

Congress of the United States
Washington, DC 20515

September 21, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 310-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Berwick:

Today we write to respectfully request that the Centers for Medicare and Medicaid Services (CMS) withdraw a proposal contained in the Calendar Year (CY) 2011 Physician Fee Schedule Proposed Rule, which would result in significant funding cuts for essential outpatient physical therapy, occupational therapy, and speech-language pathology services leading to potential loss of services for Medicare beneficiaries. Our growing concern and request is based upon newly-available information and data as to the real-life impact that application of the multiple procedure payment reduction (MPPR) policy to Medicare Part B covered therapy services would have. This builds upon the concern articulated in an August 2, 2010 letter from sixty-eight members of the U.S. House of Representatives, and a similar letter signed by twenty-four U.S. Senators on August 12, 2010.

We support CMS' goal of creating efficiencies when multiple services are provided in a single session of care, but oppose cuts that may come at the expense of the most appropriate patient care – particularly in rural and other underserved areas. Whereas the goal is laudable, we believe that the proposed policy is misguided based on the facts that 1) the practice expense (PE) values for the Current Procedural Terminology (CPT) codes were already reduced to avoid duplication; 2) the methodology used by CMS to derive the median number of units is flawed; and 3) application of the MPPR reduction across separate disciplines (physical therapy, occupational therapy, and speech-language pathology services) and on a per day basis is inconsistent with the delivery of outpatient therapy services in a variety of settings and could unfairly reduce payment for the resources used to provide these services.

Further, our request to withdraw the MPPR policy from the final CY 2011 Physician Fee Schedule, is reinforced by comments submitted to your office by the independent Medicare Payment Advisory Commission (MedPAC) that, in part, recommended that, "the agency should better justify in the final rule how a 50 percent reduction would capture the duplicate inputs related to multiple services performed in a single session." The comment letter went on to recommend that CMS ask the AMA/Specialty Society Relative Value Scale Update Committee (RUC) to "review the values of all outpatient therapy codes to ensure that practice expenses are not duplicated."

Codes Already Reduced

We are told that CMS incorrectly assumes that duplicate clinical labor and supplies are included in the practice expense relative value units when multiple services (two or more) are furnished to a patient in a single session. It is our understanding that this basic assumption is incorrect because during the development of the practice expense relative value units for the therapy services the fact that certain efficiencies exist when multiple therapy services are provided in a single session was explicitly taken into account. CMS acknowledges in the proposed rule that the time spent on pre-service and post-service activities has already been spread across the number of services in a typical physical therapy session to avoid duplication of practice expenses. Further, it is important to note that when only a single unit of service is provided or when a single therapeutic procedure is provided together with one unit of modality, the existing valuation actually produces a underpayment. Thus, fairness would demand that CMS should also consider scenarios involving current underpayment.

Flawed Methodology on Deriving the Median Number of Codes

CMS alleges that the median number of therapy services is four and therefore there is duplication. We are told by the therapy community that CMS's analysis of the median number of units per visit is flawed. CMS acknowledges that it excluded all claims with a single unit of service when identifying the median. To determine the median number of units of service in the Medicare claims data by first eliminating all the claims with a single unit of service is inconsistent with standard statistical methods. By excluding any visits during which one unit of service is billed, CMS inappropriately skews the median upward, resulting in a higher median number.

We are also told CMS only examined the median number of services in private practice physical therapist and occupational therapist settings and physician offices. Based on analysis of 2007 claims data conducted by CMS contractor Research Triangle Institute, the private practice setting and physician office setting account for only 35.9% of the outpatient therapy expenditures. The remaining 64.1% of expenditures for outpatient therapy services are from hospital, skilled nursing facility, outpatient rehabilitation facility, home health and Comprehensive Outpatient Rehabilitation Facility (CORF) settings. We are also informed that CMS combined all services provided in the course of a day in calculating the median. It seems illogical to combine services provided at separate times during the day as there are no economies of scale that can be obtained in such circumstances.

The therapy community collected its own claims data from providers from various practice settings, including hospitals, rehabilitation agencies, skilled nursing facilities, and private practices. A review of approximately 3.3 million claims from these settings showed that the median units of service on a given date is 3.0 units, not 4.0 units. While they did not have time to conduct a comprehensive analysis of these claims, they noted that the median of 3.0 is consistent with the RUC's assumption that a typical visit is 45 minutes in duration (three 15 minute services).

Application of the MPPR Reduction Across Separate Disciplines

CMS' proposal is focused on the delivery of therapy services in the office setting and fails to consider that the pattern of delivery of therapy services in provider settings is different. In certain settings, such as skilled nursing facilities, it is common for a patient to receive services from one discipline - such as physical therapy - in the morning and another discipline - such as occupational therapy or speech-language pathology - in the afternoon. In some cases the three therapies are provided on the same day to maximize a patient's recovery - a practice that could be limited by CMS' proposal. Application of this MPPR policy on a per day basis mistakenly assumes there is duplication in such circumstances. There are no economies of scale when services are provided at separate times during the course of the day. Also, application of this policy to distinct and separate disciplines is illogical.

We are concerned that the MPPR policy as applied in CMS' proposal to outpatient therapy services may inadvertently limit access to critical therapy services, and could unintentionally lead to longer stays in a facility in order to achieve the same level of independence and function, which would ultimately be more costly.

For these reasons, we believe it is necessary for CMS to withdraw its MPPR proposal as it relates to outpatient physical therapy, occupational therapy, and speech-language pathology, and work with stakeholders on a policy that creates needed efficiencies while guaranteeing Medicare beneficiaries, especially those in more rural and underserved areas, necessary access to these vital rehabilitation services.

Sincerely,



EARL POMEROY
Member of Congress



GLENN GT THOMPSON
Member of Congress