October 12, 2007

Mr. Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8050

Submitted electronically

Re: Medicaid Program: Coverage for Rehabilitative Services Proposed Rule

Dear Mr. Weems:

These comments are submitted on behalf of the National Athletic Trainers' Association (NATA) and the 30,000 licensed and certified athletic trainers we represent. Thank you for the opportunity to comment.

Athletic trainers are fully qualified to perform rehabilitative services, and are part of the physical medicine and rehabilitation medical team. Our review of the proposed changes appears to give states broad latitude to recognize those health professionals authorized by state law or state regulatory mechanism to provide physical medicine and rehabilitation services, as long as those health professionals are acting within the scope of their practice as defined by the state.

Athletic trainers work in collaboration with physicians and, in most cases, practice under the referral or direction of physicians. In almost all cases, there is a physician who is responsible for the care provided by the Athletic Trainer to the patient although the physician is not typically on-site supervising the work of the athletic trainer. The physician/athletic trainer relationship is similar to that of other mid-level health care providers.

Athletic trainers are licensed or regulated and authorized in 46 states to provide physical medicine and rehabilitation services to individuals in a variety of settings, including secondary schools and outpatient clinics.

Our comments are directed at the MEDICAID PROGRAM COVERAGE FOR REHABILITATIVE SERVICES PROPOSED RULE.

In General

Athletic trainers (AT) are a vital part of the public health care system. As you might imagine, many athletic trainers work in high schools throughout the United States and as such, come into contact with many children and young adults whose health care is paid for by the Medicaid program.

Athletic trainers are historically known for providing injury prevention, assessment, treatment and rehabilitation to active individuals. It would not be uncommon for an athletic trainer to see and provide rehabilitation services to individuals covered by a state's Medicaid program.

Also, because of their specialized skills in treating musculoskeletal injuries and illnesses, ATs often work in hospital and other outpatient therapy clinics for which Medicaid reimbursement might be sought by the hospital or clinic that employs the athletic trainer.

Overview

The current definition of rehabilitation services is rather broad and could cover a wide variety of services for which coverage may not have been intended. CMS is proposing to clarify coverage requirements by establishing formal definitions for words that previously were left up to the state to define. Current Medicaid requirements for coverage of a "Rehabilitative Service" are:

> *"…any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."*

In lieu of this brief description, CMS now proposes to insert the following new language:

1. Proposed Change to 440.130

(d) Rehabilitative Services - 1

Definitions. For purposes of this subpart, the following definitions apply:

> ***(i) Recommended by a physician or other licensed practitioner of the healing arts means that a physician or other licensed practitioner of the healing arts, based on a comprehensive assessment of the individual, has—***
>
> > ***(A) Determined that receipt of rehabilitative services would result in reduction of the individual's physical or mental disability and restoration to the best possible functional level of the individual; and***
> >
> > ***(B) Recommended the rehabilitative services to achieve specific individualized goals.***

Discussion of proposed change to 440.130(1)(d)(i)

NATA believes this is an appropriate clarification of policy as it establishes the need for a comprehensive assessment, retains the states flexibility to base coverage on the authority of the physician or other licensed practitioner of the healing arts to determine the appropriateness of care and assess the outcome of that care in terms of restoration of the individuals best functional level.

We recommend adoption of proposed 440.130(1)(d)(i)

2. Proposed Change to 440.130(1)(d)(ii)

> ***(ii) Other licensed practitioner of the healing arts means any health practitioner or practitioner of the healing arts who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law.***

We recommend adoption of proposed 440.130(1)(d)(ii)

3. Proposed Change to 440.130(1)(d)(iii)

> ***(iii) Qualified providers of rehabilitative services means individuals who meet any applicable provider qualifications under Federal law that would be applicable to the same service when it is furnished under other Medicaid benefit categories, qualifications under applicable State scope of practice laws, and any additional qualifications set forth in the Medicaid State plan. These qualifications may include minimum age requirements, education, work experience, training, credentialing, supervision and licensing requirements that are applied uniformly. Provider qualifications must be documented in the State plan and be reasonable given the nature of the service provided and the population served. Individuals must have free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid.***

Discussion of proposed change to 440.130(1)(d)(iii)

Our interpretation of this modification is that as long as an individual is otherwise qualified to provide the service under state law or state regulatory mechanism and not otherwise prohibited from providing the service under some other Medicaid provision, the individual would be considered a "qualified provider of rehabilitative services".

