

Via online submission to www.regulations.gov

August 31, 2009

The Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attn: CMS-1413-P
P.O. Box 8013
Baltimore, MD 21244-8013

**Re: Medicare Program; Proposed Revisions to Payment Policies Under the
Physician Fee Schedule and Other Part B Payment Policies for CY 2010;
Proposed Rule (CMS-1413-P)**

Dear Acting Administrator Frizzera:

The American Occupational Therapy Association (AOTA) represents the interests of over 140,000 occupational therapists, occupational therapy assistants, and therapy students, many of whom are reimbursed under the Medicare Physician Fee Schedule and are affected by Medicare Part B payment policies. We appreciate the opportunity to comment on the Proposed Revisions to Payment Policies under the Physician Fee Schedule and Other Part B Payment Policies for CY 2010 (hereinafter "Proposed Rule"), as published in the Federal Register on July 13, 2009 at 74 Fed. Reg. 33520. AOTA presents the following comments on the MPFS Proposed Rule:

I. Proposed Payment Update for Professional Services

As a result of the perceived problems with the sustainable growth rate (SGR) formula, the Proposed Rule would decrease professional payments under the 2010 fee schedule by 21.5 %. CMS proposed in the Rule that the Physician Practice Information Survey (PPIS) data replace the currently used SMS data in the calculation of administrative practice expense. AOTA urges CMS to follow through with its intent in the Proposed Rule to use the more accurate and up-to-date PPIS practice expense (PE) data. AOTA appreciates the effort of the American Medical Association and CMS in obtaining updated administrative cost data and including Non-Physician Practitioner practices in the survey process.

In fact, AOTA, along with 21 other organizations representing physicians and healthcare professionals, sent CMS a joint letter to express our support for Medicare's implementation of the AMA Physician Practice Information Survey (PPIS) data. Collectively, our groups represented more than 630,000 physicians and healthcare professionals that provide high quality care for Medicare beneficiaries every day. The survey and CMS' proposal to incorporate its data into the

2010 Medicare Physician fee schedule is a clear example of implementing the unified goal of the Administration, Congress, CMS and MedPAC of improving payment accuracy.

The current data that CMS uses to calculate the per-hour costs are more than ten years old for the vast majority of physicians and other professionals. The payments for PE for many physicians and other healthcare professionals were significantly distorted over the last several years when supplemental PE data was submitted by a small minority of specialties. Both the Government Accountability Office (GAO) and MedPAC have been calling for CMS to update all of its practice expense data. In its June 2006 Report to Congress, MedPAC stated that “The data source CMS uses to estimate total practice costs is dated and may not reflect the current practice patterns. Up-to-date and accurate data is needed for all specialties.” Previously, CMS through authority granted by Congress allowed the submission of supplemental survey data. Many organizations were unable to submit data due to the high cost of gathering the data or because they did not support doing so in such a segregated manner. In 2007, CMS indicated that it would not accept any further data from individual groups or specialties.

Seventy-two groups contributed funds to undertake a uniform, fair and accurate practice expense survey. The AMA PPIS collected data from 51 different physician specialties and other healthcare providers and was the most comprehensive effort of its kind ever. It was done for exactly the purpose of updating the practice expense data for all groups and specialties at the same time; seventy percent of those who participated will see increases in their per hour costs because of this coordinated effort.

The PPIS was a highly scientific and controlled undertaking, using a survey instrument that the AMA took great care to design, test and implement. It followed the exacting criteria that CMS has for gathering this type of data and for submitting results that are acceptable. The AMA worked with The Lewin Group, a CMS contractor, to ensure that all data met this criterion and were analyzed consistently across the various physicians and other healthcare providers. Any data that did not meet the criteria, were response outliers or were statistically unacceptable were excluded. The results of the survey were independently corroborated and Lewin recommended that CMS utilize the data. CMS showed its confidence in the data by choosing to fully implement it in 2010.

