CMS-1429-P-601

Submitter : Mr. Mark Weakland **Date & Time:** 08/31/2004 09:08:30

Organization : Astra

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the idea that anyone who charges Medicare or any other institution/individual for physical therapy charges MUST be a physical therapist or under the DIRECT supervision of a physical therapist. I believe the language needs to be strong in order to avoid any loopholes.
There is enough fraud and abuse in all professions and I believe allowing anyone, other than a physical therapist, to bill for physical therapy charges is opening the door for increased fraud and abuse by non-certified individuals.
As a physical therapist, I do not mis-represent myself as an athletic trainer, occupational therapist, physician, chiropractor, or any other occupation. Again, allowing non-PTs to charge for physical therapy is a misrepresentation of their credentials. Thank you.

Submitter : G Scheibe **Date & Time:** 08/31/2004 09:08:08

Organization : Stevenson Physical Therapy, Inc.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services

I am a Physical Therapist Assistant and have been working the past 5 years since my graduation from Broward Community College's PTA program, receiving my license in September of 1998. I am also a member of APTA and follow the requirements of 24 hours of continuing education every 2 years as indicated in our state's practice act.

I am writing to comment on the August 5 proposed rule on "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005". I work at an Out-Patient Rehab Clinic with majority of our patients on Medicare. When the physician refers them for physical therapy we treat them according to the licensed P.T.'s evaluation with outlined short and long-term goals. Our patients either see the licensed P.T. or P.T.A. for their treatment following the accepted guidelines of our Florida Practice Act and Medicare guidelines.

If treatment is given to patients at physician's office by unqualified personnel, the patient's outcomes are affected. Physical Therapists are now required to graduate with a Master's degree or a Doctorate in Physical Therapy and hold a license from the state they practice in with significant training in anatomy and physiology, have a broad understanding of the body and its functions, and have completed comprehensive patient care experience.

The difference in outcome can be great: if treated by unqualified personnel the patient may be required to continue for a longer period and without showing progress. Also, financially Medicare could be paying for treatment longer with little change in the patient's condition. I am proud to say most of our patients meet their goals in the specified time and sometimes before due to the experience and continuing education of our P.T.'s.

If the Therapy Cap would return, we could find a lot of our seniors (Medicare Patients) receiving treatment from unqualified personnel who could run out of services and still be left with deficits that could be avoided by seeing qualified, licensed P.T.'s and P.T.A's.

Thank you very much for allowing me to voice my opinion.

Sincerely,
Gretchen Scheibe, PTA

CMS-1429-P-603

Submitter : Mr. Glen Gitterman **Date & Time:** 08/31/2004 09:08:57

Organization : Mr. Glen Gitterman

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a physical therapist who has practicing for 14 years, the past 11 in an out patient private practice setting. My initial two years of practice occurred in a hospital setting where I observed "techs" and aids perform treatments to patients who had no idea what the disignation rehab tech or rehab aid meant.

As you are aware, physical therapists are required to earn their masters degree in order to qualify to sit for the state licensing board examination. Our profession is actively persuing a change in graduation requirements to the doctoral level due to the ever expannding knowledge base required to treat patients at the optimal level.

I strongly support the August 5 proposed rule on "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005. In order to provide physical therapy services a practitioner must be a graduate of an accredited university in physical therapy or have earned a license as a physical therapy assistant. The public must be protected from providers who use unlicensed personnel to provide professional services.

The Malpractice premiums at our facilty have jsut been raised 250% when there have been no claims since our practice inception 17 years ago. If premiums are going up, one strategy must be to eliminate the use of unlicensed non-professionals. We must protect the public.

I urge you to adopt the Revision to Payment Policies Under the Physican Fee Schedule for Calendar Year 2005 and I thank you for allowing me this opportunity to express my support of this provision.

CMS-1429-P-604

Submitter : Dr. Daniel Malone **Date & Time:** 08/31/2004 10:08:03

Organization : University of Wisconsin

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This comment refers to compensatoin for infusion of specialized biologicals such as infliximab and rituximab, and other complex drugs such as human immunoglobulin and cyclophosphamide, by rheumatologists. Physician oversight of administration of these specialized agents should be compensated at the same rate schedule as that used by oncologists. Indeed, several of the drugs used in infusions by rheumatologists are the same drugs used in oncology, such as cyclophosphamide and rituximab. These drugs require special expertise to infuse, and are ptentially dangerous because of infusion reactions and other side effects such as nausea and vomiting, lowered cell counts, etc. Oncologists can bill for complex infusion codes when they administer these drugs, while under current rules, rheumatologists giving the same drugs, or drugs equally complicated, can only bill simple infusion (equivalent to infusing saline) codes. This inequity needs to be remedied by allowing rheumatologists to use the complex infusion codes, since they are in fact infusing complex agents.

Submitter : Miss. Paria Mazandarani **Date & Time:** 08/31/2004 11:08:34

Organization : Miss. Paria Mazandarani

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see the following attachment

CMS-1429-P-605-Attach-1.doc

ATTACHMENT # 605

American Kinesiotherapy Association
P.O. Box 1390 , Hines Ill. 60141-1390

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

Parisa Mazandarani, RKT
1227 Paseo Los Gavilanes
San Dimas, CA 91773

September 15, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment. In the case of rural Medicare

patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

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

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

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

Sincerely,

Parisa Mazandarani, RKT

CMS-1429-P-606

Submitter : Miss. Aram Shahmirizadeh **Date & Time:** 08/31/2004 11:08:23

Organization : Miss. Aram Shahmirizadeh

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see the following attachement

CMS-1429-P-606-Attach-1.doc

ATTACHMENT # 606

American Kinesiotherapy Association
P.O. Box 1390 , Hines Ill. 60141-1390

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

Aram Shahmirizadeh, RKT
3788 Aqueduct Ln.
Chino Hills, CA 91709

September 15, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in

health care, greater cost and a lack of local and immediate treatment. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

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

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

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

Sincerely,

Aram Shahmirizadeh, RKT

CMS-1429-P-607

Submitter : Mrs. Kim **Date & Time:** 09/01/2004 12:09:07

Organization : Mrs. Kim

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

The purpose of my letter is to comment on the August 5th proposed rule on 'Revision to the Payment Policies under the Physicians Fee Schedule for Calendar Year 2005.' I strongly support CMS's proposed requirement that a Physical Therapist or Physical Therapist Assistant under supervision of a Physical Therapist working in a physician's office be graduates of accredited Physical Therapist/Assistant programs. All therapists need to be licenses in the state which allows for the public to receive the highest level of care. Without the requirement of licensure, anyone can deliver these specialized services. People who have not gone to school to become licensed do not have the skills needed or the educational background to deliver specialized services in the area of physical therapy. Licensure is very important and is required in every state. Licensure is paramount for the safety of the public and ensures the best possible care. That is why I strongly believe that individuals providing services in a physician's office must be graduates of accredited programs. Physical Therapists and Physical Therapist Assistants are the only professionals qualified and educated to deliver these services. Unqualified personnel should not be providing physical therapy to patients as it can be detrimental to their overall care and wellness.

Thank you for your time. I hope you consider these words and support the proposed changes.

Sincerely,
Kim, PTA

CMS-1429-P-608

Submitter : Mr. Clint Shuman **Date & Time:** 09/01/2004 01:09:12

Organization : Mr. Clint Shuman

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I feel that is decision is very unreasonable. I treat 18 pro athletes everyday and you are going to tell me that I am not quailified to treat them now. I have a state license and national certification. See attached letter for more info please. Thanks for you time and have a nice day

CMS-1429-P-608-Attach-1.doc

ATTACHMENT # 608

Clint Shuman
222 Quail Circle
Hutto, TX 78634

August 31, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

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

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to

utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

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

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

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

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,

Clint Shuman, LAT, ATC
222 Quail Circle
Hutto, TX 78634

CMS-1429-P-609

Submitter : Ms. Anita Byrne **Date & Time:** 09/01/2004 02:09:53

Organization : APTA

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a licensed physical therapist in VA who in the past encountered an LPN performing physical therapy treatment for incontinence patients in a urologist office. I called to meet with the physician for marketing purposes and was connected to the nurse who informed me she was doing the treatment, but did not feel competent and asked could I instruct her. She informed me she was required to perform these treatments as part of her job and she was in fear of losing her job if she refused or declined. She even asked me to notify her if I knew of any LPN jobs available. She had been given a computerized biofeedback unit by the physician to treat patients with only instruction by the sales personnel of the company selling the equipment. The physician was billing the services as PT. This is one example of personnel performing treatments they are not trained to perform with the danger being not only performing the treatment by being aware of contraindications of treatment and indications why treatment should be stopped. The personnel are put in a position where they may fear for the jobs and livelihood if they refuse. Please seriously consider the CMS-1429-P with licensure being equally important as this makes professionals answerable to the public and more likely to be ethical and legal in their billing and provision of treatment as they are held liable and may lose their ability to practice at all. Thank you for your attention to this matter.

Submitter : Mr. Robert Sembler **Date & Time:** 09/01/2004 02:09:28

Organization : Rehab Concepts

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I strongly support CMS proposal to allow only individuals who have degree and license in Physical Therapy to administer and bill for Physical Therapy. I am surrounded by Physician offices who have one PT do evalauations and let non-skilled aids and secretaries provide service. PT's go to school for 5-6 years of training and are sensitive all the precautions necessary to provide safe and aefective treatment both from quality and cost effectiveness. Please use common sense and not allow this practice to continue further. It jeopardizes patient care and safety while driving up costs for insurers, patients while lining the pockets of greedy, unethical practioners.

Submitter : Miss. Rebecca Daniels **Date & Time:** 09/01/2004 03:09:44

Organization : Miss. Rebecca Daniels

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

This letter expresses my concerns about and protests the recent proposal to limit providers of "incident to" services in physician offices and clinics.

In my opinion, significant reasons for defeating the limiting proposal include: Reduction in the availability of qualified health care professionals to provide these important and urgent services; Reduction in quality and delay in providing care for Medicare patients; Increased cost burden on the Medicare system; and, most egregiously, Removal of patients' care control from attending physicians.

Since the 1965 inception of Medicare, "Incident to" has given attending physicians the responsibility and authority to delegate the provision of prescribed services to Medicare patients by qualified individuals under the physician?s "direct supervision". Accordingly, physicians have been, and are, legally responsible for all care so ordered. Trusting our physicians to make the choice of qualified providers, such as Certified Athletic Trainers* who are fully trained in the protocols to be administrated, is not only prudent, but is respectful of their judgment on how to best serve Medicare patients in the most effective and judicious possible manner. Logically, such delegation responsibility and authority has been wisely given to reduce encumbrance on ever limited physician availability, to help expedite care, and thus shorten patient recovery times, and to lower Medicare cost.

