



Via Hand Delivery

September 24, 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

Regarding: **Therapy--Incident To**

Dear Sir/Madam:

On behalf of the 30,000-member National Athletic Trainers' Association (the NATA), I am pleased to share our comments on the Centers for Medicare and Medicaid Services (CMS) proposal to limit providers of "incident to" therapy services in a physician's office. The proposed rule, which was initially discussed in 2003<sup>1</sup> and formally proposed by CMS on August 5, 2004,<sup>2</sup> proposes to amend the regulations to include the statutory requirement that only individuals meeting the existing qualification and training standards for therapists under 42 Code of Federal Regulations Section (CFR) 484.4, pertaining to personnel qualifications of therapists in home health settings, qualify to provide therapy services incident to physicians' services.

#### **I. Summary of the NATA's Position.**

As outlined below, the NATA objects to the adoption of this proposed rule as the proposed rule is inconsistent with the intent of Congress and past CMS/Health Care Financing Administration (HCFA, hereinafter both CMS and HCFA shall be referred to as CMS) regulations and policies as they relate to Section 1862(a)(20) of the Social Security Act (the Act). Furthermore, it is NATA's position that if this proposed rule is adopted it will reduce access to therapy services for Medicare beneficiaries, reduce the quality of the therapy services that are available, and increase costs to both the Medicare program and Medicare beneficiaries.

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<sup>1</sup> 68 Fed.Reg. 49029, 49059 (August 15, 2003).

<sup>2</sup> 69 Fed.Reg. 47487, 47550 (August 5, 2004).

## **II. The Proposed Rule is Inconsistent with Congressional Intent and CMS Regulations.**

Not only does NATA believe it inappropriate to apply standards developed for a provider of services such as a home health agency to a service provided in a physician's office, but the application of these standards runs contrary to a specific Congressional directive and long-standing CMS regulations and policy. NATA also finds it unreasonable and a possible violation of the Administrative Procedures Act that CMS is substantially changing a rule that has been in place since 1998 and informing the public (including Members of Congress) that this change constitutes merely a "clarification" of long-standing Medicare policy.

### **A. 1994 OIG Report and Balanced Budget Act of 1997.**

In 1997, Congress adopted Section 4541(b) of the Balanced Budget Act (BBA).<sup>3</sup> Although there is little in the way of Congressional history associated with this provision, it seems quite apparent that it gets its genesis from the 1994 Office of Inspector General (OIG) Report entitled, "Physical Therapy Services Provided in Physicians' Offices" (the Report).<sup>4</sup>

This Report, as the notice of proposed rulemaking (NPRM)<sup>5</sup> notes, was highly critical of CMS and its failure to develop adequate safeguards to ensure that physical therapy services provided in the physician's office were medically necessary and appropriate.<sup>6</sup> The Report, which was a study that compared beneficiaries who received "physical therapy services in independently practicing physical therapists' offices" with beneficiaries who received services "in physicians' offices," found that in many cases, the need for the therapy services were poorly documented, or not necessarily related to the underlying medical problem the therapy was attempting to address.<sup>7</sup>

The Report recommended that CMS apply "its existing coverage guidelines for other settings to physicians' offices" and refers specifically to requirements related to treatment plan with goals, restorative-nonpalliative care, and frequency and duration of services.<sup>8</sup> Significantly, the Report did not address the issue of who actually performed the service<sup>9</sup> and drew no conclusions as to whether care was more appropriately provided in physicians' offices when furnished by a physical therapist as opposed to other auxiliary personnel. To the extent that Congress was simply trying to correct problems identified by the Report, there are no findings in the Report that there was a problem with "incident to" services performed by non-therapists under the physician's supervision. The Report explicitly states that its specific findings do not relate to who actually performed or supervised the service.<sup>10</sup>

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<sup>3</sup> Balanced Budget Act of 1997 § 4541(b).

<sup>4</sup> Department of Health and Human Services' Office of Inspector General's Report, "Physical Therapy Services Provided in Physicians' Offices" (March 1994).

<sup>5</sup> *Supra*, note 2.

