

December 8, 2009

Michelle Shortt  
Director, Regulations Development Group  
Office of Strategic Operations and Regulatory Affairs  
Centers for Medicare & Medicaid Services  
Attention: CMS – 10298 (OMB#:0938 – New)  
Room C4-26-05  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

**RE: Data Collection for Developing Outpatient Therapy Payment Alternatives (CMS -10298)**

Dear Ms. Shortt:

On behalf of 140,000 occupational therapy practitioners and students, the American Occupational Therapy Association would like to thank CMS for the opportunity to review and comment on the assessment tools developed as part of the Developing Outpatient Therapy Payment Alternatives Project (DOTPA). As we understand the project, RTI has been developing assessment tools for the purposes of describing the characteristics and outcomes of individuals receiving occupational therapy, physical therapy and speech–language pathology services reimbursed through Medicare Part B payment. We understand that CMS has contracted this project to better understand the patterns of Medicare Part B therapy utilization, to better identify what therapy services are necessary for individuals with Medicare Part B, and to help predict outcomes of therapy services paid for through Medicare Part B.

Thus, we assert that this project, in general, and the two assessment tools, in particular, could have a significant impact on the provision of occupational therapy services to older adults in our nation. Toward that end, we have carefully reviewed the proposed assessment tools (CARE-C and CARE-F), and solicited comments from several experts in the occupational therapy profession. Among these experts are AOTA members who served on the Technical Expert Panel for the DOTPA project in July 2008, and participated in ongoing discussions with RTI during the development of both tools. Following is a compilation of the critical points we believe are of particular significance and bear your careful consideration.

**Specific Comments on the Data Collection and Data Analysis Processes**

With respect to the plan for data collection, we would recommend careful consideration of how providers will be trained in the administration of the data collection tools. As we reviewed the items in both tools, we detected several instances where the wording of items was subject to interpretation, which may affect the integrity of the data. We strongly recommend standardized procedures for training providers participating in the data collection process.

With respect to the plan for data analyses, we would ask CMS to carefully consider the following critical points:

1. Of particular concern is the plan to conduct analyses to derive risk adjustment for all outpatient therapy services based on case mix group coefficients. The rationale for this was to avoid complications when two disciplines may be treating the same client. **However, we strongly recommend that analyses examining risk adjustment should be distinct for each discipline.**
  - We would submit that two disciplines are involved because two different approaches to intervention are needed to address the complex nature of the presenting impairment or disability. Risk adjustment for occupational therapy services should be different from risk adjustment for other therapy services because by definition, the scope, intervention, and anticipated outcomes differ.
  - We also would submit that the frequency of claims related to occupational therapy services is less than physical therapy, and therefore an unweighted analysis could skew the results as it relates to determining patient characteristics, need and outcomes of occupational therapy services.
2. **Toward that end, we recommend that CMS require a statistically valid sample of each therapy separately to make sure the data are appropriately representative of each therapy discipline.**
3. In our previous interactions with RTI, we have discussed the use of some data as “risk adjusters” and some data as “outcomes.” We submit that the same data points cannot serve both purposes, and that the use of each data point, as well as its weight in the algorithm, need to be specified clearly as this project moves forward.
4. We strongly recommend that CMS require RTI to identify their plan for managing missing data, and examining reasons for missing data. These analyses will have significant impact on the outcomes of the data analyses.

### **ICF Concept of Participation Should be Better Represented**

Overall, we endorse the use of the International Classification of Functioning, Disability and Health (ICF) in the tools. We believe that it is critical that these tools capture the “functional” needs of Medicare Part B beneficiaries, and the ICF provides a universal framework for describing “therapeutic” diagnoses addressed by therapy services.

That said, **we are concerned that the ICF concept of “Participation” is not well represented in either assessment tool, and yet it is a critical functional domain for Medicare Part B beneficiaries who require occupational therapy.** Participation, as conceptualized by the ICF, is involvement in a life situation, including one’s ability to engage in the home and the community. Participation restrictions are clear indicators of disability, and also predictors of poor health status among community-dwelling older adults.<sup>12</sup> Furthermore, occupational therapy services have demonstrated efficacy and effectiveness in reducing participation restrictions and associated

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<sup>1</sup>Field, M. J., & Jette, A. M. (2007). Future on disability in America. Washington, DC: National Academies Press.

<sup>2</sup>Wilkie, R., Peat, G., Thomas, E., & Croft, P. (2007). Factors associated with participation restriction in community-dwelling adults aged 50 years and over. *Quality of Life Research*, 16(7):1147-1156.

impairments in health status.<sup>34</sup> Thus, participation restrictions are reliable indicators of the need for occupational therapy services. Toward that end, we have provided specific suggestions as to how to address participation in the assessment tools (see comments on Section II, Sub-section C).

In addition, the CARE-C tool lacks a thorough provider-assessed section on activities of daily living, specifically self-care, functional mobility and instrumental activities of daily living. We recommend using items from the CARE-F tool (*Section VI. Functional Status, Sub-sections A, B & C*). This modification would have many important advantages:

- Self-care, mobility and instrumental activities of daily living are critical domains triggering the need for therapy services, and are the primary outcomes of interest for most beneficiaries of Medicare Part B.
- Both tools (CARE-C, CARE-F) will contain the same items addressing these critical domains (self-care, mobility, instrumental activities of daily living)
- Provider-assessed function of these critical domains can be compared with patient reported outcomes.

