

Via first class mail

July 12, 2006

Dr. Daniel J. Duvall
Blue Cross Blue Shield of Tennessee
d.b.a Riverbend GBA
801 Pine Street 6-C
Chattanooga, TN 37402

Re: **Reconsideration Request: LCD for Occupational Therapy** (Contractor's ID
Number: DL17637)

Dear Dr. Duvall:

The American Occupational Therapy Association (AOTA) represents approximately 35,000 occupational therapy professionals, many of whom provide services to Medicare beneficiaries. We appreciate the opportunity to request a reconsideration of Blue Cross Blue Shield of Tennessee's (BCBS's) local coverage determination (LCD) Occupational Therapy Services, last updated on February 20, 2006.

Our request for reconsideration is specific to BCBS's description of CPT code 97535 under the "Specific Services" section of the Occupational Therapy LCD. AOTA made similar comments in response to this LCD when it was put out for revision in draft in August 2005; however AOTA's comments regarding CPT 97535 were not referenced in the "Comments and Response" document that is an FAQ article attached to this LCD.¹ We have enclosed our earlier comments with this letter for your reference and respectfully request you review and reconsider this clinically inappropriate policy. Although BCBS has failed to provide data or evidence to support a two treatment restriction on the use of 97535, which is the core of occupational therapy practice, numerous AOTA members recently have received denials stating: "per LCD 17637, units greater than 2 on a given day will be denied as not medically necessary."

Discussion of Occupational Therapy Services

BCBS's arbitrary limitation of CPT 97535-Self Care/Home Management is clearly out of line with current occupational therapy practice, which is supported by the analysis of 2004 Medicare therapy data by CMS. Although the 2004 Medicare therapy data has not been shared with the contractors yet, AOTA was involved in a project that required review of the data, and AOTA bases its recommendations to BCBS on the 2004 Medicare therapy data. In fact, we encourage you to review the data by contacting Dorothy Shannon at CMS Central Office by email at Dorothy.Shannon@cms.hhs.gov or by phone at (410) 786-3396.

¹ The FAQ document is also located at: https://coverage.cms.fu.com/lcd_area/lcd_uploads/17637_1/DL17637FAQ.html

As further indication of presently accepted practice patterns, even CMS' CCI contractor's "medically unbelievable edits (MUEs) proposal allowed for a greater number of units per day. BCBS has provided no clinical evidence to support a limitation of 2 units. Earlier Medicare therapy studies, discussed in our previous letter, demonstrate that almost half of paid claims for outpatient occupational therapy services include at least two time-based therapy HCPCS codes, and this data set does not address whether un-timed codes (e.g., OT evaluation, OT reevaluation, ultrasound) were provided on the same date of service.² In addition, many CMS studies have concluded that factors such as diagnosis, condition, age, and setting all influence the frequency and duration of occupational therapy intervention. If BCBS is basing its policy on more conclusive evidence, AOTA would welcome the opportunity to review the studies.

The following are three case vignettes where CPT code 97535 would be appropriately billed by an occupational therapist. The first was developed for an American Medical Association project to define a "typical patient." These are not unusual or unique examples of the types of patients seen by therapists. We believe they support a rescission of the 2 unit limitation on CPT code 97535. Please note that occupational therapy treatment for activities of daily living (ADL) deficits require observation and cuing of actual performance, which is effectively provided in no less than 45 minutes and often longer, depending on the capabilities of the client. Therefore, the time component is controlled significantly by the patient, not the therapist, and the elderly often require additional time.

Typical self care training patient: The patient is a 65-year old woman recently discharged from the hospital with a diagnosis of CVA resulting in a right hemiparesis. The patient lives alone and wants to be able to remain in her home. The initial evaluation has revealed performance deficits in bathroom activities and meal preparation. At the home site, the therapist recommends and sets up proper adaptive equipment in the bathroom, so that the patient can safely transfer to toilet and bathtub using contemporary techniques. In the kitchen, the therapist teaches and observes meal preparation using one-handed techniques and special adaptive equipment. Therapist must assure that patient's functional level is sufficient to perform necessary self care and home management activities within safe limits (e.g. picking items off floor, lifting pots from stove, reaching items in cupboards, opening drawers.)