We are concerned about specific references in the introductory comments describing the intent behind these changes. Specific references to physical therapy, occupational therapy and speech language and hearing pathology services is confusing. As you have

noted, the term rehabilitative services covers a broad spectrum of services, which can be provided by a wide variety of providers.

Athletic trainers provide many of the same services that might be generically referred to as "physical therapy" but which are more accurately described as physical medicine or rehabilitation. **We strongly recommend that you delete any reference to "physical therapy" or other specific therapy providers as these are not the same as rehabilitative services and could cause some to believe that only physical therapists are eligible to provide certain rehabilitative services to Medicaid recipients.**

<u>We recommend adoption of proposed 440.130(1)(d)(iii)</u>

4. Proposed change to 440.130(1)(d)(iv)

> ***(iv) Under the direction of means that for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders (see § 440.110, ''Inpatient hospital services, other than services in an institution for mental diseases'') the Medicaid qualified therapist providing direction is a licensed practitioner of the healing arts qualified under State law to diagnose and treat individuals with the disability or functional limitations at issue, is working within the scope of practice defined in State law and is supervising each individual's care. The supervision must include, at a minimum, face-to-face contact with the individual initially and periodically as needed, prescribing the services to be provided, and reviewing the need for continued services throughout the course of treatment. The qualified therapist must also assume professional responsibility for the services provided and ensure that the services are medically necessary. Therapists must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, documentation must be kept supporting the supervision of services and ongoing involvement in the treatment. Note that this definition applies specifically to providers of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.***

<u>Discussion of proposed change to 440.130(1)(d)(iv)</u>

As previously noted, athletic trainers are state licensed and certified to provide a wide range of physical medicine and rehabilitation services. The references in this revision to CFR 440.110 and the parenthetical mention of "Inpatient hospital services, other than services in an institution for mental diseases" are confusing. Section 440.110 of the CFR deals with standards for "Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders." Not inpatient hospital services as the reference implies. **It is also not clear whether this language refers to only those**

services that would be considered "physical therapy" versus physical medicine and rehabilitation?

The rest of the revised language appears to give states broad latitude in deciding what type of health professional can be covered to provide rehabilitation services and we support that language.

<u>We recommend revising the proposed change to 440.130(1)(d)(iv)</u>

We propose that that the words

> "that for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders (see § 440.110, ''Inpatient hospital services, other than services in an institution for mental diseases'')"

be stricken and the new language read as follows:

> *(iv) Under the direction of means that the Medicaid qualified therapist providing direction is a licensed practitioner of the healing arts qualified under State law to diagnose and treat individuals with the disability or functional limitations at issue, is working within the scope of practice defined in State law and is supervising each individual's care. The supervision must include, at a minimum, face-to-face contact with the individual initially and periodically as needed, prescribing the services to be provided, and reviewing the need for continued services throughout the course of treatment. The qualified therapist must also assume professional responsibility for the services provided and ensure that the services are medically necessary. Therapists must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, documentation must be kept supporting the supervision of services and ongoing involvement in the treatment. Note that this definition applies specifically to providers of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.*

5. Proposed Change to 440.130(1)(d)(v)

> ***(v) Rehabilitation plan means a written plan that specifies the physical impairment, mental health and/or substance related disorder to be addressed, the individualized rehabilitation goals and the medical and remedial services to achieve those goals. The plan is developed by a qualified provider(s) working within the State scope of practice act, with input from the individual, individual's family, the individual's authorized decision maker and/or of the individual's choosing and also ensures the active participation of the individual, individual's family, individual's authorized decision maker and/or of the***

individual's choosing in the development, review, and modification of the goals and services. The plan must document that the services have been determined to be rehabilitative services consistent with the regulatory definition. The plan must have a timeline, based on the individual's assessed needs and anticipated progress, for reevaluation of the plan, not longer than one year. The plan must be reasonable and based on the individual's condition(s) and on general standards of practice for provision of rehabilitative services to an individual with the individual's condition(s).

We recommend adoption of proposed 440.130(1)(d)(v)

6. Proposed Change to 440.130(1)(d)(vi)

(vi) Restorative services means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function. The emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past. For example, a person may not have needed to take public transportation in the past, but may have had the ability to do so prior to having the disability. Rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services.

