care Providers According to the US Department of Labor.

Professional	Level of Education	SVP (Specific Vocational Preparation)	Job Zone	Job Zone Examples
Athletic Trainer	A bachelor's degree is the minimum formal education required for these occupations. However, many also require graduate school. For example, they may require a master's degree, and some require a Ph.D., M.D., or J.D. (law degree).	> 8.0	Job Zone Five: Extensive Preparation Needed	These occupations often involve coordinating, training, supervising, or managing the activities of others to accomplish goals. Very advanced communication and organizational skills are required. Examples include athletic trainers, lawyers, managing editors, phyicists, social psychologists, and surgeons.
Physical Therapist (PT)	A bachelor's degree is the minimum formal education required for these occupations. However, many also require graduate school. For example, they may require a master's degree, and some require a Ph.D., M.D., or J.D. (law degree).	> 8.0	Job Zone Five: Extensive Preparation Needed	These occupations often involve coordinating, training, supervising, or managing the activities of others to accomplish goals. Very advanced communication and organizational skills are required. Examples include athletic trainers, lawyers, managing editors, phyicists, social psychologists, and surgeons.
Occupational Therapist	Most of these occupations require a four - year bachelor's degree, but some do not	7.0 to < 8.0	Job Zone Four: Considerable Preparation Needed	A minimum of two to four years of work-related skill, knowledge, or experience is needed for these occupations. For example, an accountant must complete four years of college and work for several years in accounting to be considered qualified.
PT Assistant/Aide	These occupations usually require a high school diploma and may require some vocational training or job-related course work. In some cases, an associate's or bachelor's degree could be needed	4.0 to < 6.0	Job Zone Two: Some Preparation Needed	Some previous work-related skill, knowledge, or experience may be helpful in these occupations, but usually is not needed. For example, a drywall installer might benefit from experience installing drywall, but an inexperienced person could still learn to be an installer with little difficulty

Data from The Occupational Information Network (O*NET), http://online.onetcenter.org/ and developed for the US Department of Labor by the National O*NET Consortium.

- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- Athletic trainers already provide therapy under the direction of a physician in athletic training rooms, sports medicine clinics, and other venues
- 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,

Dr. Jason Bennett, DA, ATC

CMS-1429-P-2774

Submitter : Mr. Keith Tompson **Date & Time:** 09/22/2004 07:09:39

Organization : AMTA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I'm opposed to this amendent to allow only PTs to work with doctors.

Submitter : Mr. Billy Diederich **Date & Time:** 09/22/2004 07:09:00

Organization : Neuromuscular Therapist

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Please do not approve the use of physical therapist only in doctors offices. Massage Therapist are needed and a great adjunct when it comes to modalities.
Thank You Billy Diederich C.N.M.T.

CMS-1429-P-2776

Submitter : John Faulstick **Date & Time:** 09/22/2004 07:09:53

Organization : Kent State University

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

"Please see attached file"

CMS-1429-P-2776-Attach-1.doc

John C Faulstick ATC LAT
Dix Stadium
PO Box 5190
Kent State University
Kent OH 44242

Attachment #2776

September 22, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

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

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

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

- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who

are already too busy, will take away from the physician's ability to provide the best possible patient care.

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

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

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

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

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

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

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

Sincerely,

John C Faulstick ATC LAT
Assistant Athletic Director: Medical Services/
Head Athletic Trainer
(330) 672-2786
jfaulsti@kent.edu