Limiting who physicians may choose to utilize to provide Medicare patients appropriate services (such as eliminating Certified Athletic Trainers from the possibilities) will add to, rather than diminish the already too many health care related Medicare problems. Therefore, I consider it imperative that the proposed limits on authorized providers of ?incident to? services not become law.
* Certified Athletic Trainers are highly educated with a Bachelor's Degree, and in 70% of all cases a Master's Degree, from an accredited college or university. Typically, foundation courses include: human anatomy and physiology, kinesiology/biomechanics, nutrition, acute care of injury and illnesses, exercise physiology, evaluation, treatment, and rehabilitation of injuries, plus statistics and research design. Their 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). The great majority of practitioners who hold advanced degrees is comparable to the incidence among other health care professional ranks including: Registered Nurses, Physical Therapists, Occupational Therapists, Speech Therapists and other mid-level health care practitioners. Certified athletic trainers are working with the physically active populations of the United States in almost every post-secondary educational institution, in many of our junior high and high schools, with professional sports teams, with the US Olympic teams and athletes, and with "industrial athletes" in many US Corporations, as well as in physician offices and clinics.

It is apparent that to only allow Physical Therapists, Occupational Therapists, and Speech Therapists to be providers for "incident to" outpatient services would improperly remove availability of Certified Athletic Trainers from physician choice options.

Submitter : Miss. Michelle Kania **Date & Time:** 09/01/2004 03:09:01

Organization : National Athletic Trainers Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam:

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

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.

Submitter : Mr. thomas Hoye **Date & Time:** 09/01/2004 04:09:50

Organization : NATA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

see attached

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

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

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

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

Submitter : Ms. Barbara Miklos **Date & Time:** 09/01/2004 11:09:34

Organization : Ms. Barbara Miklos

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see the following attachment.

CMS-1429-P-614-Attach-1.doc

American Kinesiotherapy Association
P.O. Box 1390 , Hines Ill. 60141-1390

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

Donald J. Howard, RKT
1008 Whisperlake Court
Midlothian, VA 23114

August 17, 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 registered kinesiotherapists) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

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

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, 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.***

- 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,

Donald J. Howard, RKT

Submitter : Mr. Phillip Lowe **Date & Time:** 09/01/2004 12:09:32

Organization : Mr. Phillip Lowe

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Only Physical Therapist have the knowledge required to treat. They must have graduated an approved PT program and passed the state boards. It is dangerous to consumers to allow poorly trained and poorly supervised persons to provide care incident to physician services. It shows pure greed by physicians.

Submitter : Mr. Tim Speicher **Date & Time:** 09/01/2004 01:09:23

Organization : Connecticut Athletic Trainers Association

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attached.

CMS-1429-P-616-Attach-1.doc

August 24, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments, education, and needed immediate therapeutic interventions 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, and this will take away from the physician's ability to provide the best possible patient care.

- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor's or master's degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Athletic training 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). CAAHEP is the same body which provides accreditation review for physician assistant education programs and other allied health care educational programs.

- 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.

- The therapeutic 9700 CPT codes are *NOT* provider specific and can be utilized by all qualified health care providers with the exception of provider specific evaluation and re-evaluation codes. The American Medical Association did not intend these therapeutic codes for only select providers. When used appropriately, these codes are very specific and designate specifically, what services have been provided to the patient under the care of the physician.

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

group who would seek to establish themselves as the sole provider of therapy services.

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- 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.

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- If CMS is determined restrict the physician's scope of professional practice and who is qualified to bill for therapeutic services under a physician for the active Medicare population, then it must also list the Certified Athletic Trainer (ATC) who has long treated this population in partnership with physicians

- In regards to PTA and OTA supervision, both should be directly supervised by their respective parties. ATCs possess a higher level of education and training in providing therapy services, consisting of an advanced degree, the minimum of a BS from an accredited educational four-year college or university, with over 70% of Certified Athletic Trainers holding a MS degree, versus PTAs and OTAs who only are required to have a two-year AA or associates degree. In addition, all ATCs are required to be directly supervised when providing incident to therapy services. PTAs and OTAs should be held to the same standard of supervision.

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

Respectfully,

Tim Speicher, MS, ATC, CSCS
Chair
CATA Reimbursement Committee

Pc: P. Carter
P. Manwaring

CMS-1429-P-617

Submitter : Mr. Tim Speicher **Date & Time:** 09/01/2004 01:09:08

Organization : Sacred Heart University

Category : Academic

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attached.

CMS-1429-P-617-Attach-1.doc

August 24, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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- 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.

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- What is very troubling is that this proposed legislation will be detrimental to our student's ability to pursue gainful employment into a physician based employment setting that has long been an area of productive health care for the patient. ATCs produce as high or higher clinical outcomes than physical therapy providers. This obstruction in immediate health care access to therapeutic services will result in lost jobs among incident to health care providers such as ATCs, lowering of pay for new university graduates in our profession, 70% holding Master's degrees, and ultimately, this legislation will result in higher cost of patient care due to delayed treatment.

- In addition, this legislation will also eliminate critical educational clinical rotation sites, where students observe ATCs working in conjunction with physicians. This opportunity for our students is critical in fulfilling their education and preparing them adequately to meet their Board of Certification examination preparation. Students are given a rigorous professional exam, of nature to that of physical therapists and nurses by the BOC (Board of Certification). This certifying body is a national regulatory agency certifying Athletic Trainers (ATC) in all 50 states to practice athletic training for the purpose of providing therapy services to the active population, young or aging.

- In regards to PTA and OTA supervision, both should be directly supervised by their respective parties. ATCs possess a higher level of education and training in providing therapy services, consisting of an advanced degree, the minimum of a BS from an accredited educational four-year college or university, with over 70% of Certified Athletic Trainers holding a MS degree, versus PTAs and OTAs who only are required to have a two-year AA or associates degree. In addition, all ATCs are required to be directly supervised when providing incident to therapy services. PTAs and OTAs should be held to the same standard of supervision.

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    - Again, *since 1991 ATCs have been considered by the **American Medical Association** to be a health care provider of therapy services*

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

Respectfully,

Tim Speicher, MS, ATC, CSCS
Clinical Assistant Professor

Pc: P. Carter
P. Manwaring

Submitter : Mr. Tim Speicher **Date & Time:** 09/01/2004 01:09:23

Organization : HEALTHWORKS, LLC

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

SEE ATTACHED.

CMS-1429-P-618-Attach-1.doc

August 24, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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- 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.***

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    - Again, *since 1991 ATCs have been considered by the **American Medical Association** to be a health care provider of therapy services*

As an ATC I have personally treated countless active aging patients in a variety of employment and sport settings including, physician offices, hospitals, outpatient physical therapy clinics, and local, state and national athletic venues. Presently, I work in conjunction with a patient's physician to provide them the highest quality of therapeutic services. This is what a few of my active aging patients have said regarding my services as an Athletic Trainer:

"There is no comparison! When I discovered *HEALTWORKS* I had been diagnosed with chondromalacia and was experiencing frequent spontaneous knee dislocations, several times a week. I had been dismissed from physical therapy as my physical therapist felt that she had done everything for me that she could as I was walking and able to carefully go up and down stairs, one stair at a time. In contrast, Tim understood my goals and was optimistic about his ability to help me. He carefully evaluated all of the information from other practitioners that I shared with him, did a thorough examination, spending much more time with me than had other practitioners. He developed a careful, individualized program for me and worked closely with me to help me progress quickly. Within six weeks I was ready to go on a hiking vacation. ***I would recommend working with an athletic trainer to any person who's been dismissed by other***

practitioners, told that their recovery was "good enough" when they know that their goals are to be able to be more active." **Caltha, 58 year old rock climber**

> *"HEALTHWORKS* got me through a critical period of pain and loss of mobility that allowed me to continue to work and to pursue other activities. *HEALTWORKS* made a big difference for me in my ability to pursue my work and other activities. The relief from pain was dramatic and occurred almost immediately after therapy started and continued to improve. More remarkably is the fact the pain has not recurred and the situation is stable"
> **Donna, 51 year old scuba diver**

> "***Athletic Trainers are more focused on rehabilitation than on illness***. Tim seemed to have a better understanding of body musculature and mechanics than other healthcare providers. I valued the active approach to healing my injury and Tim's extensive knowledge about body mechanics. I had been to many health care professionals in the past (chiropractic, physical therapy, massage) for the same problem and did not get better until I participated in the very specific and active rehabilitation approach at *HEALTWORKS*."
> **Lisa, 52 year old yoga practioner**

These patients and countless others value and desire the services and expertise athletic trainers provide. In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Tim Speicher, MS, ATC, CSCS
Owner/President

Pc: P. Carter
P. Manwaring

Submitter : **Date & Time:** 09/01/2004 01:09:58

Organization :

Category : Physical Therapist

Issue Areas/Comments

Issues 10-19

SECTION 952

THERAPY ASSISTANTS IN PRIVATE PRACTICE

9/1/04

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

Re: Therapy Standards and Requirements

Dear Dr. McClellan,

I am a member of the American Physical Therapy Association and currently am the Reimbursement Chairman for the Ohio Chapter. The Ohio Physical Therapy Association represents members of multiple practice types including Physical Therapists in Independent Practice. I have been a physical therapist for 25 years and have worked in acute care hospitals, home care agencies, nursing homes and private practice. I currently own a practice that is designated as a Medicare Certified Rehabilitation Agency.

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

I serve on the Advisory Committee for a Physical Therapist Assistant program at our local community college and have been actively involved in providing clinical education for students in these programs. It has been my experience that the physical therapists graduating from these programs have the education and training to safely and effectively deliver services without the physical therapist being in the same room as the physical therapist assistant.

Allowing direct of supervision of the physical therapist assistant would be consistent with Ohio State Practice Act for Physical Therapy. The State of Ohio does not require in room supervision of the physical therapist assistant.

Finally, changing the requirement to one of direct supervision would simply return the supervision requirement that was required of physical therapists in independent physical therapists to what was required prior to 1999.