CMS chose the appropriate time to incorporate the PPIS data as 2010 is the year that the new PE methodology is fully transitioned and utilizing the most current data to reflect practice cost is key to ensuring that the methodology is fair and accurate. It is imperative that Medicare use the most current and accurate data in order to determine practice expense payments for Part B providers. By doing so, CMS will update data that is more than a decade old and will correct the serious flaws and distortions that currently exist within PE payments. Again, AOTA urges you to stand by your goal of improving payment accuracy and move forward with the use of the PPIS for determining practice expense payments.

II. Therapy Cap and Extension of Exceptions Process

AOTA continues to oppose the underlying policy to apply a financial cap on therapy services available to beneficiaries who need them. AOTA asserts that the therapy cap is an arbitrary and

inappropriate solution to assure correct utilization of and payment for therapy services. CMS has instituted many other means of ensuring appropriate utilization of therapy services. Some of these safeguards include: CCI edits, edits required by the Deficit Reduction Act, local coverage determination policies and related local contractor claims review mechanisms, and Transmittal 63, now incorporated in the Benefit Policy Manual, setting forth specific documentation requirements and evaluation guidance involving the use of standardized assessment instruments. All of these can improve appropriateness of utilization and payment.

AOTA is pleased that Congress heard the voices of the rehabilitation profession and took action to extend the exceptions process through December 31, 2009. The feedback that AOTA has heard from occupational therapists regarding the cap exceptions process has been overwhelmingly positive with regard to the diagnoses (ICD-9 codes) that are acceptable for automatic exceptions. AOTA asserts that the exceptions process is effectively achieving the original objective of Congress in instituting it: to assure appropriate therapy service utilization and create savings for the Medicare program. AOTA believes that with the other above-mentioned tools, the exceptions process should be considered as the basis for a permanent alternative to the therapy cap. In fact, in its CY 2006 Outpatient Therapy Services Utilization Report prepared for CMS, Computer Sciences Corporation (CSC) reported on data that indicated the exceptions process may have met Congressional intent to successfully control cost and assure needed therapy be available to Medicare beneficiaries.¹ While AOTA asserts that the exceptions process is a viable solution as an alternative to the caps, there is certainly room for improvement and further tightening of the system. AOTA is happy to assist with any endeavors to improve and strengthen the cap exceptions process.

In addition, AOTA and our volunteer expert workgroup members has been working closely and diligently with CMS and CMS' contractors (Research Triangle Institute (RTI) and Computer Science Corporation (CSC)) on appropriate short term and long term alternatives to the therapy cap and will continue to offer feedback to CMS and its contractors throughout these two research projects. AOTA seeks to uphold deference for the occupational therapy practitioner's clinical judgment and to maintain payment for outpatient services under the Medicare Physician Fee Schedule.

III. Medicare Telehealth Services

In the Proposed Rule, CMS addresses previous requests received by the agency to add occupational therapy and physical therapy services to the list of approved telehealth services effective January 1, 2010. CMS declined to add therapy services noting a change in law was necessary for CMS to do this and stating, "physical and occupational therapists are not permitted under current law to furnish and receive payment for Medicare telehealth services." According to

¹ Outpatient therapy data reviewed by CSC demonstrated that from CY 2002-2004, the total number of therapy users increased 14%, while expenditures increased 26%. *However, this study reveals that from CY 2004-2006, although the total number of therapy users continued to increase by 3.5% the overall expenditures actually decreased 4.7%. As stated by CSC, "This suggests that the exceptions process in CY 2006 may have satisfied to some extent the Congressional intent to assure access to medically necessary services while controlling the growth in expenditures."* Outpatient Therapy Alternative Payment Study 2 CLIN 0002: Utilization and Trend Analysis: CY 2006 Outpatient Therapy Services Utilization Report, Prepared for CMS, by Computer Sciences Corporation (CSC), p. 8. (February 1, 2008).

statute, physical therapists, [occupational therapists], speech-language pathologists and audiologists are not permitted under current law to provide and receive payment for Medicare telehealth services at the distant site. The statute permits only a physician, as defined by section 1861(r) of the Social Security Act or a practitioner as described in section 1842(b)(18)(C) of the Act (CNS, NP, PA, nurse midwife, clinical psychologist, clinical social worker, registered dietitian or other nutrition professional), to furnish Medicare telehealth services.²