Discussion of proposed change to 440.130(1)(d)(vi)

We appreciate the broad interpretation of the term restorative services. The language provides states with guidance on what is meant by restorative services without being overly burdensome or restrictive on the types of personnel who can be utilized to provide these services. As we have noted in earlier comments, **the use of broad terms such as "restorative" or "rehabilitation" rather than more restrictive terms such as "physical therapy" when it comes to physical medicine and rehabilitation services is appropriate and avoids unnecessary confusion.**

We recommend adoption of proposed 440.130(1)(d)(vi)

7. Proposed change to 440.130(1)(d)(vii)

(vii) Medical services means services specified in the rehabilitation plan that are required for the diagnosis, treatment, or care of a physical or mental disorder and are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Medical

services may include physical therapy, occupational therapy, speech therapy, and mental health and substance-related disorder rehabilitative services.

Discussion of proposed change to 440.130(1)(d)(vii)

Rehabilitative services provided by athletic trainers working under physician supervision are considered physical medicine. Therefore these services would be covered under the definition you propose. Giving states the ability to recognize or pay for therapy as a subset of medicine is appropriate.

What is not clear is what would constitute "physical therapy"? To the extent physical therapy is a service provided by a physical therapist, then we would not object to the proposed inclusion of this terms within this definition of "medical service". However some have sought to broadly define "physical therapy" as any rehabilitative service that is provided to a patient in need of physical medicine and then **seek to restrict the delivery** of physical medicine and rehabilitation therapy to individuals meeting the state definition of physical therapist.

Just as medical services can be provided by a broad range of health professionals (physicians, physician assistants, nurse practitioners, nurse midwives, etc.) so too can rehabilitation services be provided by a broad range of health professionals. Your language acknowledges that states permit many health professionals to provide medical services by inclusion of the language "other licensed practitioner of the healing arts within the scope of his or her practice under State law".

As the language is permissive (i.e. states "may") rather than mandatory, we do not believe this language will cause any confusion regarding the ability of the full range of health professionals to provide medical rehabilitation services.

We recommend adoption of 440.130(1)(d)(vii)

8. Proposed change to 440.130(1)(d)(viii)

(viii) Remedial services means services that are intended to correct a physical or mental disorder and are necessary to achieve a specific rehabilitative goal specified in the individual's rehabilitation plan.

We recommend adoption of 440.130(1)(d)(viii)

9. Proposed Change to 440.130(2)

(2) Scope of services. Except as otherwise provided under this subpart, rehabilitative services include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a individual to the best possible functional level.

Rehabilitative services may include assistive devices, medical equipment and supplies, not otherwise covered under the plan, which are determined necessary to the achievement of the individual's rehabilitation goals. Rehabilitative services do not include room and board in an institution or community setting.

We recommend adoption of the proposed change to 440.130(2)

10. Proposed change to 440.130(3)

(3) Written rehabilitation plan.

The written rehabilitation plan shall be reasonable and based on the individual's condition(s) and on the standards of practice for provision of rehabilitative services to an individual with the individual's condition(s). In addition, the written rehabilitation plan must meet the following requirements:

Discussion of proposed changes to 440.130(3)

The practice of medicine is both and art as well as a science. Each patient is different and the way a patient will respond to treatment will be different. While development of a rehabilitation plan of care is reasonable and appropriate, it is often difficult to predict the way the patient will respond to that treatment plan. It is often necessary to adjust a plan during the course of treatment. This could mean longer duration of treatment or shorter duration of treatment. Athletic trainers find shorter total duration of therapy to be particularly true when working with younger patients. In other words, many patients recover from injuries faster.

We are concerned that the proscriptive nature of this section could be disruptive to the rehabilitation of individuals. In the worst case situation, the language could force a provider to prematurely reduce the level of care to individuals in need of physical rehabilitation, which could reduce the accelerated return to activity that is the specialty of athletic trainers.

It is common that, within a plan of care, student-athletes are treated more frequently but for a shorter duration of time. This allows for quick recovery at less cost to the health care system. Otherwise, the proposed requirements for a written rehabilitation plan are acceptable.

We encourage CMS to reexamine this language to ensure that health professionals have sufficient flexibility to adjust a plan of care and carry out the adjusted plan of care in a way that best suits the rehabilitation needs of the patient.