<sup>6</sup> The Report, *supra* note 4.

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*; see ASPE letter, Attachment B.

<sup>10</sup> *Id.*; see ASPE letter, Attachment B.

The OIG concluded that the problem was that the law did not require physical therapy provided "incident to" to meet the same coverage conditions applicable to other outpatient therapy providers related to treatments plans, goals, and restorative care.<sup>11</sup> These are the conditions the NATA believes Congress had in mind when it passed BBA Section 4541(b).

In 1997, Congress, through Section 4541(b) of the BBA, mandated that CMS adopt similar standards for therapy services provided in a physician's office "incident to" a physician as were already in place for physical therapist services – in private practice. Significantly, Congress excluded the requirement that the provider be licensed to provide these services. Furthermore it is essential that CMS recognize the specific section of the Medicare statute that Congress referenced – the second sentence of Section 1861(p) of the Act when mandating this comparability.

As a result of this directive, CMS adopted Section 1862(a)(20) of the Act, which reads as follows:

“...outpatient physical therapy services furnished as an incident to a physician's professional services (as described in section 1861(s)(2)(A) of this title), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1861(p) of this title.”

The second sentence of Section 1861(p) of the Act was adopted to ensure that physical therapists in private practice could be reimbursed for their services. It is not surprising that Congress chose to reference this section of the law as this is the practice setting that is most similar to the physician's office – not a hospital, nursing home, comprehensive outpatient rehabilitation facility, and certainly not a home health agency as CMS would now seek to require. Furthermore, as noted above, the physical therapy private practice setting was the setting used for the comparative analysis undertaken by the OIG in its 1994 Report.

Section 4541(b) of the BBA requires that "standards and conditions" applicable to outpatient physical therapy provided under the second sentence of Section 1861(p) of the Act apply to therapy services incident to the physician's service "as such standards and conditions would apply to such therapy services if furnished by a therapist."<sup>12</sup> Implicit in the statutory language is the recognition that the "incident to" services are not necessarily furnished by therapists. Therefore, to interpret Section 1862(a)(20) of the Act as requiring incident to services to be provided or supervised by therapists is inconsistent with the Congressional intent of BBA Section 4541(b).

BBA Section 4541(b) specifically instructs that standards and conditions related to licensing requirements shall not apply to therapy provided "incident to" physicians' services. This means that those standards and conditions which require that outpatient physical therapy be performed by a licensed physical therapist do not apply.<sup>13</sup> What does apply are those substantive standards and conditions that are described in Section 1861(p) of the Act and in regulations at 42 CFR 410.60, *et*.

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<sup>11</sup> *Id.*

<sup>12</sup> Social Security Act § 1861(p).

<sup>13</sup> *See, e.g.*, 42 CFR 410.60(a)(3)(ii); 486.150 and 486.157(b).

*seq.* and in the Medicare Carriers Manual (MCM).<sup>14</sup> These substantive standards relate to treatment plans, the need for goals, and to the requirement that the therapy be restorative - the very issues that were the focus of the Report.

Also in effect at the same time CMS enacted Section 1862(a)(20) of the Act was 42 CFR 484.4, the provision pertaining to qualifications for home health care providers. As a result, Congress had the opportunity to instruct CMS adopt the home health standards under Section 484.4, but it did not. By attempting to amend 42 CFR 410.60 to mirror 42 CFR 484.4, CMS is directly undermining the specific intent of Congress when it enacted BBA Section 4541(b).

Additionally, in May 1998, CMS issued Transmittal No. 1606 (Transmittal 1606) of the Medicare Carriers Manual, Part 3-Claims Process. As result of Transmittal 1606, Section 2218(A) of the MCM requires that physical therapy services provided by a physician or an incident-to employee of the physician in the physician's office or the beneficiary's home must be provided by, or under the direct supervision of, a physician (a doctor of medicine or osteopathy) who is legally authorized to practice physical therapy services by the State in which he or she performs such function or action.<sup>15</sup> These requirements have been in effect since 1998.