CMS-1429-P-2777

Submitter : Ms. Elaine Ashton **Date & Time:** 09/22/2004 08:09:03

Organization : self employed

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

It is my understanding that Medicare is planning to prevent doctors and chiropractors from prescribing massage therapy/bodywork for patients. As a senior who is now on Medicare -- I have long ago realized that massage therapy has kept me healthy and I have every reason to expect that it will continue to keep me healthy for the rest of my life. That ANYBODY would even CONSIDER that massage therapy and bodywork should be curtailed in any way -- would only lead me to believe: 1) Whoever is drafting this ridiculous amendment is getting paid by the drug companies ... and 2) Somebody is obviously worried because they have seen that bodywork/massage therapy is working and they see a threat to their lucrative business. I suspect the Physical Therapists are behind this as they are making every effort to disenfranchise bodyworkers whenever they think they dream up a poor excuse to attack. WHEN WILL MEDICARE START REALLY CARING ABOUT SENIORS AND THEIR HEALTH AND STOP ENCOURAGING SICKNESS. Think about it -- if you keep the "old farts" healthy they'll live longer and you'll have even MORE seniors giving Medicare money but they will not be going to the doctors as much and they won't be in nursing homes as much. And last but not least -- CONSIDER BEING TRULY HONEST, LOVING PEOPLE. What a concept!

Submitter : K Economidis **Date & Time:** 09/22/2004 08:09:24

Organization : K Economidis

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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

CMS-1429-P-2779

Submitter : Mrs. Elizabeth Johnson **Date & Time:** 09/22/2004 08:09:34

Organization : Belpre Sports

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I believe it should be up to the physicians, health care providers, and patients as to what type of therapy is beneficial to them. Massage therapy has been proven to be a great asset and very beneficial for those in rehabilitation and pain management programs, as well as for the well being of all. I beg you NOT to pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Ms. Celeste Varas de Valdes **Date & Time:** 09/22/2004 08:09:05

Organization : Keep In Touch MindBodyTherapy Exploration

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

As a Certified CranioSacral Therapist and a C.M.T. of 18/years, I am opposed to this policy. Please do not take effective benefits away from those who need it most. They deserve modalities that are affective to their individual needs.

CMS-1429-P-2781

Submitter : **Date & Time:** 09/22/2004 08:09:16

Organization :

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment - thank you.

CMS-1429-P-2781-Attach-1.doc

Sara Kinsella, MS, LAT
90 W. 2nd St.
Fond du Lac, WI 54935

Attachment #2781

September 22, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers 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,

Sara Kinsella, MS, LAT

90 W. 2nd St. Fond du Lac, WI 54935 (920) 921-3330, ext. 14

Submitter : Ms. Martha Henry **Date & Time:** 09/22/2004 08:09:05

Organization : Upledger Institute

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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

CMS-1429-P-2783

Submitter : Marcia Scheuner **Date & Time:** 09/22/2004 08:09:35

Organization : Marcia Scheuner

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

Mastectomy Products should be excluded from the face to face prescription requirments. The effects of a mastectomy are permanent. Based on the faxt, mastectomy products are necessary for the remainder on one's life. Medicare already has parameters in place for the dispensation of these items. These should already be sufficient. The face to face prescription requirement would place an undue burden on all affected Medicare beneficiaries, physicians, suppliers and Medicare as well. This requiremnet will require the patient an inconvenience trip to the physician, the physician's time for the visit and Medicare's payment for the visit. Once a lady has had a mastectomy she will always need post mastectomy products.

CMS-1429-P-2784

Submitter : Mr. Kenneth Foster **Date & Time:** 09/22/2004 08:09:18

Organization : ABMP, AMTA, IAHP

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We urgently request that you NOT pass this policy. Excluding any capable healthcare professional is WRONG. By limiting "incident to" services only to physical therapists is monopolistic. All qualified healthcare providers should be able to provide services with physician prescription or under their supervision.

Submitter : Mr. Christopher Koppen **Date & Time:** 09/22/2004 08:09:48

Organization : National Association of Community Health Centers

Category : Other Health Care Provider

Issue Areas/Comments

Issues 1-9

SECTION 413

Proposed Section 413 implements a provision of the MMA providing for a 5% bonus payment for physician services provided in a newly defined 'physician scarcity area' (PSA). According to the preamble, Congress created this to 'make it easier to recruit and retain both primary care and specialist care physicians for furnishing services to Medicare beneficiaries in PSAs.' In addition, the Conference Report accompanying S.1 states that the 5 percent incentive payment program was 'designed to reward both primary care and specialist care physicians for furnishing services in areas that have fewest physicians available to serve beneficiaries.'