Sincerely,

Michael Jaworski

Submitter : Mr. Chuck Conner **Date & Time:** 09/01/2004 02:09:09

Organization : Valdosta State University

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

see attached letter

CMS-1429-P-620-Attach-1.doc

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

Chuck Conner
Valdosta State University
Valdosta, GA 31698

August 31, 2004

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: Therapy – Incident To

To Whom It May Concern:

This letter comes to you regarding my concern over the recent proposal that would limit providers of "incident to" services in physicians' offices, as well as clinics. If the proposal is adopted, it would eliminate the ability of qualified health care professionals to provide these services. The proposal would also reduce the quality of health care for our Medicare patients. The result of this would be an increase in health costs associated with this service and place yet another burden on the health care system.

Please consider the following points:

"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.

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

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

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

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.

Athletic Trainers are employed by hospitals, rehabilitation clinics, and industrial corporations to prevent, treat, assess, and rehabilitate individuals who have become injured at work, at home, and through various **non-athletic situations**, all of which fall within an athletic trainers **scope of practice**.

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

To conclude, there is no reason for the Centers for Medicare & Medicaid Services to institute the proposed changes. The proposed changes would result in a decrease in qualified and competent health care providers that patients desperately need and most of all, deserve.

Sincerely,

Chuck Conner

CMS-1429-P-621

Submitter : **Date & Time:** 09/01/2004 03:09:04

Organization :

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see the following attachment.

CMS-1429-P-621-Attach-1.doc

American Kinesiotherapy Association
P.O. Box 1390 , Hines Ill. 60141-1390

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

Maribella Armstrong, KT
22 Glenola Drive
Leola, PA 17540

September 15, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

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

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

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

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

Sincerely,

Maribella Armstrong, KT

Submitter : Dr. Robert Ivnik **Date & Time:** 09/01/2004 03:09:35

Organization : Psychology, Mayo Clinic, Rochester, MN

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

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

RE: Proposed Supervision Rule Change Relating to Psychological Testing

Dear Centers for Medicare and Medicaid Services:

I am a clinical neuropsychologist. I have practiced neuropsychology for 29 years. During all of this time, psychometrists have assisted me with test administration and scoring.

My purpose is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal CNS functioning. By virtue of my education and training, I possess advanced, specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among other topics). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, medical colleagues do not have the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients I can serve. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Sincerely,

Robert J. Ivnik, Ph.D., ABPP
Board Certified in Clinical Neuropsychology
Psychology (West 11-B)
Mayo Clinic
Rochester, MN 55905

Submitter : Dr. Brian Thomas **Date & Time:** 09/01/2004 04:09:12

Organization : North MS Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Dear Centers for Medicare and Medicaid Services:

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Sincerely,

Brian Thomas, Psy.D.
4579 S. Eason Blvd.
Behavioral Health Center
N. MS Medical Center
Tupelo, MS 38801

Submitter : Dr. Grant McKeever **Date & Time:** 09/01/2004 04:09:36

Organization : Lone Star Bone & Joint Clinic

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached letter regarding CMS-1429-P

CMS-1429-P-624-Attach-1.doc

Grant R. McKeever, M.D.
Lone Star Bone & Joint Clinic
902 Frostwood Drive, #309
Houston, TX 77024

September 1, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

During the decision-making process, consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide patients with comprehensive health care. The patient would be forced to see the physician and separately seek therapy, causing significant inconvenience and additional expense.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to"

the physician, it is likely the patient will suffer delays in care, greater cost and a lack of local, immediate treatment.

- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but also cost time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement.
- CMS offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. This action could be construed as an unprecedented attempt by CMS to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

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

Sincerely,

Grant R. McKeever, M.D.

Submitter : Dr. Ruth Yoash-Gantz **Date & Time:** 09/01/2004 04:09:00

Organization : Hefner VA Medical Center

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly support this proposed rule change. I am a neuropsychologist and this proposed change would allow more patients to be treated more efficiently without sacrificing the quality of the services. Psychometricians, or those trained to administer psychometric tests, should have minimal levels of training to function in the capacity suggested in this proposed change.

Submitter : Mr. HERMINSUL JARA **Date & Time:** 09/01/2004 04:09:37

Organization : Mr. HERMINSUL JARA

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

IT IS NECESSARY THAT CMS REQUIERE TO ALL PHYSISCIANS THAT PHYSICAL THERAPY PROCEDURES PERFORMED TO ALL PATIENTS IN THEIR OFFICES, MUST BE FURNISHED FOR PHYSICAL THERAPISTS OR PHYSICAL THERAPISTS ASSISTANT UNDER SUPERVISION OF PHYSICAL THERAPIST.THEREFORE THE OLD SCENEARY WHERE THE PATIENT GO TO THE BACK ROOM AND RECEIVE "skills" PROVIDED FOR SOMEONE NO LICENSED TO DO THAT, WILL FINISH FOREVER

Submitter : Dr. Gary Souheaver **Date & Time:** 09/01/2004 04:09:01

Organization : Dr. Gary Souheaver

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Use of trained technicians to administer and score objective tests is not only professionally sanctioned, but is the most cost effective method to provide services to Medicare patients. This practice is already widely used in neuropsychological assessment for non-Medicare patients, and should be available to Medicare/Medicaid recipients. Psychologists should be allowed to provide Medicare patients the same services as non-Medicare patients. The interpretation of the tests, of course, should always be reserved and restricted to the trained and licensed psychologist who supervises the testing assistant.

As a practicing clinical neuropsychologist, I strongly urge approval of the proposed rule to allow psychologists supervisory roles over trained assistants/technicians in the use of diagnostic psychological and neuropsychological tests.

Submitter : Dr. Mark Sherer **Date & Time:** 09/01/2004 05:09:42

Organization : Dr. Mark Sherer

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

As independent practitioners who are individually licensed to perform psychological and neuropsychological diagnostic tests in all states, psychologists (including neuropsychologists) should be reimbursed for testing performed by others under their supervision. This is similar to a radiology technician obtaining x-rays for a radiologist or an EEG technician obtaining EEG tracings for a neurologist. In each case, the supervising healthcare professional retains responsibility for the proper execution of the diagnostic study and the appropriate clinical interpretation of the study once it is obtained.

Submitter : Dr. John King **Date & Time:** 09/01/2004 05:09:58

Organization : Loyola University Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

September 1, 2004

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

RE: Proposed Supervision Rule Change of Neuropsychological Testing

Dear Centers for Medicare and Medicaid Services:

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Sincerely,

John H. King, Ph.D.
Clinical Neuropsychologist
Chicago Neuropsychology Group
333 North Michigan Avenue
Chicago, IL 60601

CMS-1429-P-630

Submitter : Dr. Gregory Lee **Date & Time:** 09/01/2004 05:09:40

Organization : Medical College of Georgia

Category : Physician

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

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

I strongly urge you to enact the proposed rule change.

Thank you.

Submitter : Dr. Laura Lacritz **Date & Time:** 09/01/2004 05:09:52

Organization : University of Texas Southwestern medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am in support of the recommended changes that involve allowing clinical psychologists to supervise diagnostic testing. Diagnostic assessment is a central part of our (clinical psychologists') training and teaching and a large part of the clinical practice for many psychologists. Our licensure is in part dependent on demonstration of competency in this area. Instruction in administration and interpretatin of diagnostic testing is also primarily provided by psychologists across settings.

Submitter : Mrs. Ellen Strunk **Date & Time:** 09/01/2004 05:09:32

Organization : Restore Management Services, Ltd.

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT 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

My name is Ellen Strunk and I am a physical therapist in Alabama. I have been practicing for 12 years. Currently I work as a clinical consultant for a company that provides rehabilitation services in skilled nursing facilities, outpatient, home health, and hospice.

I also serve as the Practice & Reimbursement Chair for the AL Physical Therapy Association. In this capacity, I hear from many clinicians who are faced with the challenges of providing quality physical therapy services, while at the same time, a physician owned practice can provide 'physical therapy'services that are provided by someone who may or may not have any related education.

I strongly support the position CMS has taken on this issue in its proposed rule. Physical therapists and physical therapist assistants under the supervision of physical therapists are the only practitioners who have the education and training to furnish physical therapy services. Physical therapists must be licensed in the states where they practice. As licensed health care providers in every jurisdiction in which they practice, physical therapists are fully accountable for their professional actions. Unqualified personnel are not licensed; therefore it is my belief that the people they treat are at higher risk for injury or at the very minimum, it is more likely the condition for which they sought treatment will be extended.

A financial limitation on the provision of therapy services (referred to as the therapy cap) is scheduled to become effective January 1, 2006. Under the current Medicare policy, a patient could exceed his/her cap on therapy without ever receiving services from a physical therapist. This will negatively impact patient?s outcomes. It is unfair to a person who seeks out physical therapy services with the hope of returning to his/her prior level of function to be treated by someone who is not qualified. Positive outcomes are important to the physical therapy community; therefore the integrity of the services must be maintained.

I appreciate your time and consideration of these comments. I look forward to the administration's final decision and am confident that you will choose what is best for the beneficiaries we both serve.

Respectfully,
Ellen R. Strunk, MS, PT, GCS
Restore Management Services, Ltd
205-942-6820, ext. 1119
estrunk@restoretherapy.com

CMS-1429-P-633

Submitter : Mr. Peter Pramataris **Date & Time:** 09/01/2004 05:09:44

Organization : St. Mary's Hospital for Children

Category : Individual

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a student of clinical neuropsychology. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

Clinical neuropsychologists complete advanced education and
training in the science of brain-behavior relationships. They specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of doctoral-level academic preparation and training, they possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others).
Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in
the diagnosis and care of Medicare and Medicaid patients.

Neuropsychological education and training uniquely qualifies them to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests). Neuropsychologists
are at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Submitter : Dr. Jacobus Donders **Date & Time:** 09/01/2004 05:09:18

Organization : Mary Free Bed Hospital

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists should be able to independently supervise others administering and scoring psychological tests.

CMS-1429-P-635

Submitter : Ms. Carissa Knouse **Date & Time:** 09/01/2004 05:09:43

Organization : National Athletic Trainers' Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am writing to express my concern over the recent proposal that would limit providers of incident to services in physician 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-635-Attach-1.doc

Carissa Knouse
806B Indian Creek Dr.
Wilkes-Barre, PA 18702

September 1, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

Carissa Knouse MS, MEd, ATC, PTA, CSCS
806B Indian Creek Dr.
Wilkes-Barre, PA 18702

Submitter : Dr. Michael Kirkwood **Date & Time:** 09/01/2004 06:09:33

Organization : The Children's Hospital, Denver

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Dear Centers for Medicare and Medicaid Services:

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Sincerely,

Michael W. Kirkwood, Ph.D.
The Children's Hospital
1056 E. 19th AVe.
Denver, CO 80218

Submitter : Dr. ABRAHAM MENSCH **Date & Time:** 09/01/2004 06:09:45

Organization : DCMHS

Category : State Government

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

THE CHANGES PROPOSED WOULD ALLOW FOR AN INCREASE IN AVAILABLITY OF NEUROPSYCHOLOGICAL CONSISTENT WITH PATIENT CARE/NEED. PERMITTING SUPERVISION BY LICENSED DOCTORAL PSYCHOLOGY IS CONSISTENT WITH BEST PRACTICES IN THE FIELD.