Courts have consistently held that if an agency adopts a policy in response to a Congressional mandate and Congress, in the intervening years, does not seek to overturn or change that policy, then the courts will view that the agency has complied with Congressional intent.<sup>16</sup> The policy adopted by Transmittal 1606 continues to be the language found in the MCM. Since 1997, Congress has passed at least three Medicare bills and each year has passed an appropriations bill setting the budget for CMS. Two separate Presidents have signed those bills into law. Congress has never adopted statutory language or report language in any of those laws directing CMS to change the policy adopted by Transmittal 1606 or given any indication that the policy incorporated into that transmittal was not reflective of Congressional intent. Consequently, without sufficient evidence or justification for the proposed rule, CMS's actions are inconsistent with and undermine the Congressional intent of BBA Section 4541(b).

## **B. The Proposed Rule is Inconsistent with CMS's Own Commentary.**

Since the enactment of Section 1862(a)(20) of the Act, CMS has had several occasions to issue policies and comment on the requirements of BBA Section 4541(b) and Section 1862(a)(20) of the

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<sup>14</sup> See Medicare Carrier's Manual §§ 2050, 2200, 2203, 2206, 2210, 2218.

<sup>15</sup> See Medicare Carrier's Manual §§ 2218.

<sup>16</sup> *Northrop Grumman Corp. v. U.S.*, 47 Fed. Cl. 20, 39, 2000 U.S. Claims LEXIS 125 (June 16, 2000) "When Congress fails 'to revise or repeal [an] agency's interpretation,' its inaction provides 'persuasive evidence that the interpretation is the one intended by Congress.' Citing *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 274, 40 L. Ed. 2d 134, 94 S. Ct. 1757 (1974). Also see *U.S. v. Riverside Bayview Homes, Inc.*, 474 U.S. 121, 106 S. Ct. 455, 88 L. Ed. 2d 419, (1985) "Although we are chary of attributing significance to Congress' failure to act, a refusal by Congress to overrule an agency's construction of legislation is at least some evidence of the reasonableness of that construction, particularly where the administrative construction has been brought to Congress' attention through legislation specifically designed to supplant it." Also see *Bob Jones University v. United States*, 461 U.S. 574, 599-601 (1983); *United States v. Rutherford*, 442 U.S. 544, 554, and n. 10 (1979).

Act. The proposed rule is inconsistent with CMS's past position on and interpretation of BBA Section 4541(b) and Section 1862(a)(20) of the Act.

For instance, CMS published Section 2218 of Chapter 2 of the MCM, which clearly sets forth the standards that must be met in order for a therapy service provided in the physician's office (whether by a physician or person providing the service "incident to" the physician). The provider requirements are summarized at the beginning of Section 2218 and are as follows:

Physician employees, under these guidelines, must meet all incident-to requirements set forth in §2050. For physical therapy standards applicable to physical therapists in independent practice see §2215. For occupational therapists in independent practice see §2217. For physical therapy standards for approved clinics, rehabilitation agencies, and public health agencies as well as participating hospitals, SNFs, and HHAs see §§2200, 2203, 2206, and 2210.

These requirements were adopted specifically in response to the Congressional mandate set forth in BBA Section 4541(b). Section 2218 of the MCM provides very explicit instructions on the standards required for the provision of therapy services. There are no educational criteria mentioned for "incident to" employees of the physician and none were required by BBA Section 4541(b).

Next, CMS issued final rules in November of 1998 that contained specific references to the BBA Section 4541(b) "incident to" requirement. For example, in response to public comments speaking directly to this issue, CMS stated,

As previously stated, section 4541(b) of the BBA 1997 amended section 1862(a) of the Act to require that outpatient physical therapy services (including speech-language pathology services) and occupational therapy services furnished "incident to" a physician's professional services meet the standards and conditions (other than any licensing requirement specified by the Secretary) that apply to therapy services furnished by a therapist. In May 1998, we issued Transmittal No. 1606 of the Medicare Carriers Manual, Part 3--Claims Process which implemented this provision that was effective January 1, 1998. Section 2218(A) of the Medicare Carriers Manual requires that physical therapy services provided by a physician or by an incident-to employee of the physician in the physician's office or the beneficiary's home must be provided by, or under the direct supervision of, a physician (a doctor of medicine or osteopathy) who is legally authorized to practice physical therapy services by the State in which he or she performs such function or action.<sup>17</sup>

Finally, CMS also discussed the potential for adopting standards in addition to licensure as a condition of coverage for physical therapists in private practice – the most analogous example to physicians in private practice. CMS rejected this idea noting,

We understand that all States license or certify physical therapists, so no alternative personnel qualifications need to be specified.<sup>18</sup>

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<sup>17</sup> 63 Fed.Reg. 58813, 58870 (November 2, 1998).

