

Via online submission to MBPMComments@cms.hhs.gov

June 30, 2009

Ms. Charlene Frizzera
CMS Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-1410-P, Mail Stop C4-26-05
Baltimore, MD 21244-8016

**Re: Proposed Revisions to Section 110 of the Medicare Benefit Policy Manual (MBPM)-
Chapter 1, Inpatient Hospital Services Covered Under Part A (Issued April 28, 2009).**

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 serve the Medicare populations in inpatient rehabilitation facilities (IRFs) and in other post-acute care settings. We appreciate the opportunity to comment on the proposed revisions to Section 110 of the Medicare Benefit Policy Manual (MBPM). Where appropriate, AOTA references the notice titled Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010 (hereinafter "Proposed Rule"), which was published in the *Federal Register* on May 6, 2009 (74 Fed. Reg. 21052) in conjunction with the Section 110 MBPM revisions.

AOTA presents the following comments on revisions of Section 110 of the Medicare Benefit Policy Manual:

Therapy Disciplines

AOTA appreciates that the new CMS criteria for IRF coverage emphasizes the patient's rehabilitation and functional needs. In the Proposed Rule, CMS states, "The patient's needs require the active and ongoing therapeutic intervention of at least two therapy disciplines (physical therapy, occupational therapy, speech-language pathology or prosthetics/orthotics therapy), one of which must be physical or occupational therapy."¹ AOTA strongly supports the requirement that occupational therapy be one of the two active and ongoing therapy interventions. Occupational therapy is a regulated profession and there are numerous safeguards in place, including state licensure, Medicare standards for providers and suppliers (occupational therapy has been recognized in Medicare inpatient care since the program's inception, and in outpatient care since 1987), and the profession's ethical and competency requirements. The profession of occupational therapy is regulated in all fifty states. AOTA applauds CMS for recognizing and continuing to support the critical value of occupational therapy to Medicare beneficiaries receiving care in an IRF setting.

¹ 74 Fed. Reg. 21080 (proposed regulatory text at 42 CFR 412.29(b)(i)).

AOTA supports the proposed deletion CMS made to the MBPM removing language permitting “other skilled rehabilitative modalities”² to count toward the 3-hour rule requirement. AOTA agrees that only skilled therapy should be counted toward the 3-hour rule.

AOTA supports the following proposed change to the manual:

110.2.1 - Intensive Level of Rehabilitation Services

A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient’s medical record (especially the required documentation described in section 110.1) must document that at the time of admission to the IRF the patient required the active and ongoing therapeutic intervention of at least two therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

AOTA acknowledges that other stakeholders are urging CMS to add recreational therapy to the 3-hour rule. AOTA does not regard recreational therapy as having the same status under Medicare, professional regulation under state law or impact as occupational therapy. We believe that services listed in the 3-hour rule should be reserved for high intensity skilled services.

In addition, AOTA has heard anecdotally that the services of aides may be inappropriately counted toward the 3-hour requirement in IRFs. We note that in the newly proposed policy in skilled nursing facilities, CMS makes a clear statement about the use of aides services, specifically stating, “Therapy aides are expected to provide support services to the therapists and cannot be used to provide (*sic*) skilled therapy services.”³

Thus, in other settings, CMS does not support the services of aides being provided as skilled therapy; aides are expected to provide support services to therapists. AOTA agrees with CMS’s statement on the role of aides. AOTA’s official document, *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services (2009)*, states:

An *aide*, as used in occupational therapy practice, is an individual who provides supportive services to the occupational therapist and the occupational therapy assistant. Aides do not provide skilled occupational therapy services.⁴

Most state laws do not permit use of aides to provide skilled services. AOTA urges CMS to remind providers that state law supersedes Medicare policy with respect to the role of aides. We believe that all therapeutic time spent with a patient that counts toward the 3-hour rule must be skilled therapy.

² Medicare Benefit Policy Manual (MBPM) Chapter 1, Section 110.4.3, Relatively Intense Level of Rehabilitation Services.

³ Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities, 74 Fed. Reg. 22222. (May 12, 2009)

⁴ To be published and copyrighted in 2009 by the American Occupational Therapy Association in the *American Journal of Occupational Therapy*, 63(November/December).

Group Therapy

In the Proposed Rule, CMS states the belief that therapies provided in a group mode have a role in patient care in an IRF, but that they should be used in IRFs primarily as an adjunct to one-on-one therapy services, not as the main source of therapy services provided to IRF patients because group therapy is of a lower intensity than the therapy required in the IRF setting. CMS solicits comments as to “the types of patients for which group therapy may be appropriate, and the specific amounts of group instead of one-on-one therapies that may be beneficial for these types of patients.”⁵

AOTA believes that the combination of treatment modalities appropriate for any individual patient in an IRF should be determined based on individual need and as a result of the clinical evaluation, reasoning and judgment of the attending therapist. AOTA and its practitioners in IRFs believe that group therapy can be as intense as individual therapy and may be more effective in yielding outcomes in some circumstances. Thus, group therapy can be used in combination with individual therapy in certain cases; evaluations and re-evaluations are always individual. All occupational therapy provided as a skilled service by qualified professionals should count toward to 3-hour rule. See our comments elsewhere in this letter on what therapies should be counted toward the 3-hour rule.