Submitter : Dr. Chad Grills **Date & Time:** 09/01/2004 06:09:53

Organization : Tripler Army Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

RE: Proposed Supervision Rule Change of Neuropsychological Testing

As a clinical neuropsychologist, I would like to express my support for the Centers for Medicare and Medicaid Services' proposed rule change that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

I am currently a clinical neuropsychology fellow undergoing a 2-year postdoctoral fellowship in clinical neuropsychology that is standard for the field. I have a prior 6 years of advanced education and training in the science of brain-behavior relationships. My fellowship consists of 2 years of specialized training in neuropsychological and psychological assessment. This specialized training of psychological and neuropsychological testing, psychometrics, etc. is not a part of other health care providers (e.g., psychiatrists, neurologists) training and expertise. Their training is to address patients' medical problems, not to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My 6 years of doctoral level education and 2 years of postdoctoral education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am, of course, responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision. After this much training, I and my colleagues are highly qualified to perform the above.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. This means that less patients are able to receive care. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Sincerely,

Chad Grills, PhD
1 Jarret White Rd
Honolulu, HI 96859

CMS-1429-P-639

Submitter : Dr. John Wallace **Date & Time:** 09/01/2004 06:09:57

Organization : Dr. John Wallace

Category : Individual

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a retired psychologist with over 50 years in the profession. I urge the adoption of psycologist supervision of all psychological testing and psychological diagnostic procedures.

Submitter : Dr. Robert Tomaszewski **Date & Time:** 09/01/2004 06:09:18

Organization : Dr. Robert Tomaszewski

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical neuropsychologist and would like to express my strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.
The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Submitter : Dr. Elizabeth Letsch **Date & Time:** 09/01/2004 07:09:43

Organization : Dr. Elizabeth Letsch

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

RE: Proposed Supervision Rule Change of Neuropsychological Testing

Dear Centers for Medicare and Medicaid Services:

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

Clinical neuropsychologists have completed advanced education and training in the science of brain-behavior relationships. We specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of our doctoral-level academic preparation and training, we possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Our medical colleageues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies us to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments. As a licensed psychologist, we are at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Sincerely,
Dr. Elizabeth Letsch

CMS-1429-P-642

Submitter : Dr. Sally Frutiger **Date & Time:** 09/01/2004 07:09:07

Organization : University of Kansas Medical Center

Category : Physician

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

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

Clinical psychologists have extensive training in psychometric theory, statistics, and the role of biological, cognitive, emotional, and personality factors in the control of human behavior. Because of this training they are well-prepared to select and evaluate the merits of available psychological tests and to supervise their appropriate selection and administration. Since psychologists have played a major role in developing available psychological tests, they are eminently prepared to supervise their adminstration.

I strongly urge you to enact the proposed rule change.

CMS-1429-P-643

Submitter : Dr. Brian Goodyear **Date & Time:** 09/01/2004 07:09:49

Organization : Dr. Brian Goodyear

Category : Physician

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am writing in support of the proposed CMS rule change allowing
psychologists to supervise psychometricians or other tehcnicians in the administration of diagnostic psychological and neuropsychological tests. Psychologists are appropriately trained and qualified to perform this function.

I strongly urge you to enact the proposed rule change.

Thank you.

CMS-1429-P-644

Submitter : Dr. Jennifer Manly **Date & Time:** 09/01/2004 07:09:09

Organization : Columbia University

Category : Academic

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

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

I strongly urge you to enact the proposed rule change.

Thank you.

CMS-1429-P-645

Submitter : Dr. Scott Sailor **Date & Time:** 09/01/2004 07:09:24

Organization : California State University, Fresno

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Certified Athletic Trainers are individuals who are highly educated and highly qualified to provide therapy services within a variety of settings. The provision of these services fall well within the scope of practice of a certified athletic trainer. Certified Athletic Trainers currently work under the direction of a physician in the provision of therapy services in settings such as, but not limited to, physician offices, sports medicine centers, and academic institutions. The credential held by Certified Athletic Trainers requires stringent academic preparation, similar to and often simultaneously delivered to, physical therapy students. The ATC credential requires that an individual passes a stringent national examination which has been shown to be highly reliable and valid. Along with passing an exam, ATCs are required to meet rigorous continuing education requirements to maintain their credential. In contrast to physical therapist who are not uniformally required to pursue any continuing education upon completion of their degree. The federal government has already analyzed the job of the athletic trainer and holds it on a level equal to that of a physical therapist in regards to level of education, preparation required, and duties. An ATC is much more qualified and has a more appropriate scope of practice to provide these types of services under the direction of a physician then does an occupational therapist, an occupational therapy aide, or a physical therapy aide. It is for these reasons that I believe the certified athletic trainer should be included as an entity allowed to seek reimbursement under this category. It is in the best interest of the patient to provide these types of services and the best suited to provide these services are the physical therapist and the certified athletic trainer.

Submitter : Ms. Katherine Rabe **Date & Time:** 09/01/2004 07:09:57

Organization : Pine Rest Christian Mental Health Services

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

I believe that psychologists should be able to oversee/supervise technicians giving psychological and neuropsychological assessments. Physicians are not necessarily trained in the administration and interpretation of said testing, while many psychologists are trained to do just that.

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Many psychologists are specifically trained in the admistration and interpretation of psychological tests. They are therefore the most qualified to oversee/supervise technicians administering tests.

CMS-1429-P-647

Submitter : Dr. Laurie Tis **Date & Time:** 09/01/2004 08:09:25

Organization : National Athletic Trainers Association

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY STANDARDS AND REQUIREMENTS

We, the official representatives of the undersigned organizations, wish to formally state our position on Medicare?s proposed changes to the ?Therapy-Incident To? services. We believe the health and well being of the Medicare beneficiary should be the primary consideration. To this end, physicians and all other medical professionals authorized to order ?Therapy-Incident To? services should have the continued medical authority to determine proper care and treatment for the patient and to select the best available, most appropriate health care professional to provide that care, including ?Therapy-Incident To? services. A number of complex factors affect a physician?s choice of the most appropriate health care professional to provide ?Therapy-Incident To? services in his/her office or clinic. Some examples are type of medical practice; geographic location such as rural or medically underserved areas; availability of qualified allied health care personnel; and patient access to Medicare and secondary health care system providers.
The physician is best equipped to make these medical decisions. We believe any attempt by government entities or other organizations to change this heretofore established right and purview of the physician clearly is not in the best interest of the patient.
We unequivocally request that no changes be made to Medicare or other provisions affecting ?Therapy-Incident To? services reimbursement from CMS.

Submitter : Dr. David Kauder **Date & Time:** 09/01/2004 09:09:31

Organization : Urology Consultants of the North Shore

Category : Physician

Issue Areas/Comments

Issues 1-9

PRACTICE EXPENSE

The changes in 2005 will result in the loss to our 7 doctor practice of 30% of our total bottom line. This will make it very difficult to offer the range of patient treatments that we do. This will adversely affect ALL cancer therapy.
D Kauder, MD

CMS-1429-P-649

Submitter : Kyle Momsen **Date & Time:** 09/01/2004 09:09:35

Organization : University of North Carolina at Wilmington

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached letter Re: Therapy- Incident to

CMS-1429-P-649-Attach-1.doc

Kyle Momsen, MA, ATC-L
Athletic Training Program Clinical Coordinator
Department of Health and Applied Human Sciences
University of North Carolina at Wilmington
601 South College Road
Wilmington, NC 28403

September 3, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to share my views and express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. As a certified athletic trainer, a taxpayer, and a patient, I feel obligated to voice my opinion that it is absolutely crucial that this proposal is not accepted. In my letter I hope to show that if this proposal is adopted, it would eliminate the ability of qualified health care professionals to provide important services, which in turn 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. I have included several bullet points at the end of this introduction that I feel are important, but I also wanted to start with a few less formal comments. I apologize for the length, but there are so many important points to consider that I would be remiss to leave some out for sake of brevity.

During many discussions on this topic with various professionals, many different avenues of thought have come about, so I thought I would start with a definition since that has helped my students, other professionals, and I start from the same platform. According to Taber's Cyclopedic Medical Dictionary (18^{th}) physical therapy is "rehabilitation concerned with the restoration of function and the prevention of disability following diseases, injury, or loss of a body part. The therapeutic properties of exercise, heat, cold, electricity, ultraviolet radiation, and massage are used to improve circulation, strengthen muscles, encourage return of motion, and train or retrain an individual to perform the activities of daily living." Based on that definition it seems clear to me that anyone who is trained in those functions and recognized by the American Medical Association, along with state licensure boards, should be allowed to practice, and therefore bill, for therapy services provided incident to a physicians' service. Clearly, the

medical field needs to be regulated, but that should be based through medical boards and medical associations, not based on who is legally allowed to bill for services. The medical field should be able to chose from a list of professionals that have the proper training and qualifications, and then also patients should be able to chose who they feel will best serve them. Doctors and patients must be allowed to choose from the best health care providers, not just those that have a specific certification. Specifically, athletic trainers undergo rigorous education programs that provide extensive training in the prevention, treatment, care, and rehabilitation of injuries, so a patient should be able to obtain therapy services from an athletic trainer. According to the federal government, the preparation of an athletic trainer is rated as equivalent to a physical therapist's, and it is more significant than that of an occupation therapist, occupation therapist assistant or physical therapist assistant. To allow a monopolization of therapy services could encourage less competition between healthcare providers and lower the standard of care Medicare patients receive. Conceivably, it could also end up costing patients, taxpayers, and the government more because prices no longer have to be competitive. If a certain group of professionals are the only ones able to provide a service, they have the ability to set a rate without fear of competitors offer the same service at a lower rate. If two services are equally successful, which outcome studies show athletic trainers to be successful in providing therapy services, then both should be allowed to encourage healthy business. It is imperative that patients are offered the best healthcare possible, with as little cost as possible.

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

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

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

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

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the

physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

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

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

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

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

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

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

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

- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes

to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers 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.

- 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,

Kyle Momsen

CMS-1429-P-650

Submitter : Dr. Gordon Teichner **Date & Time:** 09/01/2004 10:09:19

Organization : Dr. Gordon Teichner

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

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

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

I strongly urge you to enact the proposed rule change.