While AOTA agrees that the current law limits occupational therapy services from being provided under the Medicare telehealth services program, AOTA is currently working to change the law governing telehealth services. AOTA is supporting telehealth legislation currently pending in Congress that would authorize occupational therapy services to be provided via telehealth. In addition, AOTA has signed a petition as part of a coalition of like-minded organizations spearheaded by the American Telemedicine Association, which urges Congress to expand Medicare's limited coverage for telehealth services. AOTA asserts that such a change would greatly benefit the Medicare program from a cost savings perspective because the occupational therapy services can be provided via telecommunication technology. This is particularly true in rural areas where the use of technology can be a cost-effective way to improve the delivery of rehabilitation services.

In fact, occupational therapy practitioners have engaged in telehealth services in a variety of areas of therapy service delivery. The AOTA *Telerehabilitation Position Paper* may serve as a useful resource for CMS staff. The paper includes information about how "occupational therapy practitioners are initiating and participating in the use of telerehabilitation technology as a method for service delivery for:

- Evaluation
- Intervention
- Consultation
- Education
- Supervision of students and other personnel" (p. 656).³

Telehealth therapy services can be provided to Medicare beneficiaries efficiently and effectively. For all of the above reasons, AOTA urges CMS to engage in a pilot study to test the inclusion of occupational therapy services under the Medicare telehealth services benefit.

IV. Physician Quality Reporting Initiative (PQRI)

1. Proposed 2010 PQRI Quality Measures

AOTA was pleased to see the inclusion of the following measures reportable by occupational therapy practitioners beginning on January 1, 2010:

² See 71 Fed. Reg. 48995 and 69657.

³ American Occupational Therapy Association. (2005). *Telerehabilitation Position Paper*. *American Journal of Occupational Therapy*, 59, 656–660.

- Falls: Plan of Care
- Falls: Risk Assessment
- Documentation and Verification of Current Medications in the Medical Record
- Screening for Clinical Depression
- Pain Assessment Prior to Initiation of Patient Therapy
- Body Mass Index Screening and Follow-up: Preventative Care and Screening
- Health Information Technology: Adoption/Use of Electronic Health Records
- Inquiry Regarding Tobacco Use: Preventative Care and Screening
- Unhealthy Alcohol Use: Screening and Brief Counseling, Preventative Care and Screening

2. *Claims-Based Reporting Requirements*

One new proposal is that CMS would require a minimum 15-patient sample size to report an individual measure for at least one of the quality measures on which the professional reports in a 12-month reporting period. AOTA is concerned about this proposal because in some instances it may mean that small occupational therapy private practices that previously were able to participate in PQRI will no longer be able to meet the 15-patient requirement to participate. Instead of the 15-patient minimum, AOTA requests that CMS retain the current requirement that participants in the PQRI program must report on 80% of the applicable patients, or provide less burdensome criteria in consideration of small and solo therapy practices.

3. *Reduction or Elimination of Claims-Based Reporting after 2010*

In addition, in the Proposed Rule CMS states it may elect to phase out the claims-based reporting option as early as 2011. Currently occupational therapy practitioners only have one alternative to claims-based reporting; the use of a clinical data registry authorized by CMS. Of the 70 clinical registries approved by CMS, occupational therapy practitioners only can access one of these registries at this time. Many therapy practitioners are not yet using electronic health records in the gathering, storing, and documenting of patient information. In fact, a number of occupational therapy practitioners are still submitting paper-based claim forms and have not transitioned to electronic claims reporting. While AOTA agrees that in the long term, electronic health records and use of registries is a critical objective, many therapy practices simply will not be prepared to move from claims-based to registry reporting by 2011.

AOTA asserts that claims-based reporting is the most convenient and cost-effective way for solo and small private practices to report on the PQRI measures. Forcing practitioners to use registries before they are prepared will discourage many from participating in the PQRI, which is clearly inconsistent with the objectives of Medicare quality reporting. We request that CMS continue to allow claims-based reporting for PQRI through at least 2013 to provide more time for small and solo private practices to be educated about use of registries and EHRs and to transition internal procedures and systems.