Unfortunately, despite the statutory language and Congress stated aims, CMS' proposed regulation limits these supplemental payments only to those physicians that provide services in a PSA and bill Medicare using the physician fee schedule. Nowhere do we find in the statute that such incentive payments are only limited to certain physicians? services (those that are billed on the physician fee schedule) and exclude other physicians' services (that are billed on an all-inclusive basis), such as those provided in federally qualified health centers or rural health clinics. In fact, the statute itself clearly states:

'In the case of physicians' services furnished on or after January 1, 2005, and before January 1,2008 -- in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.'

Like other physicians' services, physicians' services provided in an FQHC setting are also provided under Medicare Part B. Had Congress intended to limit such payments only to physicians' services billed under the physician fee schedule, Congress could have specifically amended Sections 1833(a)(M) [with respect to payment for physician services under the physician fee schedule] or 1848 of the Social Security Act, rather than adding a new paragraph 1833(u) that covered all Medicare Part B payments.

Like the statute, the Conference Report accompanying S.1 does not limit the incentive payment only to physicians' services provided on the physician fee schedule.

Historically, Congress has turned to certain providers to assure access to Medicare benefits -- these providers include Federally qualified health centers, rural health clinics, critical access hospitals and others. These providers have the same difficulty in attracting and retaining physicians because of their location and we do not believe that the interpretation of statute as outlined in the preamble and the proposed rules is consistent with Congress? intent to reward physicians serving in these areas or to ensure that FQHCs and other safety net/access providers can attract and retain physicians to their clinical settings. Likewise, we believe that the PSA bonus is qualitatively different than the current HPSA supplemental payment, with a different Congressional intent. We do not believe that CMS' interpretation of the applicability of the PSA payment to FQHCs should be affected by their interpretation of supplemental HPSA payments.

COMMENT: To accordance with the statute, NACHC urges CMS to take one of two options in providing FQHCs/RHCs with the 5% PSA bonus: (1) As provided for under the statute, provide a 5% bonus payment for physician services provided in an FQHC or RHC setting when the FQHC or RHC is located in a physician scarcity area. This could be accomplished by referring to HCPCS codes on FQHC/RHC claims when physicians services are provided; or (2) Modify the Medicare cost report to allow FQHCs and RHCs a 5% add-on for the costs associated with physicians services, including 5% for any allocable overhead costs associated with physicians' services.

SECTION 611

Federally qualified health centers (FQHCs) welcome the recent addition of new preventive services to the list of Medicare services. As an important provider of primary and preventive services for medically underserved Medicare beneficiaries, the 'Welcome to Medicare' initial physical should help health centers provide initial diagnosis of chronic disease and will help seniors - many of whom may not have had a regular source of care or coverage before enrolling in Medicare - with any health problems they may have. In fact, NACHC wishes to work more with CMS to better

integrate FQHCs into CMS' efforts to expand primary and preventive services to more beneficiaries.

However, although the FQHC service package includes the services of physicians and the services of physician assistants and nurse practitioners, we are asking CMS to clarify that FQHCs will be allowed to bill for this initial preventive physical examination under the all inclusive FQHC rate. NACHC does not believe that Medicare beneficiaries that receive physician, PA or nurse practitioner services in an FQHC setting (or FQHCs that provide those services) should be discriminated against in reimbursement or in an manner that is inconsistent with Congressional intent in preserving and maintaining the FQHC infrastructure through adequate Medicare payments. Indeed, proposed 42 CFR 410.16(b) indicates that Medicare Part B payments will be provided for these services - which would include FQHC payments.