Thank you.

Submitter : Mrs. Stephanie Johnson **Date & Time:** 09/01/2004 10:09:23

Organization : Maximum Functional Performance

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I am a strong supporter of all individuals providing physical therapy in any setting to be graduates of an accredited professional physical therapist program. Physical therapists receive a minimum of a master's degree in physical therapy. The APTA supports all programs going to a doctorate level program by 2010. The potential for harm increases as other individuals begin to administer physical therapy services. Physicians are very intelligent individuals however, they do not complete any internships or fellowships in physical therapy as part of their curriculum in medical school. Why would it then be appropriate for another individual working under the supervision of a physician to provide physical therapy services. There can be no assurance of quality of service in this instance. Just the same as a para-educator works only under the direction of the kindergarten classroom teacher versus the district superintendent. It would be impossible for the superintendent to be educated in all of the precise things going on within a classroom, remaining up to date on all of the latest educational research regarding kindergarten curriculum, informed on all policies regarding the particular school, or the special needs of a parent/child.
The direction of health care needs to remain locally focused. The most appropriate way to keep health care effective with respect to treatment and cost containment, is for that care to be performed only by the professional in that particular area. Physical Therapy is a separate and independent field much the same as radiology or pharmacy or obstetrics. A radiology tech should not receive training and then assist in a labor and delivery under the direction of the obstetrical physician, and a radiology tech should not perform physical therapy evaluation and treatment under the direction of a physician. Please support the individual health care professions by making Medicare provisions that requiring that physical therapy be performed only by those professions receiving a license or registration within their respective states to do so. Keep physical therapy within the practices of a physical therapist.

Submitter : Mr. Aaron Witwer **Date & Time:** 09/01/2004 11:09:10

Organization : National Athletic Trainers' Association

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

CMS-1429-P-652-Attach-1.doc

Aaron B. Witwer, M.S., ATC/L
2475 West Pecos Rd, #3030
Chandler, AZ 85224

September 1, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

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

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- 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,
Aaron B. Witwer, M.S., ATC/L
2475 W. Pecos Rd, #3030
Chandler, AZ 85224

CMS-1429-P-653

Submitter : Mr. Benjamin Carpenter **Date & Time:** 09/01/2004 11:09:44

Organization : NATA

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

see attachment

CMS-1429-P-653-Attach-1.doc

CMS-1429-P-653-Attach-2.doc

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

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

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

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

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

Benjamin Carpenter
MeritCare Sports Medicine
2400 32nd Avenue South
Fargo, ND 58103

September 1, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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.

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

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

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

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

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

Sincerely,

Benjamin Carpenter

CMS-1429-P-654

Submitter : **Date & Time:** 09/02/2004 01:09:01

Organization :

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

please see attached file

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

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

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2. The submitter did not follow through when attaching the document.
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CMS-1429-P-655

Submitter : Mr. Stephen Knoche **Date & Time:** 09/02/2004 02:09:54

Organization : Mr. Stephen Knoche

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sirs:

I would like to express my concern over the recent proposal that would limit providers of 'incident to' services in physician offices and clinics. If this is adopted it would eliminaate some qualified health care providers to give physical therapy to Medicare patients.

I believe that physicians should be able to make determinations on their own as to who would provide services that need to be provided to their patients. With this proposal the physician is required to only use physical therapists. As a certified athletic trainer I find this type of thinking intolerable. Please consider making changes to this proposal.

thank you,
Stephen Knoche ATC

Submitter : Dr. Robert Conder **Date & Time:** 09/02/2004 02:09:19

Organization : CNS

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

-I am writing in support of allowing doctoral level Clinical Psychologists to supervise technical assistants (ancillary personnel) in the administration and scoring of psychological and neuropsychological tests.

CMS-1429-P-657

Submitter : Mrs. Laurie Bowler **Date & Time:** 09/02/2004 04:09:00

Organization : Mrs. Laurie Bowler

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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

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

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

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

CMS-1429-P-658

Submitter : Dr. Phillip Zinni III DO ATC/L **Date & Time:** 09/02/2004 05:09:53

Organization : E

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

CMS,Dept.HHS
Attn:CMS-1429-P
POB 8012, Baltimore, MD 21244-8012

Re: Therapy - Incident To

9/1/04

Dear Sir/Madam:

I am writing, as a primary care physician, to express my concern over the recent proposal that would limit providers of 'incident to' services in my clinics. If adopted, this would eliminate the ability of qualified health care professionals who provide these vital and successful services. In turn, it would reduce the quality of health care for Medicare patients, ultimately increase associated costs of this service and place an undue burden on the health care system. This CMS recommendation is a health care access deterrent.

Furthermore, 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 Certified Athletic Trainers) whom I deem knowledgeable in the protocols to be administered. My choice of qualified therapy providers is inherent in my type of practice and individual 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.
* I started my post-graduate medical education and training as a Certified Athletic Trainer. I know they 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 were similar to my medical school. 70% of all Certified Athletic Trainers have a master's degree or higher. This majority of practitioners who hold advanced degrees are comparable to other health care professionals, such as physical, occupational and speech therapists, registered nurses, 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).
* CMS does not have the statutory authority to restrict who can and can?t provide services ?incident to? a physician office visit AND this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional (Am. Physical Therapy Assoc.), to seek exclusivity as a provider of therapy services.
* Certified 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 mine, to work with physically active people to prevent, assess, treat and rehabilitate injuries sustained during the physical activity of daily life. For CMS to even suggest that Certified Athletic Trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured in a local 5K race or on the job and goes to their local physician for treatment of that injury is outrageous and unjustified.
* These issues will lead to more physician practices eliminating a number of Medicare patients.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed.

Sincerely,
Phillip Zinni III DO, FAOASM, ATC/L
Corporate Medical Director, E & J Gallo Winery

POB 1130, Modesto, CA 95354

Please see attached file.

CMS-1429-P-658-Attach-1.doc

CMS-1429-P-658-Attach-2.doc

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

Phillip Zinni III DO, FAOASM, ATC/L
Corporate Medical Director, E & J Gallo Winery
600 Yosemite Blvd
Modesto, CA 95354

September 1, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing, as primary care, 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 who provide these vital services (with much success) in the past. In turn, 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.

Furthermore, 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 certified athletic trainers) whom I deem knowledgeable and trained in the protocols to be administered. My 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 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 started my training as an Athletic trainer. I know they 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, every professional sports team in America and many corporations, including mine, 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 of walking in a local 5K race or injured on the job 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,

Phillip Zinni III, DO, FAOASM, ATC/L

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

Phillip Zinni III DO, FAOASM, ATC/L
Corporate Medical Director, E & J Gallo Winery
600 Yosemite Blvd
Modesto, CA 95354

September 1, 2004

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

Re: Therapy – Incident To

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

Sincerely,

Phillip Zinni III, DO, FAOASM, ATC/L

Submitter : Dr. Richard Berg **Date & Time:** 09/02/2004 11:09:29

Organization : Dr. Richard Berg

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

It is appropriate to use technicians for neuropsychological testing. They are highly trained and can administer tests with complete proficiency. It much the same as a technician doing an MRI with the radiologist physician reading/interpreting the test.

CMS-1429-P-660

Submitter : Dr. Patricia Walz **Date & Time:** 09/02/2004 12:09:14

Organization : Consulting Psychology, Western Arkansas

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Please approve the proposal for psychologist to be able to supervise psychological assessment. Psychologists have extensive training in administration, scoring, and interpretation of psychological tests as well as training in supervision and are well qualified to supervise assistants. As with other medical fields, the use of assistants or technicians allows costs to be kept down and for greater access to medical care. Thank you for your consideration.

Patricia Walz

CMS-1429-P-661

Submitter : Mr. John Maynard **Date & Time:** 09/02/2004 12:09:43

Organization : InLight Solutions, Inc.

Category : Device Industry

Issue Areas/Comments

Issues 1-9

SECTION 613

I am submitting these comments on behalf of InLight Solutions Inc. As a co-founder and senior executive of InLight, I lead a group of scientists, engineers and clinicians focused on developing in vivo applications of optical spectroscopy. Over the past ten years we have made significant progress in developing next generation optical biosensors capable of non-invasively monitoring glucose levels and early detection of type 2 diabetes. InLight is a 30 person Research and Development group comprised of the world's top scientists in the fields of spectroscopy, tissue optics, and multivariate analysis. To date, InLight has received 35 issued U.S. patents and has another 33 U.S. patent applications pending. InLight, a privately held company based in New Mexico, has received funding from the NIH and the DOD. In addition, InLight has extensive collaborations with the University of New Mexico, MedStar Research Institute and Sandia National Labs.

Thank you for the opportunity to provide comments on the Medicare Physician Fee Schedule and section 613 of the Medicare Modernization Act (MMA) that adds Section 1861 (yy) to the Social Security Act. InLight wishes to address an important aspect of the July 27 Proposed Rules that may unnecessarily delay access to new and improved methods of diabetes screening. Specifically, we are concerned that subjecting new diabetes screening tests to a National Coverage Decision (NCD) process is inconsistent with Congress' intent to improve early intervention for patients at risk of diabetes.

In Section 613 of the MMA Congress directs the Centers for Medicare and Medicaid Services (CMS) to cover fasting plasma glucose tests, post-glucose challenge tests and other such tests that the Secretary of Health and Human Services deems appropriate. We interpret this to mean that as future diabetes screening tests are cleared by the Food and Drug Administration (FDA), they will have automatically been deemed appropriate for their intended use by the Secretary of Health and Human Services after review of the new test's regulatory filings and consultation with appropriate organizations. Given that Congress has already mandated that diabetes screening should be covered, it seems redundant for CMS to subject future FDA-cleared diabetes screening tests to an NCD process as the Proposed Rule currently requires. We believe that requiring an NCD process for new diabetes screening tests is inconsistent with the specific objectives of Section 613 as well as other general sections of the MMA intended to make the Medicare coverage process more efficient.

The NCD process, as defined by Section 1862 of the Social Security Act, indicates that Medicare payment is contingent upon a determination that an item or service; meets a benefit category, is not specifically excluded from coverage, and is 'reasonable and necessary'. InLight recognizes that FDA coverage for a specific technology or test does not, in and of itself, require CMS to provide or even consider coverage of the item. However, Section 613 of the MMA mandates coverage for the diabetes screening in general and the Proposed Rule specifically extends coverage to all tests currently cleared by the FDA for diabetes screening. It follows that if new tests have been cleared by the FDA for the expressed purpose of diabetes screening then they have in fact been deemed appropriate by the Secretary.

