August 25, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-1631-P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 (80 Fed. Reg. 41686, July 15, 2015)

Dear Acting Administrator Slavitt:

On behalf of the National Athletic Trainers' Association (NATA), I am writing to share our comments on the proposed rule for the Calendar Year (CY) 2016 Medicare Physician Fee Schedule. We appreciate the opportunity to provide our comments on this important issue. Specifically, NATA is providing detailed comments on the incident to modifications included in the proposed rule. The Centers for Medicare and Medicaid Services (CMS) proposes to revise the regulations specifying the requirements for which physicians and other practitioners can bill for incident to services, clarifying that the physician who directly supervises the service must also be the physician who bills for the incident to service. The Agency also proposes to remove the language from the incident to regulation (42 C.F.R. § 410.26(b)(5)) that specifies that the physician or other practitioner supervising the auxiliary personnel need not be the same physician or other practitioner upon whose professional service the incident to service is based.

NATA is a professional organization serving more than 40,000 certified athletic trainers, students of athletic training, and other health care professionals. The organization's mission is to represent, engage, and foster the continued growth and development of the athletic training profession and athletic trainers as unique health care providers. As the leading organization representing athletic trainers, NATA has concerns that the incident to proposal would limit patient access to care and prevent physician extenders from performing services for which they are qualified and have extensive experience.

Providing incident to services is a core element of the role of athletic trainers. While we acknowledge that athletic trainers are not Medicare-covered providers and the proposed rule applies to health care professionals furnishing services to Medicare beneficiaries, we have concerns with the modified incident to proposal, given that commercial insurers tend to follow CMS in matters of coverage.

NATA believes that removing the language from the incident to regulation that specifies that the physician or other practitioner supervising the auxiliary personnel need not be the same

physician or other practitioner upon whose professional service the incident to service is based would restrict patient access to care and harm health care professionals' ability to provide medically necessary services to patients. If finalized, this proposal would eliminate the ability of a physician group to bill for incident to services unless the ordering physician who initially treated the Medicare beneficiary also is in the office providing the supervision for each incident to service rendered to his or her patient. We encourage CMS to maintain its current policy to the extent that the physician ordering a particular service need not be the physician who is supervising the service.

Background on the Athletic Training Profession

Athletic trainers are highly qualified, multi-skilled health care professionals who collaborate with physicians to provide preventive services, emergency care, clinical diagnosis, therapeutic intervention, and rehabilitation of injuries. Athletic trainers also specialize in preventing, diagnosing, and treating muscle and bone injuries and illnesses.[1] Athletic trainers are included under the allied health professions category as defined by the Department of Health and Human Services and are assigned National Provider Identifiers (NPIs). In addition to employment by sports and athletic organizations, athletic trainers are employed by hospitals, clinics, occupational health departments, wellness facilities, the United States military, and in a number of other health care settings.

Incident to Proposals: Billing Physician as the Supervising Physician and Auxiliary Personnel Requirements

Currently, to qualify as incident to, the services must be part of a physician's normal course of treatment, during which the physician personally performed an initial service and remains actively involved in the course of treatment. When incident to services are furnished, a physician must provide direction supervision. If a physician practices in a group, any physician member of the group may be present in the office to supervise; however, if a physician is a solo practitioner, he or she must directly supervise the care.[2]

NATA is pleased with the Agency's efforts to ensure that billing physicians and other practitioners have a personal role in and responsibility for furnishing services for which they are billing and receiving payment as incident to their own professional services. We support CMS' clarification that the physician/practitioner who bills for incident to services must also be the physician/practitioner who directly supervises the auxiliary personnel that furnishes the services.

However, language in the proposed rule also amends 42 C.F.R. § 410.26(b)(5) and removes the sentence that specifies that the physician or other practitioner supervising the auxiliary

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[1] Department of Labor Occupational Outlook Handbook (2012). Retrieved from: http://www.bls.gov/ooh/healthcare/athletic-trainers-and-exercise-physiologists.htm

[2] MLN Matters SE0441, "Incident to" Services. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf

personnel need not be the same physician or other practitioner upon whose professional service the incident to service is based. NATA acknowledges that incident to services furnished to a Medicare beneficiary are an integral part of the physician's or other practitioner's personal professional service. However, CMS' proposal to require the ordering physician to also serve as the supervising physician during the delivery of incident to services raises serious concerns for physician practices, as the proposed policy would severely restrict Medicare patients in their ability to obtain physical medicine, non-self-administrable drugs and biologicals, and therapy services.