### **Specific Comments on the Data Collection Tools: CARE-C**

#### *Section I. Administrative Information*

We recommend adding an item to identify the type of setting where the therapy is taking place (e.g., comprehensive outpatient rehab facility, outpatient rehab facility, private practice, etc.). There is little information on the context of therapy otherwise.

#### *Section II: Patient Information, Sub-section C:*

##### *C.1: Primary Condition: What is the main health/condition/reason you are receiving therapy?*

The options listed under this item are a mixture of body structure and body function impairments, health conditions, and functional problems. Consistent with the use of the ICF, we recommend that the list be split into two sections with one focusing on body function impairments, and one focusing on activity limitations. Body structure and body function impairments should be broadened to include problems with memory and problems with vision. Activity limitations should be broadened to include problems with self-care, problems managing the home, and problems maintaining activities in the community.

*Recommended Addition: Item measuring participation (as defined by the ICF).* We recommend adding the following item to this section to screen for participation restrictions.

#### **I need to be able to do more to be able to:**

- Take care of myself
- Take care of others for whom I am responsible
- Take care of my home
- Participate in my usual activities within the community

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<sup>3</sup> Macedo, A. M., Oakley, S. P., Panayi, G. S., Kirkham, B. W. (2009). Functional and work outcomes improve in patients with rheumatoid arthritis who receive targeted, comprehensive occupational therapy. *Arthritis & Rheumatism*, 61(11): 1522-1530.

<sup>4</sup> Steultjens, E. M., Dekker, J., Bouter, L. M., Leemrijse, C. J., & van den Ende, C. H. (2005). Evidence of the efficacy of occupational therapy in different conditions: an overview of systematic reviews. *Clinical Rehabilitation*, 19(3):247-254.

This item can either be added as a separate item after Item C1, or be added on to the end of Item C1 as suggested above.

*Section II: Patient Information, Sub-section F:*

While we acknowledge the value of using items scaled with Item Response Theory methods, we strongly recommend that the sub-items in F1 – F3 are scaled to a high functioning community-dwelling population of older adults and do not represent individuals at the lower end of the scale who also receive Medicare Part B services in community settings. We suggest adding items that would be more sensitive to change in this population, reflecting more basic mobility and self-care tasks.

*Section III: Provider Information, Sub-section A:*

The CARE-F tool includes an item in Section II. Admission Information: A3. *Why is this patient receiving therapy services covered by Medicare Part B.* We recommend adding an item to this subsection in the CARE-C tool to capture this specific information.

Further, we recommend separating out the components of “Specific Mental Functions” (A.1.b) just as the body structures are separated (A.2.) as these different mental functions are as distinct for assessment/intervention as are the parts of the musculoskeletal system.

*Section III: Provider Information, Sub-section C:* The wording of item C.4.c should be changed as outlined below to avoid confusion.

- Mildly impaired: Demonstrate some difficulty with one or more of these cognitive abilities.
- Moderately impaired: Demonstrate marked difficulty with one or more of these cognitive abilities.
- Severely impaired: Demonstrate extreme difficulty with one or more of these cognitive abilities.

*Section III: Provider Information, Sub-section D:*

*D.7 – D.9. Problem Solving, Memory, Attention:* The descriptions of activities in these items ranges from very simple to very complex within each domain. We recommend altering the wording of the language under “Level of Assistance” to indicate the following edits:

“Without Assistance: Patient performs all activities without cueing, external guidance....”

“With Assistance: Patient performs at least one activity with cueing, external guidance....”

*Section III: Provider Information: Recommended Addition*

We recommend adding items currently in the CARE-F tool (*Section VI. Functional Status, Sub-sections A, B & C*) to this section.

**Specific Comments on the Data Collection Tools: CARE-F**

*General Comment on the CARE-F:* We are seeking clarification for the reason there is a “2-day” assessment period. This will likely affect the provider’s ability to complete the entire form, and recommend an expansion to a “3-day” assessment period.

*Section II. Admission Information: Sub-section A:*

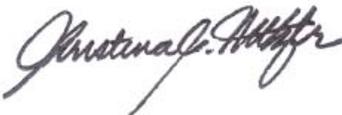
*A3. Why is this patient receiving therapy services covered by Medicare Part B?:* We recommend adding an item to this section that states, "Change or loss of caregiver" as this is a frequent reason for Part B admissions to SNF settings.

In summary, we have provided these comments to help design effective data collection tools to measure the characteristics and outcomes of individuals receiving Medicare Part B therapy services. The addition of participation (as defined by the ICF), the expansion of the assessment of self-care, mobility and instrumental activities of daily living, and recognizing the impact of caregiver support on function, will be critical to collecting data necessary to describe the characteristics and outcomes of Medicare Part B beneficiaries who receive occupational therapy services. **The charge to understand the reimbursement patterns and needs of individuals with Medicare Part B can only be met if occupational therapy services are adequately sampled.**

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We would like to thank CMS and RTI for including us in this process. AOTA requests that due consideration be given to these comments. We remain willing and committed to the data collection and development efforts associated with Medicare Part B payment, and we would be very interested in discussing our comments with the working group either by conference call or another convened meeting. We trust that you will keep us informed as this process unfolds.

Sincerely,



Christina A. Metzler  
Chief Public Affairs Officer

cc: David M. Bott, PhD, DOPTA CMS Project Officer