

Via email to craig.haug@hp.com

April 7, 2010

Craig Haug, MD
NHIC, Corp.
75 Sargeant William Terry Drive
Hingham, MA 02043

Re: Draft LCD for Outpatient Physical and Occupational Therapy Services (DL29833)

Dear Dr. Haug,

The American Occupational Therapy Association (AOTA) represents the interests of 140,000 therapists, assistants and students, many of whom provide services to Medicare beneficiaries under Parts A and B of the Medicare program. We appreciate the opportunity to provide comments on NHIC, Corp.'s (NHIC's) draft local coverage determination (LCD) for Outpatient Physical and Occupational Therapy Services (referred to hereinafter as "draft LCD") for therapy services paid under Medicare Part B.

I. Utilization Guidelines include Rules of Thumb Prohibited by Medicare

The draft LCD includes the following language under "Utilization Guidelines and Maximum Billable Units per Date of Service":

Rarely, except during an evaluation, should therapy session length be greater than 30-60 minutes. If longer sessions are required, documentation must support as medically necessary the duration of the session and the amount of interventions performed.

The following interventions should be reported no more than one unit per code per day per discipline; additional units will be denied:

97001, 97002, 97003, 97004, 97012, 97016, 97018, 97022, 97024, 97028, 97150, 97597, 97598, 97605, 97606, G0281, G0283, G0329.

The following timed modalities should be reported no more than 2 (two) units per code per day per discipline; additional units will be denied: 97033, 97034, 97035, 97036.

The following interventions should be reported no more than 4 (four) units per code per day per discipline; additional units will be denied:

97032, 97110, 97112, 97113, 97116, 97124, 97530, 97532, 97533, 97535, 97537, 97542, 97760, 97761, 97762.

Denials due to the limits described in this section of the LCD may be appealed.

We believe this utilization language, as well as other limitations throughout the Therapeutic Procedures section of the draft LCD, amounts to an overreaching “rule of thumb” and request removal of the limitations. AOTA has commented on other draft LCDs regarding our concerns about 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 various Medicare Part A and B services:

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 any other “rules of thumb” are not appropriate.¹

“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.²

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.³

We believe these principles apply to Part B occupational therapy services as well. Medicare law allows for coverage of services which meet medical necessity criteria and does not limit daily, weekly or monthly need except as related to the patient’s condition and state medical necessity criteria.

In addition, the following CMS policy also requires therapists to choose a frequency and duration of treatment appropriate to the best outcomes:

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

² Program Integrity Manual (CMS Pub. 100-08), Ch. 6, § 6.1 (Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills).

³ Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 7, § 20.3 (Use of Utilization Screens and “Rules of Thumb”).

The duration is the number of weeks, or the number of treatment sessions, for THIS PLAN of care. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.

The frequency or duration of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patients' goals. For example, it may be clinically appropriate, medically necessary, most efficient and effective to provide short term intensive treatment or longer term and less frequent treatment depending on the individuals' needs.

It may be appropriate for therapists to taper the frequency of visits as the patient progresses toward an independent or caregiver assisted self management program with the intent of improving outcomes and limiting treatment time. For example, treatment may be provided 3 times a week for 2 weeks, then 2 times a week for the next 2 weeks, then once a week for the last 2 weeks. Depending on the individual's condition, such treatment may result in better outcomes, or may result in earlier discharge than routine treatment 3 times a week for 4 weeks. When tapered frequency is planned, the exact number of treatments per frequency level is not required to be projected in the plan, because the changes should be made based on assessment of daily progress. Instead, the beginning and end frequencies shall be planned. For example, amount, frequency and duration may be documented as "once daily, 3 times a week tapered to once a week over 6 weeks". Changes to the frequency may be made based on the clinicians clinical judgment and do not require recertification of the plan unless requested by the physician/NPP. The clinician should consider any comorbidities, tissue healing, the ability of the patient **and/or caregiver to do more independent self management** as treatment progresses, and any other factors related to frequency and duration of treatment.⁴

Further, the following CMS policy clearly indicates more than 5 (15 minute) units per day may be acceptable:

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

⁴ Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 15, § 220.1.2 (Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services)

Units	Number of Minutes
1 unit:	≥ 8 minutes through 22 minutes
2 units:	≥ 23 minutes through 37 minutes
3 units:	≥ 38 minutes through 52 minutes
4 units:	≥ 53 minutes through 67 minutes
5 units:	≥ 68 minutes through 82 minutes
6 units:	≥ 83 minutes through 97 minutes
7 units:	≥ 98 minutes through 112 minutes
8 units:	≥ 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.⁵

Medicare rules also support qualified professionals using their clinical judgment to ensure that each Medicare beneficiary is receiving services that are medically necessary and tailored to their individual condition. Medicare guidelines for the therapy cap exception process set forth that by including the KX modifier on a claim, the clinician “attests” that the services they provided “are medically necessary and justification is documented in the medical record.”⁶ Further, the guidelines establish that by including the KX modifier “the provider is attesting that the services billed are reasonable and necessary services that require the skills of a therapist, are justified by appropriate documentation in the medical record, and qualify for an exception using the automatic process exception.”⁷ We feel Medicare’s reliance on the therapist’s clinical judgment is well expressed in the draft LCD’s provision that “each service must be medically reasonable and necessary for the specific patient and his or her condition. Additionally, Medicare expects that the patient’s medical record will clearly demonstrate that medical necessity.” Allowing providers to use their clinical judgment based on the condition of each specific patient still requires that providers demonstrate that their skilled therapy services are reasonable and necessary to improve a patient’s impairment or functional limitation, and therefore meet the requirements for Outpatient Rehabilitation Therapy Services set forth in the Medicare Benefit Policy Manual.⁸

AOTA argues that the minute/unit/frequency/duration limitations in this LCD are attempting to impose a cap on access to therapy services for NHIC beneficiaries similar to the cap imposed by the Balanced Budget Act of 1997, but which Congress has seen fit to override with the implementation of an exception process that assures access to medically necessary, appropriate and skilled services beyond the arbitrary limit of the annual cap. NHIC is attempting to make a decision that is not within its purview but rather in the purview of Congress.

⁵ Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 5, § 20.2(C) (Reporting of Service Units With HCPCS).

⁶ Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 5, § 10.2(C)(1) (The Financial Limitation; Exceptions to Therapy Cap – General).

⁷ Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 5, § 10.2(C)(6) (The Financial Limitation; Use of the KX Modifier for Therapy Cap Exceptions).

⁸ Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 15, § 220.2 (Reasonable and Necessary Outpatient Rehabilitation Therapy Services).

The exception process has the added important element of supporting and promoting the value of the therapist's judgment in determining the medical necessity of therapy. The therapist must attest to the fact that the beneficiary's situation meets all of the Medicare coverage criteria when billing for additional therapy. Although it was always the case that the therapist confirmed that the patient met the coverage criteria, the emphasis in the exception process is a salute to the importance of the therapist's clinical judgment and professional behavior.

NHIC fails to provide any evidence or scientific studies to support the arbitrary frequency limits on therapy services referenced in the draft LCD. 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.

For the reasons listed above, AOTA urges the removal of the frequency and duration limitations, or "Rules of Thumb," in the draft LCD.

II. MEDICAL NECESSITY SECTION

Under "Medical Necessity" the draft LCD states:

There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time.

AOTA is concerned about conditions such as ALS, Parkinson's, and end stage Alzheimer's patients where patients may not demonstrate overall improvement, but would still benefit from occupational therapy to some degree. Occupational therapists (OTs) are able to provide services for seating and positioning to reduce risk of wounds and provide safety, comfort and caregiver training. These interventions, which obviously do not address the underlying illness, are appropriate care for such patients and should not be precluded from coverage.