4. *Extension of PQRI Program to Part B Services Provided in Facilities*

In comments on the FY 2009 Proposed Rule, AOTA requested that CMS address in the FY 2009 Final Rule whether CMS is considering extension of the PQRI program to outpatient services (billed under Medicare Part B) in settings such as acute care hospital outpatient departments, skilled nursing facilities, CORFs, or rehabilitation agencies. Many occupational therapy practitioners are employed in these various settings and are interested in the prospect of

participating in the PQRI program. Data obtained from these additional outpatient rehabilitation settings would greatly enhance the quantity and quality of information related to quality indicators for essentially the same Part B therapy services. Indeed, for occupational therapy, a large portion of Medicare Part B services are billed through these settings; it would appear to be in the interests of CMS to assure that these services are covered by efforts to improve quality.

In response to AOTA and other commenters in the FY 2009 Final Rule, CMS stated, "Our analysis of the two registry-based alternatives suggested by the commenters indicate that it would be possible for therapists in this situation to participate in a registry because there are registries 'qualified' to participate in our PQRI program that intended to report all of the PQRI measures and that are open to all eligible professionals who would like to participate with them. However, it would not be possible to calculate an incentive payment for the therapists' participation since our claims processing systems do not allow us to attribute services furnished by therapists who bill through fiscal intermediaries to an individual eligible professional to calculate the incentive amount." In the same section, CMS stated that it was in the process of evaluating potential changes to the fiscal intermediary claims processing system, but was not yet clear on the potential burden on the system or what the time frame for such a change might be.

AOTA continues to urge CMS to upgrade its fiscal intermediary claims processing systems so as to allow for new possibilities for eligible professionals afforded by registries and EHRs. AOTA supports efforts to attribute individual claims, even when submitted through fiscal intermediaries, to be attributed to an individual professional. Submission by electronic clinical information from registries and/or EHRs is the best way to increase participation of data submission and address the limitations of claims based quality measures data submission. Claims data is very limited and doesn't provide the best data for measuring quality of care improvements. This can be achieved with current technology. We urge CMS to begin working with the appropriate parties to make the necessary changes in processes and structures to implement submission of data from registries and/or EHRs in the 2010 PQRI.

V. Payment and Coverage Improvements for Patients with Chronic Obstructive Pulmonary Disease and Other Conditions--Cardiac Rehabilitation Services

In the Proposed Rule, CMS implements provisions of the 2008 Medicare Improvements for Patients and Providers Act (MIPPA) that provides for coverage of cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation under Medicare Part B, beginning January 1, 2010. Occupational therapists and occupational therapy assistants participate as personnel in these programs, which are furnished in physician offices or outpatient hospital settings.

1. Cardiac and Intensive Cardiac Rehabilitation Services

According to CMS in the Proposed Rule, a cardiac rehabilitation program is physician-supervised and would include the following: physician-prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; and outcomes assessment. Occupational therapy practitioners are educated to provide many of these skilled interventions and do provide them currently, billing the services as therapy.

Of particular note, Section 144(a) of the MIPPA requires CR and ICR programs to furnish items and services including “cardiac risk factor modification.” This includes education, counseling, and behavioral intervention to the extent these services are closely related to the individual’s care and treatment and tailored to patients’ individual needs. CMS describes risk factor modification as involving the following:

We are proposing that patients must be provided with the information and tools to improve their overall cardiovascular health. Items and services furnished as part of the risk factor modification component should be highly individualized as multiple risk factors contribute to poor cardiovascular health. For example, these items and services may include smoking cessation counseling or referral, nutritional education and meal planning, stress management, prescription drug education and management information, disease history education in order to foster a better understanding of disease origins and disease symptomatology, and any other education, counseling and behavioral intervention deemed appropriate in each patient’s individualized treatment plan.

AOTA asserts that occupational therapy practitioners are appropriate personnel to provide cardiac risk factor modification interventions, as well as functional interventions and therapeutic exercise activities to increase functional status and promote energy conservation. In fact, therapists are specifically trained to teach patients to adopt different daily routines and alter lifestyle choices based upon their conditions. AOTA urges CMS to continue to include occupational therapy practitioners as potential personnel who may provide services under cardiac and intensive cardiac rehabilitation programs.