<sup>18</sup> *Id.*

The proposed rule is inconsistent with these examples of CMS' prior comments concerning these provisions. Furthermore, without justification or evidence of quality or cost concerns that necessitate the proposed changes, CMS's actions in proposing this rule are inappropriate and in direct defiance a Congressional directive.

**C. CMS Incorrectly Represents the Requirements of 42 CFR 484.4.**

CMS asserts that it is endeavoring to develop consistent standards, stating that

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 [42 CFR Section] 484.4.<sup>19</sup>

This citation is presented as the basis for extending the standards of Section 484.4 to the physician's office. However, NATA believes CMS has misstated the requirement of Section 485.705 and it's relevance to this proposal. Furthermore, it is worth noting that at one time, Section 485.705 did apply to physical therapists in independent practice (later revised to private practice) and CMS removed the additional educational requirements from the physical therapist conditions of participation.

Section 485.705 establishes conditions of participation for clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services. The regulation reads as follows:

Except as specified in paragraphs (b) and (c) of this section, all personnel who are involved in the furnishing of outpatient physical therapy, occupational therapy, and speech-language pathology services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which they perform the functions or actions, and must act only within the scope of their State license or State certification or registration.<sup>20</sup>

The relevant paragraph for purposes of this discussion then is paragraph (c), which reads as follows:

(c) Exceptions when no State Licensing laws or State certification or registration requirements exist. If no State licensing laws or State certification or registration requirements exist for the profession, the following requirements must be met--

- (1) An administrator is a person who has a bachelor's degree and:
  - (i) Has experience or specialized training in the administration of health institutions or agencies; or
  - (ii) Is qualified and has experience in one of the professional health disciplines.
- (2) An occupational therapist must meet the requirements in part 484 of this chapter.

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<sup>19</sup> *Supra*, note 2.

<sup>20</sup> 42 CFR 485.705.

- (3) An occupational therapy assistant must meet the requirements in part 484 of this chapter.
- (4) A physical therapist must meet the requirements in part 484 of this chapter.
- (5) A physical therapist assistant must meet the requirements in part 484 of this chapter.<sup>21</sup>

I have underlined the sections of the regulation that apply. Note that Section 484 is only relevant “if no state licensing law or state certification or registration requirements exist.” In 1998, as now, licensure, certification or registration existed for physical therapists in all fifty states. Congress had access to this information and still chose to instruct CMS otherwise. When Congress instructed CMS to adopt standards consistent with the standards for outpatient physical therapy, explicitly excluding licensure, they did not need to explicitly extend that exception to any other education standards that might have existed in other settings (i.e. home health) because licensure was the standard that was relevant to physical therapists. Therefore, since government agencies cannot arbitrarily interpret unambiguous statutory language, CMS’ representation of the requirements of 42 CFR Section 484.4 is incorrect.

#### **D. Incident To Services Under the Medicare Program.**

In addition to being inconsistent with the statute and with Congressional intent of BBA Section 4541(b) and Section 1862(a)(20) of the Act, any interpretation of BBA Section 4541(b) which requires physical therapists to provide or supervise "incident to" services would be inconsistent with well-established law and policy related to "incident to" billing.