11. Proposed change to 440.130(5)

(5) Settings. Rehabilitative services may be provided in a facility, home, or other setting.

Discussion of proposed change

42 percent of secondary schools have access to an athletic trainer and on-site athletic training facilities are very common in secondary and middle schools. These athletic training facilities—sometimes called sports medicine facilities—are where rehabilitation services are delivered. It is important for patient continuity of care that rehabilitation started in these facilities be completed in these facilities, whenever possible.

We appreciate the recognition by CMS that rehabilitative services can be delivered in a variety of settings and that no limitations have been placed on where these services can be delivered.

We recommendation adoption of the proposed change to 440.130(5)

12. Proposed creation of a new 441.45 Rehabilitative services.

Discussion of the creation of a new 441.45 Rehabilitative Services.

It is essential that Medicaid beneficiaries have the freedom of choice of qualified providers as determined by the State. As more and more athletic trainers provide physical medicine and rehabilitation services to high school students, many of whom may be covered by the Medicaid program, it is critical that the states have the authority to cover these rehabilitative services if provided by a state licensed and physician supervised athletic trainer. The athletic training room in the high school may be the least restrictive and most accessible location for the delivery of physical medicine and rehabilitation services to these high school students.

13. Proposed limitations on covered services 441.45(b)(3)

> ***(3) Recreational or social activities that are not focused on rehabilitation and not provided by a Medicaid qualified provider…***

NATA points out that athletic training services provided by athletic trainers are typically defined as physical medicine or rehabilitation services. However, there are some elements of athletic training services that are non-medical in nature. It is noted that Medicaid would not reimburse for non-medical services. Only those services that are medical, rehabilitative or, depending on individual State Medicaid rules, performed in order to prevent the worsening of an injury would be subject to reimbursement.

The services performed by athletic trainers, as described in this paper, are not intrinsic elements of program other than Medicaid. In other words, these services are not reimbursable by any other federal or state government health care programs. If a service was determined to be recreational in nature, it would not be subject to reimbursement by Medicaid.

CMS is encouraged to allow states, through the Medicaid program, to explore the beneficial patient outcomes and cost effectiveness of early intervention of injury and illness provided by athletic trainers. Athletic trainers have found that preventing an injury from worsening often means a reduction of physical disability, faster recovery from injury and an improved quality of life over a lifetime. We would be pleased to consider a Medicaid demonstration or similar project with states and CMS.

14. Regulatory Impact Analysis: Overall Impact

> *The Secretary certifies that this major rule would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1905(a)(13) of the Act. The rule would directly affect states and we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule.*

Discussion of the impact

NATA and its 30,000 athletic trainer members have serious concerns that the Secretary may not have considered the role of athletic trainers in providing physical medicine and rehabilitation medical care to Medicaid beneficiaries. Despite the use of what appears to be board, inclusive language, we are concerned about possible "unintended consequences."

Athletic trainers have a 55 year history of working with student athletes and other individuals benefiting from the public health system. Because of our history of working under the direction of a physician and not commonly billing directly for services, the positive impact and benefits have not been widely known. It is our desire to make CMS aware of the vital role of athletic trainers as qualified providers.

Consequently, we are taking this opportunity to share with you information about Athletic trainer education and credentialing so you can be better informed about the role and responsibilities of athletic trainers in our health care delivery system.

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.

Education and Training of Certified Athletic Trainers

Certified athletic trainers have national academic and certification standards. ATs are highly skilled allied health care 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 ATs have a bachelor's degree, and almost 70 percent have a master's degree. Medically related continuing education is required to

maintain certification. The athletic training profession has recognized as allied health care profession since 1990. It should be noted that athletic trainers and personal trainers are different: personal trainers are concerned with fitness and aesthetics not health care.

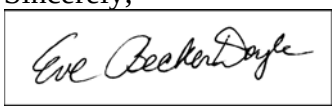
Athletic trainers work in a wide array of settings, including clinics, hospitals, physicians' offices, corporate health programs, secondary schools, colleges and universities, and professional athletics. ATs satisfy stringent educational and experiential requirements, and are required to pass an extensive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

The coursework for ATs 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, ATs practice in collaboration with physicians, generally under referral or direction.

Conclusion

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 Patty Ellis at (1-800-879-6282) or our Washington Representative, Bill Finerfrock (202-544-1880).

Sincerely,



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