III. SKILLED THERAPY SECTION

Transient and Easily Reversible Loss or Reduction in Function

Under "Skilled Therapy" the draft LCD states that "*Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction in function which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.*" We would grant that with a younger population many individuals this may be the case. However, AOTA disagrees with the statement with respect to an elderly population. With an elderly population the resumption of normal activities is often stalled or slowed due to age and/or illness. One example is the case of an elderly patient who develops pneumonia that causes reduction in function and progress to slow. This is where the evaluation, consultation and/or short-term treatment from an occupational therapist can prevent further deterioration and long-term disability. AOTA requests removal of the

statement quoted above because occupational therapy could benefit an elderly patient who has suffered a short term loss of function.

AOTA is concerned that the draft LCD as currently written could lead Medicare contractors to deny coverage for occupational therapy interventions that were medically necessary. We would recommend that in cases where the diagnosis and medical record suggests that spontaneous recovery should be possible, that the documentation by the treating therapist should illustrate why such natural resumption of activities was at risk for disruption.

Activities Planned by a Clinician

Under “Skilled Therapy” the draft LCD states:

There may be circumstances where the patient, with or without the assistance of an aide or other caregiver, does activities planned by a clinician. Although these activities may be supportive to the patient’s treatment, if they can be done by the patient, aides or other caregivers without the active participation of qualified professional/personnel, they are considered unskilled.

AOTA is concerned about this language because OTs often provide skilled services addressing patients’ activities of daily living (ADLs) a few times a week. On those days when the patient does not receive therapy, the nursing staff may assist the patient in getting dressed or bathing. We would not want this draft language to imply that the qualified and steps toward progress should be important factors in determining whether ADL training should be covered.

That section goes on to state:

If a patient’s limited ability to comprehend instructions, follow directions, or remember skills that are necessary to achieve an increase in function, is so severe as to make functional improvement very unlikely, rehabilitative therapy is not required, and therefore, is not covered. However, limited services in these circumstances may be covered with supportive documentation, if the skills of a therapist are required to establish and teach a caregiver a safety or maintenance program.

AOTA is concerned about this provision, because it assumes that the patient must always have intact cognitive abilities for services – that is not the case. OTs work with patients that have advanced dementia, or other related conditions, who may need occupational therapy for unrelated conditions to, for example, reduce a hand contracture and issue a splint. This is not a “one shot deal” as it may require diathermy, skilled therapeutic manual manipulation of the hand, and positioning strategies. The same would be true for a seating and positioning evaluation. An OT may intervene with a patient that has advanced Alzheimer’s who is combative during performing an ADL or is refusing to eat. In these instances, it often takes the skills of a therapist to determine the most effective approach to the patient to achieve the desired care outcome.

IV. THERAPEUTIC PROCEDURES SECTION

As stated at the beginning of this comment letter, AOTA has grave concerns with the use of “rules of thumb” to predetermine a patient’s need for therapy service. Please refer to Section I of this letter for discussion of the inappropriateness of the use of frequency and duration alone to determine medical necessity.

CPT 97110 - Therapeutic Exercises

The draft LCD states:

Therapeutic exercises are used for the purpose of restoring strength, endurance, range of motion and flexibility where loss or restriction is a result of a specific disease or injury and has resulted in a functional limitation.

The fourth paragraph of the section states,

Exercises to promote overall fitness, flexibility, endurance (in absence of a complicated patient condition), aerobic conditioning, weight reduction, and maintenance exercises to maintain range of motion and/or strength are non-covered.

Aerobic capacity impairment has a direct impact on a patient’s function and in the elderly who may not spontaneously recover. Aerobic conditioning may require the skills of a therapist to prescribe and monitor a safe and effective exercise program to remediate, especially those diagnosed with cardiopulmonary conditions. AOTA requests that “aerobic capacity” be added to the first sentence, and the word “aerobic” removed from the reference to aerobic conditioning in the second referenced sentence (see below):

Therapeutic exercises are used for the purpose of restoring strength, endurance, range of motion, flexibility and aerobic capacity where loss or restriction is a result of a specific disease or injury and has resulted in a functional limitation.

Exercises to promote overall fitness, flexibility, endurance (in absence of a complicated patient condition), conditioning, weight reduction, and maintenance exercises to maintain range of motion and/or strength are non-covered.