Section 1861(s) of the Act defines medical and other health services covered in Medicare Part B. Section 1861(s)(2)(A) of the Act covers "services and supplies furnished as an "incident to" a physician's professional service and which are commonly furnished in the physician's office and either rendered without charge or included as an element in the physician's bill for his or her own services."<sup>22</sup> Medicare regulations at Section 414.34 specify that "services of nonphysicians that are covered as incident to a physician service are paid as if the physician had personally furnished the service."<sup>23</sup> Physician services are defined in the statute as services of MD's, DO's, podiatrists (and others), furnished within the scope of practice authorized under a state license.<sup>24</sup> The scope of physician practice, at least for DO's and MD's, includes services by the physician assisted by supervised office employees. Section 410.20 defines covered physician services and specifically refers to "therapy" services.<sup>25</sup>

The MCM provisions elaborate further on the statute and regulations regarding services incident to a physician's service. They require that services incident to physicians’ services be "an integral and incidental part of a physician's professional service in the course of diagnosis or treatment."<sup>26</sup> Services and supplies in a private physician's office practice can be considered incident to the physician’s professional service "only where there is direct, personal supervision by the

<sup>21</sup> *Id.* (emphasis added).

<sup>22</sup> Social Security Act § 1861(s)(2)(A).

<sup>23</sup> 42 CFR 414.34(d) (emphasis added).

<sup>24</sup> Social Security Act Section 1861(r).

<sup>25</sup> 42 CFR 410.20.

<sup>26</sup> Medicare Carriers Manual, §§ 2050.1 and 2050.2. (emphasis added).

physician."<sup>27</sup> The supervision requirement applies to all auxiliary personnel including physical therapists regardless of whether their scope of practice under state law allows them to provide care without supervision.<sup>28</sup> These provisions clearly establish that an "incident to" service is a physician service with the auxiliary personnel serving as an extension of the physician's service.

Nothing in the BBA changes the law with respect to "incident to" services. Moreover, Section 4541(b) specifically refers to physical therapy services provided incident to the physician's service under Section 1862(s)(2)(A) of the Act. Services incident to a physician's professional services are physician services. Under Medicare law and policy as set forth above, inclusion of services of a nonphysician must be as an incidental part of the physician service under direct personal supervision of the physician.

If CMS were to interpret BBA Section 4541(b) to require that physical therapy provided incident to a physician's service be provided by a therapist or be supervised by a therapist, this would be inconsistent with CMS requirements for "incident to" services because services incident to a physician service must be supervised by the physician. The result would be to turn a physician service into an independent practicing therapist service. This was clearly not the intent of Congress in enacting BBA Section 4541(b).

### **III. NATA's Public Policy Concerns**

Beyond the legal arguments outlined above, NATA objects to this proposed rule based on the fact that it represents poor public policy and would be a step backwards in efforts to improve beneficiary choices and access to care, efforts to improve quality of care, and initiatives to combat increasing health care costs.

#### **A. Access, Quality and Cost Concerns.**

If adopted, the proposed rule would have a detrimental effect on patient access to and quality of care. The proposed rule would likely render physicians unable to provide their patients with comprehensive, easily attainable therapy services within their facilities. For instance, if physicians do not employ a health care professional to deliver outpatient therapy services, patients would likely be forced to see the physician and separately seek therapy treatments at another facility. The result would be additional expense and inconvenience to the patient, as well as additional expense to Medicare. Many patients would likely forego therapy services altogether for these reasons. Moreover, patients may not receive a variety of services, such as preventative care, if they have no access to incident to services delivered by allied health care professionals often provided in physicians' offices.

According to the American Hospital Association (AHA), our country is currently experiencing a critical shortage of physical therapists. Hospitals are offering so-called signing bonuses in excess of \$10,000 dollars to recruit physical therapists and finding no takers for these positions. Institutions are reporting increasing numbers of vacant physical therapist positions and the length of time to fill a

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<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

vacant physical therapist position can be anywhere from 6 – 12 months. While this may be good news for physical therapists it is not good news for patients in need of therapy services – particularly rural patients where the availability of physical therapists appears particularly acute.