We therefore urge CMS to rewrite the regulations by removing the 'subject to NCD process' provision and instead allow for new diabetes screening tests that have been approved by the FDA to be also covered without subjecting the new test to a new NCD process.

We ask that CMS consider these comments and would welcome the opportunity to clarify any questions you may have.

Thank you.

John Maynard

Submitter : Dr. Robert Denney **Date & Time:** 09/02/2004 12:09:14

Organization : Neuropsychological Associates of Southwest MO

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

Sincerely,
Robert L. Denney, Psy.D., ABPP
Clinical Neuropsychologist
MO License R0316

Submitter : Dr. Jody Hagen **Date & Time:** 09/02/2004 12:09:31

Organization : Living Well

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Please approve the proposal for psychologists to be able to supervise psychological assessment. Psychologists have extensive training in administration, scoring, and interpretation of psychological tests as well as training in supervision and are well qualified to supervise assistants. As with other medical fields, the use of assistants or technicians allows costs to be kept down and for greater access to medical care. Thank you for your consideration.
Dr. Jody Hagen, Psychologist

CMS-1429-P-664

Submitter : **Date & Time:** 09/02/2004 01:09:05

Organization :

Category : Individual

Issue Areas/Comments

Issues 1-9

SECTION 413

1

Submitter : Dr. Brian Carpenter **Date & Time:** 09/02/2004 01:09:27

Organization : Washington University in St. Louis

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly support this revision to the current standards. Clinical psychologists have extensive training on the use and interpretation of psychological tests, and they possess the technical and professional competence to supervise the use of these tests. Allowing clinical psychologists to provide oversight on the use of these tests would ensure a high level of expertise in test supervision. In addition, allowing psychologists to supervise testing would expand the availability of testing, diagnosis, and treatment in rural areas that are underserved.

CMS-1429-P-666

Submitter : **Date & Time:** 09/02/2004 01:09:14

Organization :

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-666-Attach-1.doc

CMS-1429-P-666-Attach-2.doc

Kelly Weir ATC
1418 Sunset Dr.
Wolverine Lake, MI 48390

September 2, 2004

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

Re: Therapy – Incident To

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

- 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,

Kelly Weir ATC, PES, CSCS
1418 Sunset Dr.
Wolverine Lake, MI 48390

Kelly Weir ATC
1418 Sunset Dr.
Wolverine Lake, MI 48390

September 2, 2004

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

Re: Therapy – Incident To

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

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

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

Sincerely,

Kelly Weir ATC, PES, CSCS
1418 Sunset Dr.
Wolverine Lake, MI 48390

CMS-1429-P-667

Submitter : Dr. Fred Unverzagt **Date & Time:** 09/02/2004 01:09:31

Organization : Indiana Univ. School of Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I urge you to support the rule change allowing Psychologists to supervise trained technicians to adminmister psychological tests. This is a standard practice that has been endorsed in writing in "white papers" from several professional groups including the American Psychological Association Division - 40 and the National Academy of Neuropsychology.

CMS-1429-P-668

Submitter : Dr. Joseph Snow **Date & Time:** 09/02/2004 01:09:36

Organization : Dr. Joseph Snow

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists have the greatest level of training, experience, and expertise in diagnostic psychological testing and therefore are the best qualified to supervise others
administering and scoring such tests.

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

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

CMS-1429-P-669

Submitter : Dr. J. Judd Harbin **Date & Time:** 09/02/2004 02:09:21

Organization : psychologist in private practice

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists' use of assistants and technicians in diagnostic psychological testing helps to keep down the costs of psychological care. Psychologists have extensive training in administration, scoring, and interpretation of psychological instruments as well as training in supervision and are well qualified to supervise assistants. Please approve the proposal for psychologists to supervise psychological assessment. Thank you.

Submitter : Dr. Eric Ecklund-Johnson **Date & Time:** 09/02/2004 02:09:38

Organization : Allied Services

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Dear Centers for Medicare and Medicaid Services:

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services'proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is
needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and
neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Sincerely,

Eric Ecklund-Johnson, Ph.D.
Clinical Neuropsychologist
Assistant Director of Psychology
Allied Services
100 Abington Executive Plaza
Clarks Summit, Pa 18411
eecklu@allied-services.org

Submitter : Dr. Richard Sugden **Date & Time:** 09/02/2004 02:09:08

Organization : Dr. Richard Sugden

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

As a neuropsychologist who teaches residents in a university-based hospital, I know that we are the only ones qualified to oversee any psychological assessments. MD's have little to no knowledge in this area, much less expertise for supervision. Therefore, I whole-heartedly suppport the proposed changes to the regulations that clarifies this.

Submitter : Dr. Judith O'Jile **Date & Time:** 09/02/2004 02:09:38

Organization : University of Mississippi Medical Center

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 North State Street
Jackson, MS 39216-4505

Judith O?Jile, Ph.D.
Director, Neuropsychology Laboratory Telephone: 601/984-5804
Psychology Division Fax: 601/815-4047
Department of Psychiatry and Human Behavior E mail: jojile@psychiatry.umsmed.edu

September 2, 2004

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

RE: Proposed Supervision Rule Change of Neuropsychological Testing

Dear Centers for Medicare and Medicaid Services:

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that
assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality
of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in
neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I

strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Sincerely,

Judith R. O?Jile, Ph.D.
Director, Neuropsychology Laboratory
University of Mississippi Medical Center

CMS-1429-P-673

Submitter : Ms. Dianne Jackson **Date & Time:** 09/02/2004 02:09:32

Organization : Miller Orthopaedic Clinic

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

As the administrator for the physical therapy department in a physician's office, I strongly support the proposed rule that all physical therapy services provided in a physician's office 'incident to' the physician's professional services must be furnished by personnel who meet certain standards. I support that these individuals should be physical therapists and physical therapy assistants who work under the supervision of a physical therapist. While other professionals, such as athletic trainers and exercise physiologists, receive education in exercise prescription, their training is not comprehensive to include the complete evaluation skills, manual therapy skills, and biomechanical analysis necessary for quality care. I have also been the administrator for a outpatient Rehab Agency, where these supervisory rules are in place. Athletic trainers and exercise physiologists were not able to treat Medicare beneficiaries as they function as a clinical aide. This standard ensures that the public receives quality services in all settings. Physician offices should be under the same supervisory requirements to provide physical therapy services as all other health care settings. We currently follow these supervisory requirements in our physician office without any difficulties.

Submitter : Dr. Fiona Hill **Date & Time:** 09/02/2004 03:09:49

Organization : Fiona Hill, Psy.D., P.C.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

RE: Proposed Supervision Rule Change of Neuropsychological Testing

Dear Centers for Medicare and Medicaid Services:

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services'proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize inthe application of assessment and intervention principles based on thescientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services. I believe many of my colleagues who currently refuse to take Medicare or Medicaid would reconsider if these changes were made.

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

Sincerely,

Fiona Hill, Psy.D., PC

Submitter : Mrs. Eliabeth Canoni **Date & Time:** 09/02/2004 04:09:09

Organization : Allied Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Issues 10-19

THERAPY ASSISTANTS IN PRIVATE PRACTICE

ALLIED PHYSICAL THERAPY
Elizabeth Canoni MS,PT
37 Chandler Street
Suite One
Worcester, MA 01609
Tel. 508-753-0700
Fax. 508-753-0330
aecanoni@yahoo.com

September 2, 2004
RE: CMS 1429P, The supervision of Physical Therapist Assistants

To whom it may concern,
I am writing this letter in strong support of the CMS?s proposal to replace the requirement that physical therapists provide personal supervision (in the room) of physical therapist assistants in the physical therapist private practice office with a direct supervision requirement.
As an owner of a small out patient clinic in Worcester in which I currently employ one physical therapist assistant, I feel that this change to the requirement is needed. Physical therapist assistants are recognized under the law all states as being able to provide physical therapy services safely and effectively without a physical therapist being in the room. It therefore is not reasonable to require excessive in room supervision of physical therapist assistants. Allowing instead direct supervision requirement is feasible and would be consistent with the previous Medicare supervision requirement for assistants that physical therapists in independent practice (PTIPs) were required to meet prior to 1999.

I feel that as an outpatient physical therapist, my professional judgment should decide the amount of supervision that is needed for the treatment of my patients by the physical therapist assistant. As licensed physical therapist we are held fully accountable for the proper delegation and direction of services to physical therapist assistant. This change will not effect the way that physical therapist practice in outpatient clinics.

Thank you for your consideration of my comments.

Sincerely,

Elizabeth Canoni MS,PT

Submitter : Dr. Craig Bottoni **Date & Time:** 09/02/2004 04:09:35

Organization : Tripler Army Medical Center

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

In last year's proposed rule, we requested comments on clarifying that the personnel qualifications of therapists in home health settings at Sec.484.4 apply consistently to all therapy settings, including the offices of physical and occupational therapists, physicians, and nonphysician practitioners. We received comments from therapists, physicians, nontherapist health care providers and their representative organizations. After consideration of all comments, we now propose to revise 42 CFR 410.26, 410.59, 410.60 and 410.62 to reflect that physical therapy, occupational therapy, and speech-language pathology services provided incident to a physician's professional services are subject to certain limitations as described at section 1862(a)(20) of the Act.

Regulations in 42 CFR 485.705 specify that, in almost all settings, outpatient rehabilitative therapy services, (physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP)) can be furnished only by the following individuals meeting the qualifications in Sec.484.4: physical therapists, occupational therapists, appropriately supervised physical therapist assistants, appropriately supervised occupational therapy assistants, and speech-language pathologists. Some States permit licensed physicians, physician assistants, clinical nurse specialists, and nurse practitioners to furnish PT, OT, and SLP services also. Therapy services, and those who provide therapy services, must also meet the standards and conditions as specified in Medicare manuals.Section 1862(a)(20) of the Act permits payment for therapy services furnished incident to a physician's professional services only if the practitioner meets the standards and conditions that would apply to such therapy services if they were furnished by a therapist, with the exception of the licensing requirement. We are proposing to amend the regulations to include the statutory requirement that only individuals meeting the existing qualification and training standards for therapists (with the exception of licensure) consistent with Sec.484.4 qualify to provide therapy services incident to physicians' services.