CPT 97112 - Neuromuscular Re-education

The draft LCD lists several specific documentation requirements for “When therapy is instituted because there is a history of falls or a falls screening has identified a significant fall risk.” AOTA is concerned that these documentation requirements are excessive and too limiting. If the patient is living in the community, the patient may not even know/remember much of the information resulting in a fall. In such an instance, the therapist may not be able to obtain all of the information included in the bulleted items in the draft LCD. In a facility (e.g., SNF) this information is gathered by a quality assurance team and much of the information and fact

finding is part of the Quality Assurance which is entitled to the protection of the peer review, medical review, quality assurance, or other similar privileges provided by state and federal law. AOTA respectfully requests that the sentence “When therapy is instituted because there is a history of falls or a falls screening has identified a significant fall risk, documentation should indicate” be changed to:

When therapy is instituted because there is a history of falls or a falls screening has identified a significant fall risk, documentation may include...

CPT 97532 – Development of Cognitive Skills to improve attention, memory, problem solving

Under the CPT code 97532, development of cognitive skills, the LCD states: “[t]his activity is designed to improve attention, memory, and problem-solving, including the use of compensatory techniques. Cognitive skill training may be medically necessary for patients with acquired cognitive deficits resulting from head trauma, or acute neurologic events including cerebrovascular accidents.” AOTA is concerned that the following policy in the LCD would preclude occupational therapy practitioners from billing CPT code 97532 for conditions involving dementia, such as Alzheimer’s or Parkinson’s disease. Additionally, occupational therapy services defined by this code may be reasonable and necessary where a patient’s cognitive impairments are interfering with physical rehabilitation or affecting patient and/or staff safety.

The LCD states that coverage should be limited to the following conditions:

- *310.1 PERSONALITY CHANGE DUE TO CONDITIONS CLASSIFIED ELSEWHERE*
- *310.8 OTHER SPECIFIED NONPSYCHOTIC MENTAL DISORDERS FOLLOWING ORGANIC BRAIN DAMAGE*
- *310.9 UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER FOLLOWING ORGANIC BRAIN DAMAGE*

Please also add the ICD-9-CM code for the underlying disorder (cause).

This list of ICD-9 codes is highly restrictive and does not acknowledge the cognitive changes that occur with traumatic brain injury such as TBI or CVA, or symbolic dysfunction that occurs in conjunction with organic brain damage. This list is also inconsistent with the earlier statement in this section of the draft LCD that states “Cognitive skill training may be medically necessary for patients with acquired cognitive deficits resulting from head trauma, or acute neurologic events including cerebrovascular accidents.”

AOTA is greatly concerned about the above proposed policy indicating that the patient must have a diagnosis indicating brain damage in order for an OT to bill using CPT 97532. We are especially concerned about coverage of cognitive training by OTs for conditions such as Alzheimer’s or Parkinson’s disease. The above proposed policy seems to require that one of the above diagnoses must be listed as an additional diagnosis on the claim form in order for procedures under 97532 to be covered. Some AOTA members do not typically feel comfortable

coding for a strictly medical diagnosis like organic brain damage because they are not trained to run the tests necessary to confirm that diagnosis; only a physician is qualified. Is it NHIC's expectation that OTs question the physician, who is probably not familiar with the therapy policy, to determine whether the patient meets these specific diagnoses?

There is abundant evidence that patients diagnosed with dementia benefit from skilled therapy intervention using cognitive intervention techniques, especially those based in procedural memory and cognitive-behavior interventions (See: Allen, C.K., et. al. 1992; Brush, J.A., & Camp, C.J., 1998; Camp, C.J., 1999; Gatz, M., et. al., 1998; Glantz, C. & Richman, N., 2007; Resnick, B., & Daly, M.P., 1997; Warchol, K., Copeland, & C., Ebell, C., 2002.).

The clinical vignette used in creating this code was a patient with Organic Brain Syndrome and depression; however the draft LCD leaves out the very diagnoses that were intended for this code. The following vignette was included "CPT Changes 2001: An Insider's View" by the American Medical Association:

An older adult has a combination of depression and organic brain syndrome. Although she lives with her daughter's family, she is alone during the day at their home. She has difficulty remembering when to take her medicines and frequently forgets to eat the meals that her daughter prepares for her. By analyzing the patient's home environment and daily routine, the provider develops a structured system by which the patient incorporates taking her medication and eating her meals into her daily activities.