In a June 2004 letter to Senator Maria Cantwell, endorsing legislation the Senator proposed to increase federal support for allied health education, the AHA wrote,

Hospitals and health care facilities across America are experiencing a critical shortage of allied health professionals, including occupational and physical therapists, clinical laboratory technologists, imaging technicians, pharmacy technicians, and radiology technologists, to name a few.<sup>29</sup>

Similar to the experience of hospitals, physicians find it increasingly difficult, if not impossible, to find a physical therapist who would be willing, let alone available, to provide physical therapy in the physician's office. In fact in some states, it is illegal for physicians to employ physical therapists or have a financial relationship with a physical therapist. Even in states that allow physicians to employ physical therapists, the physical therapists have little incentive to accept less pay when they can bill independently and are in such high demand. Furthermore, the American Physical Therapy Association (APTA) is diligently lobbying for state and federal "direct access" legislation where it has not already succeeded. If this endeavor is successful, access to physical therapists through physicians will be even more problematic.

The proposed rule will ultimately cause the costs associated with therapy services to increase because fewer health care workers would be available to deliver services. Therefore those limited providers who are deemed "qualified" will likely raise their prices as a result of the monopoly this proposed rule would create. This is unwise because current and future labor trends indicate a substantial shortage of qualified health care workers, especially in rural areas. This places an undue burden on the health care system.

This is exactly the type of government regulation of allied health professionals upon which the recently issued report by the Federal Trade Commission and the Department of Justice casts doubt. Although such report is more particularly directed toward state licensure and registration restrictions, it shows that the proposed rule at issue here would likely lead to anticompetitive behavior and is ultimately harmful to consumers, both patients and payors (i.e. Medicare).<sup>30</sup>

The NATA maintains that a wide range of health care professionals are well qualified to provide "incident to" therapy services. The CMS proposal includes some of these professionals (physical therapists and physical therapy assistants, occupational therapists and occupational therapy assistants, speech and language pathologists) – **but other groups are equally as qualified and capable, including certified athletic trainers, rehabilitation nurses, kinesiologists and exercise therapists.**

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<sup>29</sup> Personal Communication, letter from American Hospital Association to U.S. Senator Maria Cantwell, June, 2003

<sup>30</sup> Federal Trade Commission and Department of Justice Report, "Improving Healthcare: A Dose of Competition," (July 23, 2004).

If enacted, the patients will ultimately suffer the consequences. If physicians cannot offer therapy services in their offices, there will be an adverse impact on patient access to care. In rural areas and certain areas with an extremely limited number of physical therapists, the adverse impact on access to care will be more obvious to patients. Likewise, patients will suffer a decrease in quality of care and eventually an increase in cost of care.

The APTA itself provides evidence in support of this position in testimony to the CMS Practicing Physician's Advisory Council (PPAC). In relevant part, the testimony reads as follows:

**The need for a physician visit every 30 days is arbitrary and problematic. In many instances, it takes a week or two before the patient is able to see the physical therapist after seeing the physician. After receiving two weeks of treatment, the 30 days expires, and the patient then needs to see the physician again in order to continue treatment. Returning to the physician's office in this time frame is an inconvenience to the patient and the physician. It is particularly problematic in rural areas, where the patient may have to travel a long distance to get to a physician's office.<sup>31</sup>**

The argument from the physician's perspective is that the harm that will occur rests in the travel that is occurring if from a rural physician to an urban-based physical therapist rather than from an urban physician to a rural-based physical therapist. By making physical therapy services available in the physician's office, you increase the likelihood that the patient will utilize these medically necessary services and benefit from the care they are receiving.

The proposed rule is a serious threat to patients' access to therapy services, the quality of care the patient will receive, and the costs of health care services. This is especially true for elderly Medicare patients who do not have a great deal of flexibility due to physical or mental limitations, or transportation and supervisions requirements. It is a very real possibility that many patients will not receive medically necessary therapy services due to lack of access to these services, which will certainly adversely impact the quality of care they receive.

It is noteworthy that not once in the 2003 request for comments or the recent NPRM does CMS provide evidence that current providers of outpatient therapy services incident to physicians' services provide inferior-quality care. In fact, although provider "qualifications" are an issue, CMS relies on the fact that "there is currently no process to ensure the quality of the services provided in [these] settings,"<sup>32</sup> and the OIG's 1994 Report, which does not draw any conclusions about who provides the care or quality of care.<sup>33</sup> CMS does not provide any evidence that quality of care is a concern, that quality of care will improve, *or that quality of care will not diminish* if this proposed rule is adopted.