COMMENT: CMS should clarify that physicians and qualified non-physician practitioners that work in a FQHC setting can provide and bill for the initial preventive physical examination benefit under the FQHC all-inclusive payment rate provided for under Medicare Part B.

CMS-1429-P-2785-Attach-1.doc

CMS-1429-P-2785-Attach-1.doc

Attachment #2785

September 1, 2004

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Public Comments on: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for calendar year 2005; Proposed Rule

Centers for Medicare and Medicaid Services:

The National Association of Community Health Centers, Inc. ("NACHC") is pleased to respond to the above-cited solicitation from the Centers for Medicare and Medicaid Services ("CMS") for comments on the proposed revisions to payment policies under the Physician Fee Schedule for Calendar Year 2005.

NACHC is the national membership organization for Federally-supported and Federally-recognized health centers (hereinafter interchangeably referred to as "health centers" or "FQHCs") throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization.

I. BACKGROUND

At present, there are more than 1000 FQHCs nationwide. Most of these FQHCs receive Federal grants under Section 330 of the Public Health Service Act (42 U.S.C. §254b) from the Bureau of Primary Health Care ("BPHC"), within the Health Resources and Services Administration of the Department of Health and Human Services ("HHS"). Except for a limited number of public health centers (*i.e.*, health centers operated by local governmental units such as health departments), each health center is a charitable, non-profit, tax-exempt IRC Section 501(c)(3) corporation formed under the laws of the particular state in which it operates.

To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center must

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Health Care Financing Group
2001 L Street, NW Suite 300
Washington, DC 20036
(202) 296-2175 * (202) 296-3526 (F)

make services available to all persons in its catchment area, regardless of their ability to pay. BPHC's grants are intended to provide funds to assist health centers in serving uninsured, indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities[1] who are not indigent and able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately thirty-nine percent (39%) of the patients served by health centers are uninsured, while approximately thirty-six percent (36%) are Medicaid recipients and approximately seven percent (7%) are Medicare beneficiaries.

II. COMMENTS

NACHC is submitting three comments on the 2005 Medicare Physician Fee Schedule proposed rule:

1. Section 611 – Initial Preventive Physical Examination

Federally qualified health centers (FQHCs) welcome the recent addition of new preventive services to the list of Medicare services. As an important provider of primary and preventive services for medically underserved Medicare beneficiaries, the "Welcome to Medicare" initial physical should help health centers provide initial diagnosis of chronic disease and will help seniors – many of whom may not have had a regular source of care or coverage before enrolling in Medicare – with any health problems they may have. In fact, NACHC wishes to work more with CMS to better integrate FQHCs into CMS' efforts to expand primary and preventive services to more beneficiaries.

However, although the FQHC service package includes the services of physicians and the services of physician assistants and nurse practitioners, we are asking CMS to clarify that FQHCs will be allowed to bill for this initial preventive physical examination under the all inclusive FQHC rate. NACHC does not believe that Medicare beneficiaries that receive physician, PA or nurse practitioner services in an FQHC setting (or FQHCs that provide those services) should be discriminated against in reimbursement or in an manner that is inconsistent with Congressional intent in preserving and maintaining the FQHC infrastructure through adequate Medicare payments. Indeed, proposed 42 CFR 410.16(b) indicates that Medicare Part B payments will be provided for these services – which would include FQHC payments.

COMMENT: *CMS should clarify that physicians and qualified non-physician practitioners that work in a FQHC setting can provide and bill for the initial preventive physical examination benefit under the FQHC all-inclusive payment rate provided for under Medicare Part B.*

[1] We use the term "community" in this context to refer to either a geographic area or the specific population toward which the program is aimed.

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Washington, DC 20036
(202) 296-2175 * (202) 296-3526 (F)

2. Section 413 – Physician Scarcity Areas

Proposed Section 413 implements a provision of the MMA providing for a 5% bonus payment for physician services provided in a newly defined "physician scarcity area" (PSA). According to the preamble, Congress created this to "make it easier to recruit and retain both primary care and specialist care physicians for furnishing services to Medicare beneficiaries in PSAs." In addition, the Conference Report accompanying S.1 states that the 5 percent incentive payment program was "designed to **reward** both primary care and specialist care physicians for furnishing services in areas that have fewest physicians available to serve beneficiaries."

