

Via email to TriSpanLCD@trispans.com

June 16, 2008

TriSpan Health Services AX1MC7
Attention: Dawn James, R.N., B.S.N.
P.O. Box 23046
Jackson, MS 39225

**Re: Draft LCD for Chronic Wound Care
Draft DL27394 – Region IV – LA and MS**

Dear Ms. James:

The American Occupational Therapy Association (“AOTA”) represents more than 38,000 occupational therapy professionals, many of whom provide services to Medicare beneficiaries under Parts A and B of the Medicare program. We appreciate the opportunity to comment on TriSpan Health Services’ (TriSpan’s) draft local coverage determination (LCD) for Chronic Wound Care (referred to hereinafter as “draft LCD”).

Occupational Therapists Are Providers of Chronic Wound Care Services

The draft LCD does not specifically include occupational therapists as providers of chronic wound care services, however chronic wound care is within the Occupational Therapy scope of practice and may be appropriately provided by occupational therapists. An occupational therapist or occupational therapy assistant is bound by the Occupational Therapy Code of Ethics to demonstrate competency in the services they perform.¹ AOTA’s *Model Definition of Occupational Therapy for State Practice Acts*² includes wound care as within the Occupational Therapy scope of practice, as does its *Scope of Practice* official document.³ Occupational therapists and occupational therapy assistants routinely work with individuals and populations who are at risk for or have sustained wounds.⁴ We request that the LCD clearly state that occupational therapists are appropriate providers of chronic wound care when the services are performed as part of the therapy plan of treatment. This would prevent confusion as to whether occupational therapists may also provide chronic wound care.

Specifically, in the “General Information” section under “Documentation,” item numbers six (6) and seven (7) reference physical therapy but not occupational therapy. We recommend adding references to occupational therapists to clearly indicate that skilled therapists may perform hydrotherapy (whirlpool) and active debridement, such as:

¹ AOTA *Occupational Therapy Code of Ethics*, Principle 4 (2005)

² AOTA *Model Definition of Occupational Therapy for State Practice Acts* (2006)

³ *Scope of Practice Document* official AOTA document (2006)

⁴ AOTA *Wound Management White Paper* (2007)

6. When hydrotherapy (whirlpool) is billed by a physical therapist *or occupational therapist* with CPT Code 97597 or 97598, the documentation must reflect that the skills of a physical therapist *or occupational therapist* were required to perform this service in the given situation.

7. Active debridement performed by a physical therapist *or occupational therapist* must be ordered by a physician and performed under a treatment plan as any other physical *or occupational therapy* service outlining specific goals, duration, frequency, modalities, an anticipated endpoint, and other pertinent factors as they may apply. Departure from this plan must be documented.

Rules of Thumb

“Rules of thumb” are identified in the draft LCD, such as items three (3) and four (4) under “Indication and Limitations of Coverage and/or Medical Necessity” and item one (1) under “Utilization Guidelines”:

Debridements of the wound(s) must be done judiciously and at appropriate intervals. It is rarely necessary to debride a wound more than once daily in the early stages of chronic wound care (approximately the first one to two weeks of care), more than three times a week in the intermediate stages (approximately the second through fourth weeks of care) or more than approximately weekly thereafter.

AOTA has grave concerns with the use of “rules of thumb” to predetermine a patient’s need for therapy service. CMS, through its Medicare Manuals, has stated that the use of rules of thumb on the frequency or duration of therapy and other services is not permitted by CMS and is not an option for contractors. Please see the following sections for guidance on the prohibition on the use of restrictions on frequency and durations under Medicare (applies to both Parts A and B):

Medicare recognizes that determinations of whether hospital stays for rehabilitation services are reasonable and necessary must be based upon an assessment of each beneficiary’s individual care needs. Therefore, denials of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms, “the three hour rule,” or another other “rules of thumb” are not appropriate.⁵

“Rules of thumb” in the MR [medical review] 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.⁶

⁵ Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 1, § 110.1 (General).

⁶ Program Integrity Manual (CMS Pub. 100-08), Ch. 6, § 6.1 (Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills).

Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate.⁷

In addition, TriSpan fails to provide in the draft LCD any evidence or scientific studies to support the arbitrary frequency limits on therapy visits referenced throughout this document. Appropriate treatment of chronic wound care is based on several factors, such as the type of wound, whether there is an infection or a large amount of debris, and the location of the wound on the body. AOTA is opposed to the use of "rules of thumb" because positive outcomes can result only from the therapist's clinical evaluation of all factors affecting a person's progress in rehabilitation and the development of an individualized plan of care based on these clinical factors. AOTA urges the removal of the "rules of thumb" used throughout the LCD.

We hope that these comments are helpful and greatly appreciate the opportunity to comment on the draft LCD. We look forward to continuing dialogue with TriSpan on these issues as they apply to occupational therapy. Should you have any questions or comments, please contact me at (301) 652-2682 ext. 2019 or via email at cwillmarth@aota.org. Thank you once again for considering the comments submitted above, and for your continued work on the behalf of Medicare beneficiaries.

Sincerely,



Charles Willmarth
Director, State Affairs and Reimbursement and Regulatory Affairs

Enclosures: AOTA Occupational Therapy Code of Ethics
AOTA Model Definition of Occupational Therapy for State Practice Acts
Scope of Practice AOTA official document
AOTA Wound Management White Paper

⁷ Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 7, § 20.3 (Use of Utilization Screens and "Rules of Thumb").