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<sup>31</sup> Public Testimony of APTA before the Practicing Physician's Advisory Committee, February 10, 2003.

<sup>32</sup> *Supra*, note 1

<sup>33</sup> *Supra* note 4; *see* ASPE letter, Attachment B.

## **B. Certified Athletic Trainers.**

Increasingly, physicians are turning to other health care professionals to provide therapy services to their patients for quality, access and cost reasons. One approach has been to hire certified athletic trainers to provide these services in the physician's office under the direct supervision of the physician. If the CMS proposal is adopted as currently proposed, physicians would not have this option.

As you may be aware, athletic trainers are used in urban and rural high schools throughout America. These health professionals are available to provide rehabilitation services to student athletes, school faculty and staff. It is increasingly common in many rural communities for the local primary care physician to hire the high school athletic trainer on a part-time basis to provide therapy services in the physician's office under an incident to arrangement. The physician is familiar with the work of the athletic trainer because the local physician is often the school's team physician. It is an efficient collaborative relationship between the physician and athletic trainer that develops on the playing field and extends to the physician's office.

This has allowed therapy services to not only be available to the high school athletes, faculty and staff in a rural community but to all residents of that community – including Medicare beneficiaries. The latest NATA data estimates that between 3,000 and 4,000 athletic trainers are employed either full-time or part-time in a clinical setting where they are providing therapy services.

By hiring certified athletic trainers (ATCs) and making these services available in the physician's office, physicians are making these services more easily accessible, at lower cost and with the same quality outcomes compared to patients who are being referred out to physical therapists in private practice.

A soon to be published study comparing utilization of ATCs with utilization of physical therapists in large group practice dramatically demonstrates the clinical and economic value of this clinical arrangement. A summary of the findings of this study has been attached for your review and consideration.<sup>34</sup>

As you will note, patients receiving therapy from an athletic trainer were restored to pre-injury status in a shorter time frame and at less cost than identical patients treated by a physical therapist.

By limiting the number of professionals who can provide "incident to" therapy services, the quality of health care for Medicare patients will be reduced – not because athletic trainers or other providers are better than physical therapists – there's no data to support that conclusion. Rather, the quality of care will decline because Medicare patients simply will not or cannot travel the distances necessary to obtain the therapy services they need. CMS cannot ignore the correlation between access and quality as it relates to these services or any other service for that matter.

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<sup>34</sup> See Attachment

We have even seen evidence of this in urban practices that utilize athletic trainers in the physician's office. When the athletic trainer informs the patient that he or she has the option of obtaining therapy services from a physical therapist in private practice if that is the patient's preference, the elderly patient will decline that option because it would mean taking a different bus or going to a different part of town to obtain the care being recommended. Consequently the patient chooses to remain in the familiar and convenient setting rather than travel to an unfamiliar or inconvenient location.

### **C. Education and Training of Certified Athletic Trainers.**

ATCs have national academic and certification standards. ATCs are highly skilled allied medical professionals who specialize in the prevention, assessment, treatment and rehabilitation of injuries and illnesses that occur to both the physically active and athletes, of all ages. All ATCs have a bachelor's degree, and more than 70 percent have a master's degree. Medically related continuing education is required to maintain certification. The American Medical Association has recognized ATCs as allied health care professionals since 1990.

ATCs work in a wide array of settings, including clinics, hospitals, physicians' offices, corporate health programs, secondary schools, colleges and universities, and professional athletics. ATCs satisfy stringent educational and experiential requirements, and are required to pass a daylong, three-part competency examination administered by the NATA Board of Certification (NATABOC). The NATABOC is reviewed and re-accredited every five years by the National Commission for Certifying Agencies.

The coursework for ATCs includes therapeutic modalities and exercise, risk management and injury prevention, pathology of injury and illnesses, pharmacology, nutritional aspects of injury and illness, and health care administration.