Unfortunately, despite the statutory language and Congress stated aims, CMS' proposed regulation limits these supplemental payments **only** to those physicians that provide services in a PSA and bill Medicare using the physician fee schedule. Nowhere do we find in the statute that such incentive payments are only limited to certain physicians' services (those that are billed on the physician fee schedule) and exclude other physicians' services (that are billed on an all-inclusive basis), such as those provided in federally qualified health centers or rural health clinics. In fact, the statute itself clearly states…

> *"**In the case of physicians' services** furnished on or after January 1, 2005, and before January 1,2008—…in addition to the amount of payment that would otherwise be made for such services **under this part**, there also shall be paid an amount equal to 5 percent of the payment amount for the service **under this part**."*

Like other physicians' services, physicians' services provided in an FQHC setting are also provided under Medicare Part B. Had Congress intended to limit such payments only to physicians' services billed under the physician fee schedule, Congress could have specifically amended Sections 1833(a)(M) [with respect to payment for physician services under the physician fee schedule] or 1848 of the Social Security Act, rather than adding a new paragraph 1833(u) that covered all Medicare Part B payments.

Like the statute, the Conference Report accompanying S.1 does not limit the incentive payment only to physicians' services provided on the physician fee schedule.

Historically, Congress has turned to certain providers to assure access to Medicare benefits – these providers include Federally qualified health centers, rural health clinics, critical access hospitals and others. These providers have the same difficulty in attracting and retaining physicians because of their location and we do not believe that the interpretation of statute as outlined in the preamble and the proposed rules is consistent with Congress' intent to reward physicians serving in these areas or to ensure that FQHCs and other safety net/access

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providers can attract and retain physicians to their clinical settings. Likewise, we believe that the PSA bonus is qualitatively different than the current HPSA supplemental payment, with a different Congressional intent. We do not believe that CMS' interpretation of the applicability of the PSA payment to FQHCs should be affected by their interpretation of supplemental HPSA payments.

COMMENT: *To accordance with the statute, NACHC urges CMS to take one of two options in providing FQHCs/RHCs with the 5% PSA bonus…*

- *As provided for under the statute, provide a 5% bonus payment for physician services provided in an FQHC or RHC setting when the FQHC or RHC is located in a physician scarcity area. This could be accomplished by referring to HCPCS codes on FQHC/RHC claims when physicians services are provided; or*

- *Modify the Medicare cost report to allow FQHCs and RHCs a 5% add-on for the costs associated with physicians' services, including 5% for any allocable overhead costs associated with physicians' services.*

Thank you for the opportunity to comment on these proposed rules. We appreciate your consideration and favorable action on these comments. Please do not hesitate to contact me at (202) 296-2175 if you have any questions.

/s/

_____

Christopher Koppen, Director
Health Care Financing Policy

Division of Federal, State, and Public Affairs
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Washington, DC 20036
(202) 296-2175 * (202) 296-3526 (F)

CMS-1429-P-2786

Submitter : Mrs. Ingrid Grutzmacher **Date & Time:** 09/22/2004 08:09:29

Organization : National Athletic Trainers Association

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a Licensed and Certified Athletic Trainer in the state of Illinois. I have been employed in Physical Therapy clinics for the last 13 years. The clinic I am employed at has such confidence in my knowledge and skills as a health care professional that I am able to treat patients on my own and I am often consulted by the Physical Therapists on how to create programs to benefit the well being of the patients. Athletic Trainers are highly trained and well educated health care professionals and are a great asset to the industry. We have always been required to take continuing education classes in order to maintain our certification which expands our skill levels and overall knowledge of a variety of health care issues. It would be a great disservice to the healthcare industry to deny us the opportunity to treat all patients. We do have the knowledge and skills needed to help patients return to there activities of daily living despite their age or degree of function. We are not trying to take over for the Physical Therapists. We are trying to be recognized for the skilled healthcare professionals that we are. Please don't disregard our profession that we are proud of.