Treatment Plans

AOTA believes that in order for a cardiac rehabilitation (CR) program to be successful and meet the needs of patients, the program must be designed to meet the patient’s individual needs and goals. This concept is at the core of occupational therapy education and practice. The proposed requirements of 60 minute minimum sessions, 2 sessions of CR per week, and requiring aerobic exercise in every CR session limit the programs ability to be successful in meeting the needs of all patients because it does not allow the physician to tailor the patients’ treatment plans.

AOTA urges CMS to make the following changes:

1. Allow CR sessions that are less than a 60-minute time frame. Documentation should support the decreased session length.
2. Maintain the 60 minute requirement for all non-monitored CR sessions to ensure ample time for education and counseling to occur.
3. Allow CR sessions that do not include aerobic exercise. This would allow for flexibility in meeting the treatment plan and goals for education/counseling and exercise.

Staff Qualifications

AOTA agrees with the position of the American Association of Cardiovascular and Pulmonary Rehabilitation that a multidisciplinary team approach provides the highest quality of specialized

services because individual staff would not likely have all the core competencies required to work with CR patients who have multiple co-morbidities to meet their education and counseling needs.⁴ As stated above, occupational therapy practitioners are specifically trained to teach patients to adopt different daily routines and alter lifestyle choices based upon their conditions. Occupational therapists work closely as part of a team with other professionals under physician supervision to implement and provide medically necessary therapy services under the program. AOTA urges CMS to continue to include occupational therapy practitioners as potential personnel who may provide services under cardiac and intensive cardiac rehabilitation programs.

2. *Pulmonary Rehabilitation Services*

Similarly, CMS states in the Proposed Rule that a pulmonary rehabilitation program would include the following: physician-prescribed exercise; education or training; psychosocial assessment; and outcomes assessment. Of particular note, Section 144 of MIPPA requires that education or training provided to beneficiaries must meet the statutory requirements that mandate that it must be closely and clearly related to the individual's care and treatment, as well as meeting the specific needs of the individual. CMS states that as part of the written individualized treatment plan the physician should evaluate and include only that education and training which addresses the needs particular to the patient that will further their independence in activities of daily living. Under the Proposed Rule, the prescribed training and education for beneficiaries should assist patients in learning to adapt to their limitations and improve the quality of their lives.

For reasons similar to those discussed in the cardiac rehabilitation section above, AOTA asserts that occupational therapy practitioners are appropriate personnel to be included as part of the interdisciplinary team to provide education and training, as well as functional interventions and therapeutic exercise activities to increase functional status and promote energy conservation for beneficiaries participating in pulmonary rehabilitation programs. In fact, OT practitioners have significant experience providing interventions for patients with COPD and related pulmonary conditions to assist patients to successfully manage their disease and maintain a more consistent functional level. AOTA urges CMS to continue to include occupational therapy practitioners as personnel who may provide services under pulmonary rehabilitation programs.

Treatment Plans

AOTA believes that in order for a pulmonary rehabilitation (PR) program to be successful and meet the needs of patients, the program must be designed to meet the patient's individual needs and goals. This concept is at the core of occupational therapy education and practice. The proposed requirements of 2-3 sessions of PR per week, 60 minute minimum sessions, and no more than 1 session per day limit the programs ability to be successful in meeting the needs of all patients because it does not allow the physician to tailor the patients' treatment plans. AOTA urges CMS to make the following changes:

⁴ AACVPR Position Statement: Core Competencies for Cardiac Rehabilitation Professionals (JCR 1994;14:87-92).

1. Allow PR sessions that are less than a 60-minute time frame. Not all patients can tolerate a 60 minute session at the beginning of treatment and certain patients may need to work up that minimum standard.
2. Consider permitting more than 1 PR session per day to assure that the patient is able to participate in all the components of the PR program (education and training, for ex.). This way, CMS would be permitting the physician in consultation with the PR team to individualize the treatment plan to meet each patients' specific needs.

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AOTA requests that due consideration be given to these comments. Thank you, again, for the opportunity to comment on the MPFS 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,



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