Further, most ATCs practice under the direction of a licensed physician. The Commission on Accreditation of Allied Health Education Programs (CAAHEP), which certifies programs representing 21 allied health education professions, accredits programs for athletic training based on input and approval of the American Academy of Family Physicians, the American Academy of Pediatrics, the American Orthopedic Society for Sports Medicine, and the NATA. CAAHEP provides that "the athletic trainer, with the consultation and supervision of attending and/or consulting physicians, is an integral part of the health care system associated with physical activity and sports."

To restrict "incident to" services to a small list of providers would be unreasonable, arbitrary and anti-competitive. It would also unreasonably restrain trade. In NATA's view, the delegation of "incident to" therapy services should remain at the discretion of the physician who is on site and directing the patient's care. Incident to billing should not be limited to a designated exclusive group of providers because to do so displays unwarranted favoritism to a select group of health care providers.

#### IV. What NATA Asks CMS to Consider.

NATA sincerely requests that CMS consider the following during its decision-making process:

? A physician has the right to delegate the care of his or her patients to trained individuals 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, individual patient, geographic location and labor pool.

? The physician signs off when "incident to" services are provided. This is a sufficient stamp of quality assurance for those procedures and no other means is needed. It would be highly counterproductive and unethical for a physician to designate unqualified providers to administer in-office therapy. It is imperative that **physicians** be allowed to continue to make decisions that are in the best interests of the patients.

? In many cases, the change to "incident to" therapy 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. This would create significant inconvenience and additional expense to the patient, and ultimately to Medicare.

? The U.S. 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 also, as mentioned above, cost the patient in time and travel expense. Most importantly, 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 will take away from the physician's ability to provide the best possible patient care in the shortest amount of time.

? To allow only physical therapists and physical therapy assistants, occupational therapists and occupational therapy 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 administer therapy in a physician's office have education and credentials that exceed those held by physical therapy assistants and occupational therapy assistants -- 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.

**V. Summary of NATA's Position.**

In summary, NATA is deeply concerned that CMS is:

- A. Adopting a policy that is inconsistent with Congressional intent when it enacted Section 4541(b) of the Balanced Budget Act of 1997.
- B. Misstating current policy by telling individuals that they are in violation of CMS policy if they are providing incident to therapy services yet do not meet the physical therapist education and credentialing standards.
- C. Violating the Administrative Procedures Act by suggesting that this major change in policy is in fact a "clarification" of CMS policy.
- D. Misapplying the standards found in 42 CFR 485.705 to the physician's office.
- E. Incorrectly changing the 42 CFR 410.60 to reflect the home health standards when Congress clearly stated that you were to apply the physical therapist in private practice standards.
- F. Overturning a long-standing CMS policy without adequately explaining or justifying the change.
- G. Doing significant harm to beneficiary access to therapy services. Such a change will result in higher Medicare outlays that have not been accounted for in the budget and could adversely affect future physician payments as a result of higher than anticipated payments for outpatient therapy services.
- H. Promoting anticompetitive behavior that is harmful to both patients and the Medicare program by restricting market access and establishing a virtual monopoly for physical therapists in the delivery of therapy services. Nothing in the Medicare statutes or regulations encourages such actions.
- I. Unnecessarily restricting access to therapy services in rural areas where it is unlikely that a physical therapist will practice.

The proposed rule is inconsistent with Congressional intent, contrary to prior CMS rules and policies, and is contrary to the spirit of “incident to” as they have existed under the Medicare system for the past forty years. In addition, the NATA urges CMS to carefully consider the impact this proposed rule will have on access, quality, and costs in the health care industry as they relate to patients and health care providers, both physician and nonphysician.

Thank you for the opportunity to voice NATA’s concerns. We look forward to receiving information on the CMS decision after the comment period. If you need any additional information or would like clarification of any of NATA’s points, please contact me directly (1-800-879-6282) or our Washington Representative, Bill Finerfrock (202-544-1880).

Sincerely,

A handwritten signature in black ink that reads "Eve Becker-Doyle". The signature is written in a cursive, flowing style.

Eve Becker-Doyle, CAE  
Executive Director