Self-care training in the area of dressing and bathing for a person with COPD (10.7 million adults in 2003): The therapist educates and demonstrates energy conservation techniques, task simplification, and breathing techniques during actual activities. During the session, the therapist also monitors pulse ox (SPO2) and adjusts oxygen levels. The patient must gather clothes and bathing supplies, turn on and adjust room humidity in order to ease breathing difficulty, take a seated shower, dry off and get dressed. During these activities, the client must stop for instruction, monitoring and breathing exercises. The time necessary for this session is dependent on the abilities of the patient. Other diagnoses where self care is a complex session include Parkinson's, MS, and paraplegia. These sessions frequently require or exceed 45 minutes.

² See analysis of Medicare Program 2002 outpatient occupational therapy data at <http://www.cms.hhs.gov/providers/therapy/> under the heading Therapy Studies and Reports, Policy and Utilization, and select AdvanceMed Model Report, November 2004.

Self-care training in the area of toileting: A patient has a strong desire to learn how to use the bathroom efficiently because of some accidents due to frequent urination. Pharmaceutical intervention is also being addressed. As part of her therapy program, use of the commode is incorporated into treatment. This process consists of wheeling into the bathroom and positioning the wheelchair at the most advantageous angle to the commode after the footrests are swung out of the way. Once positioned the patient pushes up on both armrests with assist to come to standing, then leans on a safety rail while working her pants and underpants down to her knees. She needs to sit down between these steps secondary to the effort returned. However, she is motivated so that does not stop her, and she is finally ready to stand pivot to the elevated commode seat. Once she has completed this task, she now must clean herself, a key part of this process that she wants to be independent in because of her dignity and desire for privacy. Once that step is completed, she then must reverse the steps needed to get dressed and back into her wheelchair. This process takes 45 minutes, as she now requires moderate assists. However, her goal is supervision for getting on and off the commode and independent cleaning of herself.

AOTA asserts that it is inappropriate for BCBS to assign frequency and duration figures strictly based upon the type of service being provided to a beneficiary, especially when it is unsupported by CMS contractor research. In fact, our research has identified Medicare authority to the contrary with respect to use of “rules of thumb,” as follows:

“Rules of Thumb” in the MR process are prohibited. Intermediaries must not make denial decisions solely on the reviewer's general inferences about beneficiaries with similar diagnoses or on general data related to utilization. Any “rules of thumb” that would declare a claim not covered solely on the basis of elements, such as, lack of restoration potential, ability to walk a certain number of feet, or degree of stability is unacceptable without individual review of all pertinent facts to determine if coverage may be justified. Medical denial decisions must be based on a detailed and thorough analysis of the beneficiary's total condition and individual need for care.³

BCBS has failed to provide the clinical basis for limits on units for 97535 and has imposed a wholly unreasonable and burdensome process on providers and occupational therapists. We also maintain that the timing for this type of policy is inappropriate, considering the initiatives to determine clinically appropriate unit edits nationally. AOTA is interested in knowing what coverage criteria, industry literature, or professional standards were relied upon by BCBS in drawing its conclusion to restrict 97535.

Occupational therapists are bound by their professional and ethical standards to use the most appropriate code for medically necessary services and to provide beneficiaries with medically necessary care that they need. BCBS’s arbitrary restriction on CPT code 97535 keeps occupational therapists’ from being reimbursed for appropriate and needed services they provide and keeps beneficiaries from obtaining the quality rehabilitative care they need, which is likely to lead to re-injury and re-hospitalization and ultimately higher costs to the Medicare program.

AOTA requests that due consideration be given to this reconsideration request. Thank you,

³ Program Integrity Manual (CMS Pub. 100-08), §6.1 (Medical Review of Skilled Nursing Facility Prospective Payment System (SNFPPS) Bills).

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again, for the opportunity to comment on this LCD. We look forward to a continuing dialogue with BCBS on these issues as they apply to occupational therapy. Should you have any questions or comments, please contact me at (301) 652-2682 ext. 2863 or via email at ssandhu@aota.org.

Sincerely,

Sharmila Sandhu, Esq.
Regulatory Counsel

cc: Roger Perez, CMS Regional Administrator, Atlanta Regional Office
Peter Clendenin, Executive Vice President, National Association for Support of Long Term Care
Monica Robinson, Rehabilitation Systems Consultant, HCR ManorCare
Dave Boerkoel, Vice-President of Clinical Operations, Paragon Rehabilitation
Kathleen Drab, OT Clinical Practice Director