This activity is designed to improve attention, memory, and problem-solving, including the use of compensatory techniques. Impaired functions may include but are not limited to ability to follow simple commands, attention to tasks, problem solving skills, memory, ability to follow numerous steps in a process, perform in a logical sequence and ability to compute.

These activities are incomplete as compared with the additional items listed for testing under the Cognitive Assessment CPT Code 96125: "memory (short-term, long-term, and organizational), reasoning, sensory processing, visual perceptual status, orientation, right hemisphere processing for temporal and spatial organization, social pragmatics, and elements of decision-making and executive function." The treatment activities should match the items being assessed.

The draft LCD states:

Conditions without potential for improvement or restoration, such as chronic progressive brain conditions, would not be appropriate. Evidence-based reviews indicate that cognitive rehabilitation (and specifically memory rehabilitation) is not recommended for patients with severe cognitive dysfunction.

In fact, the evidence suggests that there is tremendous value to cognitive rehabilitation for patients with mild to moderate cognitive loss (e.g., citations within the last 5 years from authors including Acevedo, Lowenstein, Camp, Bourgeois, Bayless & Tomoeda, Hopper). The National Institutes on Aging (NIA) at the National Institutes of Health (NIH) are conducting ongoing

research that is bearing out the value of cognitive rehabilitation in preserving memory function despite progressive neurological disease such as dementia of the Alzheimer's type.

According to "CPT Changes 2001: An Insider's View," the CPT code 97532 "is intended to report a focus of occupational therapy which is often required for adults with diagnoses of psychiatric disorders, brain injury, and cerebral vascular accidents (CVAs)." The focus of the CPT code 97532 was intended to be functionally related. Upon request, AOTA would be happy to provide copies of the CPT Changes 2001 OT case examples for your review and incorporation into the LCD.

In addition to the Supportive Documentation Recommendations listed in the draft LCD, we suggest that the therapist's evaluation must document specific impairments in attention, memory, problem-solving, or other cognitive components that affect functional performance. We emphasize again the comments made in Section III of this letter (Skilled Therapy section) with regard to NHIC restrictions placed on therapy services addressing the ability to comprehend instructions, follow directions, and remember skills. In addition to conditions like traumatic brain injury, NHIC's restriction could inadvertently result in denials for needed therapy services for patients with conditions such as Alzheimer's or Parkinson's disease. AOTA requests that NHIC permit the therapist, in coordination with the physician, to exercise their clinical judgment as to whether OT services for a cognitive impairment are medically necessary.

The draft LCD's approach of restricting a CPT code to a specific list of diagnoses is inconsistent with the approach taken in the rest of the LCD, which does not list any ICD-9 codes in relation to any other particular CPT codes. The diagnostic codes suggested in this section are very limited and rather idiosyncratic in current OT practice. Such a policy demonstrates a lack of trust in the treating physician's and occupational therapy practitioner's clinical judgment.

Finally, AOTA believes that the "supportive documentation" guidelines in the draft LCD address any concerns that NHIC may have with potential misuse or abuse of CPT code 97532. OT practitioners routinely document the following recommended information in their patient plans of care to justify the medical necessity of providing development of cognitive skills interventions. This language is pulled directly from the draft LCD:

Supportive Documentation Recommendations for 97532

- *Objective assessment of the patient's cognitive impairment and functional abilities*
- *Prognosis for recovery of the specific impaired cognitive abilities (remediation)*
- *A determination of a range of compensatory strategies that the individual can realistically utilize to improve daily functioning in a meaningful way*
- *Specific cognitive activities performed, amount of assistance, and the patient's response to the intervention, to demonstrate that the skills and expertise of the therapist were required*

Occupational therapists treat cognitive deficits as part of a person's rehabilitation plan of treatment, regardless of the medical diagnosis. Historically, Medicare policy has acknowledged an occupational therapy cognitive assessment and treatment as part of an occupational therapy

plan of treatment. If there have been problems with billing under this code by other types of practitioners, we do not believe they should be corrected by a “broad brush” policy, which may exclude patients from receiving appropriate occupational therapy services.