For example, in an oncology clinic, a patient may undergo a series of treatments, and the supervising physician may differ from the treating physician. If the treating physician is not the supervising physician for each treatment furnished by auxiliary personnel, the chemotherapy drugs and administration may fail to qualify under the new rule as incident to services and would no longer be covered.

This proposal also would affect orthopedic practices, as orthopedic surgeons regularly work in the operating room rather than the office. If the treating physician is on call and the patient arrives for his or her appointment, but the treating physician is called to surgery and can no longer supervise, the clinic would be required to send the patient home and reschedule the patient's visit for a later date when the treating physician is in the office. This could potentially result in an appointment that is weeks or months after the patient requires treatment, resulting in adverse patient outcomes. The policy also would lead to confusion and uncertainty in situations in which auxiliary personnel provide a service, but is unaware the treating physician was called away moments prior to the delivery of treatment, and a different physician is the supervisor during the delivery of care. We urge CMS to address these issues and clarify how clinics and other practices should interpret the proposed incident to provision.

Additionally, NATA has serious concerns how this proposal may impact access for rural and/or low-income populations. As CMS seeks to expand patient access to medical services in rural regions, we worry that this proposal would obstruct access to medical care and potentially worsen patient outcomes. In many instances, patients who reside in rural areas must take an entire day off of work and travel great distances to reach a physician, and often, rurally-located clinics employ physicians who rotate their visits on a weekly basis. The proposed rule would cause scheduling difficulties and render it extremely difficult to coordinate a patient visit with auxiliary personnel for when the treating physician is also serving as the supervising physician.

Further, should the treating physician become sick or called to the hospital to do rounds when the patient arrives for his appointment, practices would be forced to make the decision whether to reschedule the patient for a later date or treat the patient under the supervision of a different physician. It is reasonable to assume that in these situations, auxiliary personnel would treat their patients under the supervision of a physician different from the treating physician and not bill incident to services. Unfortunately, this may result in insufficient Medicare payments, prompting many rural clinics to shut their doors.

Health care professionals are committed to improving the quality of outcomes for patients and providing greater efficiencies through care coordination. Should the proposal be implemented, patient access to necessary medical services would be hindered, as physician practices would be forced to reschedule patient visits, unless they choose to provide medical services without payment. In virtually every medical setting, providers rely heavily on auxiliary personnel to furnish direct patient care. To ensure patient safety and the quality of health care is maintained, we encourage CMS not to require that the physician/practitioner providing the supervision be the same physician/practitioner upon whose professional service the incident to service is based. Health care providers are increasing their efforts to furnish high-quality, cost-effective care and improve patient outcomes. As the health care industry strives to achieve the triple aim – improving the health of the population, enhancing the experience of the patient, and reducing health care costs, we encourage the Agency to develop initiatives designed to increase patient access and reduce administrative burdens.

Athletic trainers and other similar professionals, often described as physician extenders, are highly educated, credentialed, licensed, trained, and qualified to furnish incident to services under the supervision of a physician. Qualified health care professionals must be provided with the means to deliver care in a manner that positively impacts the quality of care for patients. On behalf of patients and all health care professionals, we encourage CMS to maintain the current policy and clarify that the ordering physician and the supervising physician *do not* need to be the same individual when billing incident to services.

Thank you for the opportunity to share NATA's comments on the CY 2016 Medicare Physician Fee Schedule proposed rule. We look forward to continuing to share information with you and working together to develop policies that facilitate the provision of quality care to patients. Should you have any questions, please do not hesitate to contact our Health Policy Associate, Kara Gainer (kara.gainer@dbr.com / 202-230-5649). We thank you for your consideration of our concerns, recommendations, and requests.

Respectfully submitted,

Scott Sailor, EdD, ATC
NATA President