Submitter : Mr. MARK DELABARRE **Date & Time:** 09/22/2004 08:09:55

Organization : LMT, AMTA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do NOT pass this policy whereby a physician can only refer "Incident to" services to physical therapists. Beyond the simple fact that many P.T.'s do NOT have but the most rudimentary of massage training, patients should have access to ANY qualified health care providers, with a physician's prescription or under their supervision.

Thank you for your kind and thoughtful consideration,
Mark DeLaBarre, LMT, AMTA

CMS-1429-P-2788

Submitter : Sandra Lehman **Date & Time:** 09/22/2004 08:09:21

Organization : Essentially Women

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

Mestectomy products should be excluded from the face to face RX requirments. Once a lady has had a mastectomy she will continually need post mastectomy products. Medicare already has parameters in place fo r the dispensation of these items. These parameters should be sufficient. This new requirment would cause a burden on all affected Medicare beneficiaires, physicians, suppliers and Medicare as well. This requirment would cause an inconvenience for the beneficiary, physician, the physician's time for the visit and Medicare's payment for the visit.

Submitter : Ms. Jeannine Mecca **Date & Time:** 09/22/2004 08:09:56

Organization : Massage Mecca

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Hi. My name is Jeannine Mecca L.M.T. I have been practicing massage therapy for 14 years. The clients that come to see me have usually been everywhere else I.E. physician, chiropractor, specialty doctor ect.. ect.. The type of work I provide to my clients enables them to become much more mobile,active, balanced and overall health improves dramatically. Please do not take payment away from massage therapists as it is an integral part of everyones well-being and good health. Thank you. Jeannine Mecca L.M.T.

Submitter : Mr. Leonard Berner **Date & Time:** 09/22/2004 08:09:44

Organization : Mr. Leonard Berner

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I sincerely request that you NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers (Massage Therapists, Chiropractors, etc.) should be allowed to provide services to patients with a physician's prescription or under their supervision as has been the policy up to the present. Individuals operating within the legal scope of their practice should not be prevented from doing so. Hence,
again I urge you to NOT pass this change of policy. Thank you.

Submitter : Karen Windham **Date & Time:** 09/22/2004 08:09:43

Organization : Karen Windham

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I oppose restricting this to Physical Therapists only. Massage therapists should be allowed as incident to physicians and chiropractors - private practice and in hospitals/clinics.

CMS-1429-P-2792

Submitter : **Belinda Durham** **Date & Time:** **09/22/2004 08:09:48**

Organization : **Essentially Women**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

Mastectomy products should be excluded from the prescription requirments. The effects of a mastectomy are permanenet. Based on the fact, mastectomy products are necessary throughout the life of the recipient. Medicare already has parameters in place for the dispensation of these items. These should be sufficient. This requirement would place a burden on all affected Medicare beneficiaries, physicians, suppliers and Medicare as well. This requirement will require a visit to the physician, the physician's time for the visit and Medicare's payment for the visit. Thus resulting in more cost.

Submitter : Mr. Scott Green **Date & Time:** 09/22/2004 08:09:48

Organization : NATA - Atlanta Thrashers (NHL)

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached letter concerning this issue.

CMS-1429-P-2793-Attach-1.doc

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

The attachment to this document is not provided because:

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

Submitter : Miss. Nina Evangelista **Date & Time:** 09/22/2004 08:09:01

Organization : Miss. Nina Evangelista

Category : Academic

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Nina Evangelista
51 The Circle
Passaic Park, NJ 07055

September 22, 2004

I am a second year student physical therapist in the Doctoral Program of the University of Medicine and Dentistry of New Jersey. I am also a current member of the American Physical Therapy Association (APTA). The organization as well as the faculty at UMDNJ keep students like me updated on the various issues that concern our profession and the quality of care of our patients.