AOTA requests that NHIC delete the limitation on 97532 to specific conditions, expand the activities described under CPT Code 97532 to include the intended diagnoses, and acknowledge in the LCD that patients with severe cognitive loss (which need not be associated with brain damage) may benefit from cognitive training as provided under an occupational therapy plan of treatment. Physicians and therapists must be allowed to use their clinical judgment to determine if services are reasonable and medically necessary in the overall rehabilitation of a patient.

V. NON-COVERED SKILLED THERAPY SERVICES SECTION

Miscellaneous Services (Non-covered)

The draft LCD lists a number of “miscellaneous services” as non-covered skilled therapy services. AOTA is concerned about two of those listed: Constraint Induced Movement Therapy (CIMT) and Driving assessments.

Constraint Induced Movement Therapy (CIMT)

There is nearly two decades of research supporting the use of CIMT to improve upper extremity function following stroke or head injury. More recent research has shown this treatment to be effective when applied at a frequency, intensity and duration of treatment usually associated with outpatient services. See- Page, SJ, et al. Phys Ther. 2008 Jan 3, Modified Constraint Induced Therapy in Chronic Stroke: Results of a Single-Blinded Study.

Driving Assessments

AOTA asserts that a consideration of driving skills as part of an evaluation of a patient’s functional status is a medical necessity for many individuals with a recent onset of disability and who are receiving community re-integration services under CPT 97537. Documentation in the care plan should clearly support the need for, and relevance of, driving skills as part of a patient’s overall functional status.

A comprehensive Medicare coverage policy should support the inclusion of the assessment of driving skills in an OT evaluation so that an occupational therapist can identify functional problems related to driving with an impairment. In addition, the coverage policy should permit an OT, as part of the evaluation, to include in the plan of care treatment addressing the goal of driving and/or education of patients and their families on alternative mobility options so that community reintegration is achieved. Upon request, AOTA would be happy to provide NHIC with a copy of its Practice Guideline titled, “Driving and Community Mobility for Older Adults” for your review. For these reasons, AOTA requests that NHIC remove “driving assessments” from the list of non-covered skilled therapy services in the LCD.

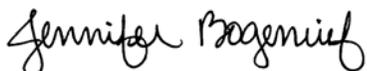
VI. UTILIZATION GUIDELINES AND MAXIMUM BILLABLE UNITS PER DATE OF SERVICE SECTION

On a final note, we reiterate our concerns about the various restrictions related to frequency and duration of services. In this section the draft LCD states, “rarely, except during an evaluation, should therapy session length be greater than 30-60 minutes. If longer sessions are required, documentation must support as medically necessary the duration of the session and the amount of interventions performed.” However, in following specific paragraph about timed modalities and interventions, the draft LCD also states that modalities “should be reported no more than 2 (two) units per code per day per discipline; additional units will be denied” and interventions “should be reported no more than 4 (four) units per code per day per discipline; additional units will be denied.” Such language is very confusing and contradictory to CMS’ policy against frequency or duration of treatment alone being used to determine medical necessity. AOTA urges NHIC to provide additional explanation as to the evidence and research supporting this coverage policy or to eliminate such language entirely.

* * *

We hope that these comments are helpful and greatly appreciate the opportunity to comment on the draft LCD. We look forward to a continuing dialogue with NHIC on these issues as they apply to occupational therapy. Should you have any questions or comments, please contact me at (301) 652-2682 ext. 2017 or via email at jbogenrief@aota.org. Thank you once again for considering the comments submitted above, and for your continued work on the behalf of Medicare beneficiaries.

Sincerely,



Jennifer Bogenrief
Senior Regulatory Analyst, Reimbursement and Regulatory Policy

cc: Alan Dunn, OTR/L, President, Maine Occupational Therapy Association
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