Section 1862(a)(20) of the Act refers only to PT, OT, and SLP services and not to any other type of therapy or service. This section applies to services of the type described in section 1861(p), 1861(g) and 1861(ll) of the Act; it does not, for example, apply to therapy provided by qualified clinical psychologists. This section also does not apply to services that are not covered either as therapy or as evaluation and management services provided incident to a physician or nonphysician practitioner such as recreational therapy, relaxation therapy, athletic training, exercise physiology, kinesiology, or massage therapy services.2. Qualification Standards and Supervision Requirements in Therapy Private Practice Settings[If you choose to comment on issues in this section, please include the caption ``Therapy Standards and Requirements'' at the beginning of your comments.]

Section 1861(p) includes services furnished to individuals by physical and occupational therapists meeting licensing and other standards prescribed by the Secretary if the services meet the necessary conditions for standards for health and safety. These services include those furnished in the therapist's office or the individual's home. By regulation, we have defined therapists under this provision as physical or occupational therapists in private practice (PTPPs and OTPPs).

Under Medicare Part B, outpatient therapy services, including physical and occupational therapy services, are generally covered when reasonable and necessary and when provided by physical and occupational therapists meeting the qualifications set forth at Sec.484.4. Services provided by qualified therapy assistants, including physical therapist assistants (PTAs) and occupational therapy assistants (OTAs), may also be covered by Medica

Submitter : **Date & Time:** 09/02/2004 04:09:01

Organization :

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Julio C. Gonzalez, MD
Central Indiana Orthopedics, P.C.
3600 West Bethel Avenue
Muncie, IN 47304

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1476-P
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Sir/Madam:

I am writing to express my concern over recent discussions about limiting providers of ?incident to? in physician clinics. If adopted, this proposal 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:

? 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.

? 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.

? The list of providers being recommended for this Medicare reimbursement is arbitrary. Any number of providers who can administer therapy in a physician?s office have education and credentials that exceed those held by PTAs and OTAs ? such as certified athletic trainers, nurses, nurse practitioners and physician assistants. This is not to suggest PTAs and OTAs are not qualified, but simply that other practitioners are at least as qualified.

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

In summary, it would not be advantageous for CMS to institute the changes proposed. This CMS recommendation would deter access to timely healthcare for our senior citizens.

Sincerely,
Julio Gonzalez, MD

CMS-1429-P-678

Submitter : Dr. Mark Skrade **Date & Time:** 09/02/2004 04:09:23

Organization : Forest Institute

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

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

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

CMS-1429-P-679

Submitter : **Date & Time:** 09/02/2004 04:09:38

Organization :

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I strongly endorse any and all measures to limit the performance of physical therapy procedures to those and only those individuals who have completed the professional education and licensure requirements as outlined by the American Physical Therapy Association and each state licensure board. Without proper training and supervision patients are exposed to potential hazards while under the impression they are receiving therapy from a fully trained professional. I have seen situations where well-meaning "practitioners" have improperly applied physical therapy modalities generally with the phylosophy that "if a little is good a lot must be better". This generally comes from an incomplete understanding of the physics and physiological effects of these modalities. Some of these instances have occurred within the immediate supervision of a physician many of which lack training in this aspect of medicine. Practitioners such as Physical Therapy "aides", LPN's, Athletic Trainers, and even PA's and Nurse Practitioners are often "OJT'd" to apply physical therapy procedures. While many of these providers do have extensive medical education and/or experience, that training tends to lack the in-depth understanding of the principles that physical therapy has been built upon.
Liken this situation to keeping your house "healthy". You do not hire a carpenter to fix your plumming nor a plummer to remodel your kitchen. Why then, would you want anything less than a fully trained physical therapy professional to entrust your health to?
Please support CMS's bill to limit the application of physical therapy to only those individuals that have successfully completed all required education and licensure procedures. Thank You

Submitter : Dr. Vanessa Honn **Date & Time:** 09/02/2004 05:09:29

Organization : Dr. Vanessa Honn

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

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

Psychologists consistently receive extensive training in psychodiagnostic testing as part of the requirements for the PhD degree, leading to clear expertise in the uses and limitations of psychological tests. In contrast, physicians rarely have any formal training in the use of standardized psychological tests. Based on this difference in training, psychologists have superior expertise in this type of testing and should be permitted to supervise others
administering and scoring such tests.

I strongly urge you to enact the proposed rule change.

Thank you.

CMS-1429-P-681

Submitter : Dr. Robert Schulte **Date & Time:** 09/02/2004 05:09:17

Organization : University Associates, PC

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please protect the consumer from receiving physical therapy services from others who are not licensed physical therapists or physical therapy assistants. If a physician is licened as a physical therapist they should be able to provide those services to their patients. However, if they are not licensed they should refer these services to licenced physical therapy providers are are trained to provide these profesional services. The incident to loophole is not in the best interest of the patient. The ability to practice physical therapy should be from those who are trained in a professional program to do so. This should be the standard for any profession to protect the consumer.

CMS-1429-P-682

Submitter : Dr. Charles Faltz **Date & Time:** 09/02/2004 05:09:56

Organization : California Psychological Association

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists are the best trained health professional to supervise non-psychologists in carrying out diagnostic psychological and/or neuropsychological testing. An understanding of the reliability and validity of these tests as well as their interpretation requires highly the highly specialized expertise of doctorally trained psychologists. Without this kind of oversight, the quality of this health service cannot be maintained and patients are at risk.

Submitter : Dr. Mary (Molly) Warner **Date & Time:** 09/02/2004 05:09:45

Organization : Children's Hospital, Seattle

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I fully support the plan to allow psychologists to supervise technicians in the administration and scoring of psychological tests. This is an important part of my practice and allows me to contrate on the important issues of data interpretation. Molly Warner, Ph.D./ABPP, Treasurer, Pacific Northwest Neuropsychological Society, and Neuropsychologist, Children's Hospital, Seattle.

CMS-1429-P-684

Submitter : Mr. Michael Mandich **Date & Time:** 09/02/2004 06:09:07

Organization : Mr. Michael Mandich

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

The changes proposed regarding incident to therapy are unprecedented and threaten the health and way of life for many Americans. To suggest that a physician would jeopardize his/her license by allowing an unqualified practitioner treat patients is asinine. With the current shortage of healthcare providers in our country, CMS proposes further limiting patient acess. Why? In making these proposed changes CMS threatens to grant a narrow group of practitioners exclusive access to patients. This is neither to the benefit of patients nor CMS, as it will prevent patients from recieving timely care, delaying the healthcare process and increasing costs to CMS. Please do not put Americans out of work by approving these changes.

Sincerely,
Michael J. Mandich, ATC

CMS-1429-P-684-Attach-1.doc

Michael J. Mandich, ATC
413 Fenmore Court
Genoa City, WI 53128

September 2, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam: jeopardize

I am extremely concerned and upset over the recent proposal to limit providers of "incident to" services in physician offices and clinics. If adopted, 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. It is imperative that physicians continue to make decisions in the best interests of the patients.

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

Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor's or master's degree*** from an accredited college or university. 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, or greater than, other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners.

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 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.

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,
Michael Mandich

Submitter : Mr. Keith Wiedrich **Date & Time:** 09/02/2004 06:09:53

Organization : MSU Moohread/MeritCare Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-685-Attach-1.doc

Keith Wiedrich
1115 25th Ave S.
Moorhead, MN 56560

September 2, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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

qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest

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

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

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

Sincerely,

Keith Wiedrich

1115 25th Ave. S.

Moorhead, MN 56560

Submitter : Dr. **Date & Time:** 09/02/2004 07:09:15

Organization : Dr.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists are well-qualified, moreso than other health care providers, to administer psychological tests and interpret them. More specifically, neuropsychologists have particular expertise and experience, through didactic and practical training, in neuropsychological assessment, including the administration and interpretation of intellectual, cognitive, behavioral and personality/mood measures, and they are quite capable of supervising non-psychologists such as technicians and students in test administration. Although there are some physicians with specific training in neuropsychology, most do not have the expertise required to supervise nonpsychologists in testing, even if they have proficiency in neurology and brain-behavior relationships. Test administration is "harder than it looks" and requires knowledge of each individual test and its purpose in the evaluation, understanding of standardized administration and when to deviate from that, if necessary, the ability to maximize each individual's performance while working within specific administration guidelines, strong interpersonal skills, attention to detail in test scoring and continued practice and retraining. If CMS believes (neuro)psychologists to be capable of practicing (neuro)psychology, then they should be deemed to be capable of supervising others in this domain as well.

Submitter : Dr. Karen Wilhelm **Date & Time:** 09/02/2004 07:09:25

Organization : WakeMed

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

To Whom it May Concern:

I am a clinical neuropsychologist in Raleigh, North Carolina. I am writing to express my full support of the Centers for Medicare and Medicaid Services' proposed rule change that will allow for the supervision of psychological and neuropsychological testing by doctoral level psychologists.

As a doctoral level neuropschologist, I have undergone extensive training in the science of brain/behavior relationships. My graduate training has allowed me, and my fellow neuropsychologist colleagues, to develop a specialized, unique area of expertise that is generally not shared by our medical colleagues in other fields and specialties. Because of this training, I believe neuropsychologists are in a unique position to direct test selection and perform interpretation of psychological and neuropsychological test results that have been collected by non-doctoral level personel, who assist with the technical aspects of these assessments. These individuals would simply administer and score the tests as directed by the neuropsychologist, who would then interpret the test results, and be fully responsible for the accuracy, validity, and overall quality of all aspects of the assessment provided under the supervision of the doctoral-level psychologist. Such an arrangement is akin to an x-ray technician, or a phebotomist who is directed by a physician to take an x-ray of a specific body part, or to draw blood for a certain lab test. The actual direction of the activity, interpretation of results, and ultimate culpability lies with physician.

As currently written, CMS policy requires that the neuropsychologist personally adminster all tests to all Medicare and Medicaid patients. Unfortunatly, this policy in effect limits the number of Medicare and Medicaid patients that any one provider can serve, and may serve to limit access to care provided to Medicaid and Medicare patients by a neuropsychologist or psychologist. I strongly urge you to approve the proposed rule change (CMS-1429-P).

Thank you for you attention to this matter.

Sincerely,

Karen L. Wilhelm, Ph.D.
Licensed Psychologist
Clinical Neuropsychologist
WakeMed Rehab
3000 New Bern Avenue
Raleigh, North Carolina, 27616

Submitter : Dr. daniel gripshover **Date & Time:** 09/02/2004 07:09:59

Organization : Dr. daniel gripshover

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

9/2/04

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

RE: Proposed Supervision Rule Change of Neuropsychological Testing

Dear Centers for Medicare and Medicaid Services:

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in

neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

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

Sincerely,
Daniel Gripshover, Ph.D.
Neuropsychologist
PO Box 17277
Ft. Mitchell, KY 41017

Submitter : Dr. GLoria Miele **Date & Time:** 09/02/2004 08:09:54

Organization : Columbia University

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Clinical psychologists should supervise technicians who conduct diagnostic psychological tests. The training and expertise of a clinical psychologist in selecting, administering and interpreting psychological should be applied in these circumstances.

