Via online submission to http://www.regulations.gov

September 4, 2012

Ms. Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1358–P
P.O. Box 1816
Baltimore, MD 21244-1816

Re: **Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements, and Surgery and Enforcement Requirements for Home Health Agencies (CMS–1358–P)**

Dear Ms. Tavenner:

The American Occupational Therapy Association (AOTA) represents the interests of over 140,000 occupational therapists, occupational therapy assistants, and therapy students, many of whom serve Medicare beneficiaries through home health agencies. We appreciate the opportunity to comment on the proposed rule for Home Health Prospective Payment System Rate Update for Calendar Year 2013 (hereinafter "Proposed Rule").

I. Technical Correction to G-Code Description

AOTA appreciates CMS' response to our concerns about code G0158 used to describe services provided by a qualified occupational therapy assistant. AOTA supports the proposed correction and commends CMS' action to make the code consistent with 42 CFR 484.4 and national occupational therapy practice standards.

II. Therapy Reassessments

AOTA supports efforts to establish appropriate guidelines for therapy reassessments. We appreciate the difficulty for CMS in providing specific therapy reassessment requirements that are flexible enough for home health providers and appropriate to meet patients' needs. We are concerned that CMS guidelines have the potential to create further problems with patients that have the most intense needs and require the most complicated care. Scheduling for the most complex patients, such as those requiring all three therapy disciplines

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(occupational therapy, physical therapy and speech-language pathology), can be difficult without taking into account CMS' home health therapy reassessment requirements. For example, a patient receiving occupational therapy twice a week, physical therapy three times a week, and speech therapy twice a week may not be able to receive one type of therapy on time if they have to wait for a reassessment first in order to comply with threshold visit requirements for reassessments on the 11th, 12th and 13th visits.

Patients with the most intense therapy needs where all three therapy disciplines are involved have the greatest likelihood to exceed the thresholds for therapy visits. These patients typically do not experience enormous change in a short amount of time. For these patients, AOTA recommends that therapy reassessment requirements not be based on number of visits. Instead, complex patients requiring all three therapy disciplines should be reassessed within a certain number of calendar days. There must be strong support for why the patient has such complex needs.

AOTA continues to believe that unfettered clinical reasoning and judgment of the therapist should determine a patient's therapy needs. AOTA supports that the occupational therapist's clinical decision making and evaluation must determine the need, amount and type of therapy that will be provided, based on the individual patient's condition. Therapists should be given the latitude to determine when there is a change in the patient's status that affects therapy utilization. Only therapists are suited to evaluate the patient's function and status to determine a change in the plan of care or discharge from therapy. CMS should focus on outcomes rather than using a complicated assessment schedule that does not adequately take into account the individual patient's needs and condition.

AOTA recommends that CMS base therapy reassessment requirements for complex patients on calendar days rather than number of visits to allow therapists to put the patients' needs first while still meeting CMS requirements for reassessment.

III. AOTA Requests Occupational Therapy Examples in the Medicare Benefit Policy Manual

Last year, CMS adopted clarifications to ensure that qualified patients receive continued home health services by virtue of receiving occupational therapy services after initial eligibility has been fulfilled by the need for intermittent skilled nursing or skilled and billable physical therapy or speech-language pathology services. AOTA appreciates CMS' efforts to resolve confusion about occupational therapy in home health. We urge CMS to provide further explanation of the home health occupational therapy policy by including specific examples in Chapter 7, Section 30.4 of the Medicare Benefit Policy Manual. We

believe this would help ensure that home health agencies will accurately integrate CMS' interpretation of the occupational therapy policy.

We believe the following examples illustrate situations where continuing need for occupational therapy would qualify a beneficiary for the home health benefit and support the provision of dependent services.

> Example 1: In the first episode, occupational therapy was initially ordered and provided services along with an initial qualifying service(s). After initial qualifying service(s) discharge(s), occupational therapy becomes continuing qualifying service in that certification period and (if other eligibility criteria are met) continues eligibility in subsequent certification periods with no further visits from nursing or another qualifying service.
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>> A patient with multiple sclerosis (MS) has an initial plan of care requiring physical therapy, occupational therapy and home health aide services. Physical therapy goals were met and physical therapy discharged on day 45. Occupational therapy and home health aide services continue through the end of the certification period. The physician recertifies continued occupational therapy and home health aide services for the next certification period. In the second certification period, the home health aide services are discharged on day 12 and occupational therapy services are discharged on day 20 working on increasing independence and skills to perform activities. The patient's need for continued occupational therapy qualifies her for home health services, including home health aide services, through the end of the initial certification period and throughout the second certification period (presuming that all other qualifying criteria are met.)
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> Example 2: Following breast cancer surgery, skilled nursing and occupational therapy services are ordered for a patient. The physician's order specifies that occupational therapy should begin after nursing services are discharged in order to ensure appropriate patient recovery before occupational therapy begins. While the patient is receiving nursing services, eligibility is based on the current need for intermittent nursing. When the first occupational therapy service is provided, eligibility is based on the prior need for skilled nursing in the current certification period. Following the first occupational therapy visit, eligibility is established based on the continuing need for occupational therapy.

We request that CMS include specific examples of the occupational therapy policy in the Preamble to the Final Rule and Chapter 7, Section 30.4 of the Medicare Benefit Policy Manual to ensure that Medicare home health beneficiaries have appropriate access to occupational therapy services.

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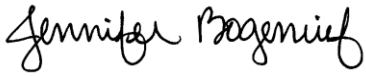
Thank you for the opportunity to comment on the Proposed Rule. AOTA looks forward to a continuing dialogue with CMS on coverage and payment policies that affect the ability of occupational therapists to provide quality care to Medicare beneficiaries.

Sincerely,



Jennifer Bogenrief
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