I would like to take this opportunity to voice my support for the proposed personnel standards for physical therapy services that are provided ?incident to? physician services in the physician?s office. If this proposal is not passed, physicians will continue to allow any of their employees to provide such specialized services regardless of their educational background. This could pose harm to the patients as well as allow physicians to refer patients to their own offices which reveal some ethical concerns.

Physical therapists are those who have specialized training in the area of physical rehabilitation. The required courses and clinical rotations in our graduate programs provide us with the extensive knowledge that is necessary to evaluate, diagnose and understand physical impairments and pathologies, and treat patients appropriately. While physicians are highly qualified, they do not spend as much time with the patients as we do in a given time period. This has on many occasions made it necessary for the therapist to use their expertise to identify health issues that were overlooked or may have developed during treatment that an unqualified employee would have missed.

I strongly support the proposal for personnel standards for physical therapy services that are provided by employees of physician?s offices.

Sincerely,

Nina Evangelista, SPT

CMS-1429-P-2795

Submitter : John Neel **Date & Time:** 09/22/2004 08:09:51

Organization : National Athletic Trainers Association

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To whom it may concern,
I graduated from Indiana University with a bachelors degree and an emphasis in Athletic Training in 1985. My educational background included classes such as anatomy, physiology, exercise physiology, biology, kinesiology, recognition of athletic injuries, theraputic modalities, chemistry, adapted physical education and nutrition. While at Indiana I worked as a student athletic trainer with student athletes in the recognition, treatment and rehabilitation of athletic injuries. I left the university and passed a thorough examination given my the National Athletic Training Association giving me the credential of certified athletic trainer. I was hired by a hospital based sports medicine clinic that was directed by a duel credentialed individual (physical therapist/athletic trainer) in Phoenix Arizona to help rehabilitate orthopedic injuries. I was able to practice under an exemption of the physical therapy laws during that time. Our patients demographics ranged from 8 years of age to 85 years of age. Some were in therapy with work or home related injuries, some automobile injuries and some sports related. Non the less the physician, physical therapist, athletic trainer and exercise physiologist worked as a team to rehabilitate these individuals. Each person from the team brought an important component to this team. I was also fortunate through contracts gathered by the hospital to be the team athletic trainer for a professional hockey team, semi-professional soccer team and a local high school. Diversity of working with other allied health care professionals and patiens allowed me to open an exercise clinic in Scottsdale 7 years ago that continues today to be successful. I get referrals from family and orthopedic physicians, physician assistants, physical therapist, athletic trainers and coaches to work with a wide range of individuals. These individuals for the most part pay cash for the services that myself and staff deliver each day. Many of these patients have medicare as secondary insurance coverage. Even though the state of Arizona granted a medical license to athletic trainers in 2001 third pary payers do not recognize our credentials for reimbursement of theraputic services. I am not sure how or why but they do. My guess is that they are following the standard set my the gold standard or medicare. My educational background, years of work in the field of rehabilitation and continued persistance through continuing education courses should be enough for any person to recognize and trust my ability to deliver services of orthopedic rehabilitation to anyone in need. Having a govermental agency decide that individuals that are covered by their insurance, who have been receiving excellent care by athletic trainers for over twenty years are now not elegible to do so makes no sense and seems to be politically motivated. Dictating to a physician who they can use for services, not allowing patients choice of a qualified heathcare provider, cutting jobs of individuals who services are needed a wide variety of patients is unjust and wrong. If their is documentation of fraudulent or negligent activity to justify this injustice to athltetic trainers I would like to see the evidence. Just remember, for the most part athletic trainers have been unable to bill for their services. The professions that have should be scrutinized thoroghly. I hope you will not consider taking my and many other athletic trainers jobs away. The economy and state of our country have enough problems to deal with without adding to the unemployment rate of qualified hard working allied health care professionals.
Sincerely,
John Neel ATC/L
Scottsdale, Arizona