CMS-1429-P-690

Submitter : Kenneth Fine **Date & Time:** 09/02/2004 08:09:38

Organization : George Washington University

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

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

During the decision-making process, consider the following:

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

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

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

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

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

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

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

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

CMS does not have the statutory authority to restrict who can and cannot provide services ?incident to? a physician office visit. This action could be construed as an unprecedented attempt by CMS to seek exclusivity as a provider of physical therapy services.

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

These issues may lead to more physician practices limiting medicare patients in their practice.

Submitter : Mrs. Montessa Spohn **Date & Time:** 09/02/2004 08:09:23

Organization : Healthsouth (LATC)

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please reconsider this issue you will be hurting patient care and possibly raisings costs. This initiative eliminates qualified health care professional namely ATC's and will ultimately hurt Medicare recipients. Please see attached file

CMS-1429-P-691-Attach-1.doc

National Athletic
Trainers' Association

Montessa Spohn LATC
Healthsouth
125 North Main
Belchertown MA 01007

September 15, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system. You would be eliminating other qualified highly trained health care providers just to help one special interest group. Don't let them fool you into thinking they are the only qualified healthcare providers. As certified athletic trainers we provide many services that would help care for Medicare patients

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.***

- 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.***

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

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

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

- 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,
Montessa Spohn

Submitter : Dr. Shari Altum **Date & Time:** 09/02/2004 09:09:50

Organization : Community Mental Health Center, Inc.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I would like to support the rule change allowing clinical psychologists to supervise appropriately trained technicians in the provision of psychological testing. Even more than physicians, psychologists have extensive specialized education and training in psychometrics, statistics, test construction, sampling theory, tests and measurement, individual differences, personality theory, and psychopathology. This training makes them an appropriate choice for supervising. This is particularly important in the rural area where I work. My agency employs only 2 psychiatrists who see the large majoity of clients in our 5 county area, covering 6 different offices. Thus, the availability of psychiatrists to be on site and supervise testing cases is quite a burden and often unrealistic. The addition of clinical psychologists as supervisors would ease this burden.

Respectfully,
Shari Altum, Ph.D., HSPP
Clinical Psychologist
Community Mental Health Center and
Rising Sun Medical Center
(812) 438-2555
fax (812)438-1236

CMS-1429-P-693

Submitter : Dr. steven tucker **Date & Time:** 09/02/2004 10:09:49

Organization : Medical oncology association of southern californi

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 1-9

SECTION 303

September 2, 2004

This is in response to the Federal Register volume 69, Number 150 / Thursday, August 5, 2004 / Proposed Rules publication. The Medical Oncology Association of Southern California (MOASC) is an advocate for, protects, and advances the interests of cancer patients and their treating physicians in providing effective and state of the art cancer care.

Since 1990, the Medical Oncology Association of Southern California (MOASC) has represented oncologists and their patients in affecting insurance company policies in facilitating and expanding the allowable coverage for many drugs and services required for cancer treatment, resulting in appropriate, state of the art access to cancer care. MOASC is recognized by the California Medical Association as the representative of the Southern California oncology community, as well as government and private insurers.

The Medicare Modernization Act of 2003 or 'the MMA,' signed into law in December 2003, is primarily intended to provide seniors and people living with disabilities with a prescription drug benefit. Included in the bill are provisions addressing payments for drugs and drug administration services that institute significant cuts to cancer care over the next 10 years.

MOASC's first priority is to ensure that cancer patients have access to the highest quality cancer care, including comprehensive community-based care.
CMS's interpretation of the MMA for 2005 underestimated the impact on community oncology. CMS estimated a negative impact of 2%-8% in 2005. Actual data from moderate sized practices, in Congressman Drier's district specifically, realized a negative impact of 12%-25%.
Because many drugs will not be able to be purchased at the ASP price listed by CMS, the patients' site of treatment has the potential to be shifted to the hospital.
Hospitals do not have the capacity to absorb the number of patients that require chemotherapy. Patients do not want their care delivered in the hospital.

We encourage a transition payment extension with a payment floor based upon 2004 levels while correcting the current proposal and implementing the ASP system.

If you have any questions or concerns, please contact us at the MOASC office (909) 985-9061.

cc: The White House; Mark McClellan, M.D.; California Congressman and Senators; Rep. Nancy Johnson

CMS-1429-P-694

Submitter : Mr. Douglas Strand **Date & Time:** 09/02/2004 10:09:36

Organization : SwedishAmerican Infusion Services

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

This comment is related to CMS-1429-p, Sec.305

I am a pharmacy manager with a home health agency based pharmacy. We currently provide nebulizer medications to approximately 70 patients, on a monthly basis, delivered to their residence. We also have respiratory therapists available to these clients. The services of the respiratory therapists are not billable to Medicare, but we offer help with initial training and equipment setup for nebulizer therapy
for COPD and emphysema patients. Our pharmacists and respiratory therapists are on-call to these patients 24hr/day for any emergency.
Our respiratory patient population is a very compliant group, and use and refill their medications very appropriately. I have been employed here 3 years, and have seen very few (less than 5) hospital readmissions for exacerbations of respiratory symptoms in this population.

The proposed cuts in reimbursement for inhalation drugs (ASP plus 6%)
will barely cover the cost of the medications, and with at least one drug will not even cover our drug cost. The previous system of AWP minus allowed us to cover our overhead (respiratory therapists, delivery and setup, clinical pharmacy monitoring, etc) and make a small profit. With the current proposed rule, we will not be able to provide the drug, let alone any of the necessary services.

The rationale that the majority of these patients could or should be managed using multi-dose inhalers is not sound. Our patient population is elderly, and most of them have been trialed on the MDI's with limited success at best. These inhalers are very difficult to use for someone with limited dexterity and strength of respiratory musculature.

The MDI's will not be covered by the new Part D until 2006, which leaves our patients struggling to purchase these items. Our experience is that this population has a difficult time affording their Medicare co-pay. They most likely will not be able to afford the MDI's.

I stand in favor of the dispensing fee for providers, but 5$/month is certainly not enough. In order for us to be able to provide reasonable services for these patients, dispensing fees in the range of $20-25 per month would be more appropriate. This would work best if the three month dispensing clause is left in place.

The bottom line as I see it is that unless some provisions are made to keep providers in this business, the hospital systems will be seeing many of these patients in the emergency rooms and clinics, secondary to symptom exacerbation. Many will be admitted for care, and CMS will be spending more dollars for these hospital admissions than they could save by cutting the reimbursement for inhalation drugs to providers.

Thank you for considering my comment.

Submitter : Mrs. Jami AuBuchon **Date & Time:** 09/02/2004 11:09:59

Organization : National Athletic Trainer's Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-695-Attach-1.doc

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

Jami AuBuchon, M.Ed., ATC/L
5 Trestlewood Ct. #3
Columbus, GA 31909

September 2, 2004

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

Re: Therapy – Incident To

Dear Sir/Madam:

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

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

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- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
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- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license

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

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

Jami AuBuchon, M.Ed., ATC/L

5 Trestlewood Ct. #3
Columbus, GA 31909

CMS-1429-P-696

Submitter : Dr. Kurt Moehle **Date & Time:** 09/03/2004 01:09:12

Organization : Dr. Kurt Moehle

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

psychologists must be allowed to generally supervise testing technician if psychological testing is to be used in any kind of cost-effective way. This has been a tradition among neuropsychologist for over 40 years and is a well established precedent.

CMS-1429-P-697

Submitter : Dr. Jane Sachs **Date & Time:** 09/03/2004 01:09:10

Organization : Dr. Jane Sachs

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

This proposed rule change has my avid support, because there is simply no question that psychologists have the greatest level of expertise in testing and therefore are the best qualified
to supervise others performing such tests.

CMS-1429-P-698

Submitter : Dr. Richard Ruth **Date & Time:** 09/03/2004 01:09:44

Organization : Dr. Richard Ruth

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support allowing psychologists to charge for supervising QUALIFIED/TRAINED technicians, psychology associates (and persons in similar categories in states other than Maryland), and paraprofessionals assisting psychologists in performing diagnostic psychological tests, and services performed by these kinds of "psychologist extenders" under psychologist supervision. Parallel to what physicians are now allowed to do, this will help make psychological services more accessible to more consumers, with no sacrifice in quality as with the current regulations, which permit physicians to supervise such persons, though physicians with few exceptions have no training to understand how to give and interpret psychological tests, much less to supervise others in doing so. I ALSO recommend that there be a tiered payment system, where elements of diagnostic testing requiring the direct service of a psychologist are reimbursed at a higher rate than elements that can be performed by lesser trained persons. My comments apply to both psychological and neuropsychological testing. Your curent reimbursement rates are so low that many psychologist Medicare providers in my area refuse to perform diagnostic testing for Medicare patients; they simply cannot afford to do so. If this important service and it is very importanbt, sometimes lifesaving is to continue to be available, something has to give. Thank you for considering my views.

Submitter : Dr. Molly Hauck **Date & Time:** 09/03/2004 01:09:31

Organization : Dr. Molly Hauck

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Current Federal regulations require physician supervision when anyone other than a psychologist (e.g., a technician or other staff person) performs psychological or neuropsychological testing. Psychologists
have the greatest level of expertise in testing and therefore are the best qualified to supervise others performing such tests. Physicians do not know how to do psychological testing, so they are not qualified to supervise people doing it. Please change the current rule.

Submitter : Dr. Andrew Burns **Date & Time:** 09/03/2004 01:09:09

Organization : Dr. Andrew Burns

Category : Individual

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

As a trained and studied psychologist, I am sure that in the best interest of all parties involved, only a licensed psychologist should supervise the administration, interpretation, and conveyance of psychological testing to interested and appropriate parties. The nature of psychological testing/assessment warrants a comprehensive and well trained understanding of the theories behind such testing that can only be provided by those of us who have devoted our careers to such. It would be costly to all involved and future such involved parties to enable those without the specified trainig and education in the area of psychology to offer supervision and traing in this domain. Misinterpretation and inappropriate diagnoses will lead to poorly prescribed treatment plans and ineffective and quite possible damaging treatment(s). Please strongly consider this arguement and do not support the supervision and/or adminstration of psychological assessment to anyone other than a licensed psychologist.