Submitter : Mrs. Ashley Hodge **Date & Time:** 09/22/2004 08:09:50

Organization : Mrs. Ashley Hodge

Category : Occupational Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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

CMS-1429-P-2797

Submitter : Ms. Amanda Anne Cochran **Date & Time:** 09/22/2004 08:09:17

Organization : Northern Arizona University

Category : Academic

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I, Amanda Cochran, am a first year student at Northern Arizona University in the Doctorate of Physical Therapy program. I have gained knowledge in the field of Physical Therapy by working as a Physical Therapy Tech./Volunteer in the U.S. and Australia during the last six years. After being presented with the August 5th proposed rule on "Revisions to Payment Policies Under the Physcician Fee Schedule for Calendar Year 2005.", I feel an urgent need to comment. I am strongly against the CMS's proposal for the "grandfathering clauses", which would allow persons who have not had the proper education and/or accredited training to deliver "physical therapy services" to patients. The background and in-depth training in clinical anatomy/physiology, neurology, integumentary theraputics, and the other multiple courses regarding an overall understanding of the function of the human body compose an essential base of knowledge ALL practicing Physical Therapists obtain in an accredited college/university level P.T. program. I strongly feel this "base of knowledge" is EXTREMELY vital in the treatment process. Without sound knowledge in these topics and areas, I do not feel optimal treatment can be delivered. Patients' outcomes may be negativley affected due to the lack of understanding in what the most optimal treatment method would be. If the person providing physical therapy doesn't understand WHY they are administering the treatment, it sets considerable limitations on the entire practice process. I believe approving this proposed rule would be a step-back for the entire province of Western Medicine as a whole. I will summarize my feelings this way; just because my Mother knew to administer me tylenol to decrease fevers during my 18 years of childhood, doesn't entitle her to practice medicine with the status of a Medical Doctor. Thank you for your time and consideration.

Submitter : Ms. Anasuya Batliner **Date & Time:** 09/22/2004 08:09:37

Organization : AOBTA

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision. Consumers have a right to choose from a variety of qualified professionals.

CMS-1429-P-2799

Submitter : Dr. Glen Cureton **Date & Time:** 09/22/2004 08:09:40

Organization : Dr. Glen Cureton

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

RE: File Code CMS-1429-P, Re: GPCI. We would like to protest the categorization of Santa Cruz County as a rural county for re-imbursement of medical expenses by private and public insurers. In 1997 we moved to this county for retirement. Our first internal medicine physician left his practice, and we got a good recommendation for replacement. After 1 year of going to this new physician, whom we liked very much, his office told us that our insurance, Blue Cross, would no longer be accepted by the medical clinic as their reimbursements were not high enough and the insurer would not negotiate adequate compensation for the physicians at Western Medical Association. We finally located another physician to our liking at Santa Cruz Medical Clinic. Also, Our rheumatologist tells us that she has been unable to hire a second rheumatologist over several years period of time to help in her practice; she has therefore closed her practice to new patients.

I am retired and a recipient of Medicare A & B. I believe these low reimbursement apply to Medicare as well, which make it difficult to retain physicians in this community. Most of Santa Cruz County is occupied highly by retired people. My cousin, one of those retired persons, just told me that there is no longer one gerontologist in Santa Cruz. What a tragedy for the many older people here!

The average home in Santa Cruz County sells for around $600,000. This is not a cheap place to live for residents, including physicians. Even though the population may not be very high, this area is an extension of Santa Clara County for purposes of employment, activities, and residences. The living costs in Santa Cruz County are about the same as Santa Clara County, where I lived for 25 years. I understand that there is a 25% differential in (Medicare) reimbursements between these two adjoining counties. How can this be?--it doesn't make any sense.