With regard to CMS’ concerns regarding the value of group therapy, AOTA argues that occupational therapy provided to patients in a group can be of benefit with specified goals individualized to the patient. Some occupational therapy groups will have clients with similar diagnoses (for example, an exercise group for cardiac patients might be closely monitored through use of Holter monitors while they are working on functional and endurance activities), while others will mix patients with varying diagnoses to provide a richer experience (for example, a cooking group where one person sits and cuts with an adapted cutting board while another works on kitchen mobility gathering items and a third person works on endurance washing the dishes at the end).

In fact, in certain cases, group therapy can be exceedingly intense for a patient and can be the preferred form of occupational therapy for certain patients because patients share experiences and educate each other about how to accomplish a task more efficiently, build social relationships and interact collaboratively (especially since patients can often become socially isolated and depressed with complex medical conditions), build confidence, and can learn to work as a unit to accomplish a task. For example, one individual may not have enough skill to cook something alone, but feels a great sense of accomplishment to say he/she was part of the group that cooked together successfully.

Moreover, in the Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities published in the *Federal Register* on May 12, 2009, CMS authors specifically stated that, “In a group setting, the patients are performing similar activities. By interacting with one another, the patients observe and learn from each other. They then apply this new information into their own therapy program to progress and, thus, benefit from the group setting.”⁶ At the same time, AOTA believes that group therapy should never be the only type of therapy that a patient receives in the IRF setting. AOTA strongly values the importance of individualized 1:1 therapy and believes there is a place for both types of therapies for appropriate patients to meet their treatment goals. Professional judgment based on individual cases must

⁵ 74 Fed. Reg. 21070.

⁶ 74 Fed. Reg. 22223

guide these decisions, not arbitrary constructs based on simple diagnosis rather than the full picture of the patient.

AOTA urges CMS to explore these issues in greater depth and to conduct research regarding outcomes of individual therapy v. group therapy before proposing IRF group therapy policy changes. One option is to use the Post Acute Care (PAC) Payment Reform Demonstration CARE instrument to collect data to further study the effectiveness of different modes of therapy delivery. In addition, a review of IRF patient discharge information, namely discharge destination, might be of assistance to CMS in getting at the outcomes and quality of the various modes of therapy delivery. Defining rules for therapy approaches outside the context of achieving appropriate outcomes is not good policy.

The patient's functional status is a critical consideration when a therapist is evaluating including a patient in an occupational therapy group. A patient's rehabilitation needs can change during the IRF stay. As the patient becomes stronger and increases their endurance, group therapy may become more dominant for some patients. It is highly unlikely that a patient would be placed into group occupational therapy upon IRF admission. Individual therapy should be used in combination with appropriate group therapy during the course of treatment in an IRF based on the occupational therapist's clinical judgment and the patient's changing needs. For instance, group therapy may be used more heavily at the end of an IRF stay as the patient achieves his or her goals.

AOTA asserts that groups play a vital role in the IRF therapeutic environment and should not be restricted from the 3-hour rule. Ultimately the decision as to whether group therapy is appropriate for a given patient should be left up to the occupational therapist's clinical judgment. Accordingly, AOTA respectfully requests that CMS revise the language below as it appears in the proposed MBPM with regard to group therapy (additions are in italics):

The intensity of therapy services typically required to meet the needs of a beneficiary requiring an IRF level of care is expected to exceed the intensity of therapy services provided in a SNF. For this reason, therapy services provided in an IRF must generally exceed the SNF therapy requirements. This means that an IRF patient's daily therapy requirements *can be met by a combination of one-on-one therapy and group therapy as appropriate for the individual* and as documented in the patient's medical record.⁷ ~~Group therapies are to be used in IRFs primarily as an adjunct to one-on-one therapy services.~~

Documentation Requirements

AOTA urges CMS to reinsert the following deleted language in the MBPM, Chapter 1 section 110.1 with regard to the role of Medicare contractors and documentation requirements:

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

⁷ MBPM, chapter 1, Section 110.2.1, Intensive Level of Rehabilitation Services (proposed section). Note that AOTA recommends deleting the last sentence in this section that states, "Group therapies are to be used in IRFs primarily as an adjunct to one-on-one therapy services."

or specific treatment norms, "the three hour rule," or any other "rules of thumb," are not appropriate.⁸

AOTA has frequently used this section to advocate against inappropriate and overly restrictive Medicare local coverage determinations (LCDs) that relate to IRFs, and also as an example of an important national policy that local contractors must follow in LCDs affecting other settings. Numerical utilization screens, diagnostic screens and other "rules of thumb" standards are an enormous problem for AOTA in LCDs that cover occupational therapy. They are used to arbitrarily restrict access to needed and beneficial therapeutic care. Further, such rule of thumb standards significantly interfere with the physician's and therapy professional's clinical judgement as to the medical need and functional status of their patients. Re-insertion of this language will assist occupational therapy practitioners to continue to advocate to protect the scope of practice of occupational therapy and to assure the local contractors follow the clear coverage rule set by the Medicare program that national coverage policies (where they exist) always supersede local coverage policies.

Exception to 3-Hour Rule

AOTA supports the proposed addition of specific language permitting exceptions to the 3-hour rule for circumstances in which an unexpected clinical event occurs during the course of a patient's IRF stay that limits the patient's ability to participate in at least 3-hours of therapy a day. CMS specifically states:

If these reasons are appropriately documented in the patient's medical record, such a break in service (of limited duration) will not affect the determination of the medical necessity of the IRF admission. Thus, Medicare contractors may approve brief exceptions to the intensity of therapy requirement in these particular cases if they determine that the initial expectation of the patient's active participation in intensive therapy during the IRF stay was based on a diligent preadmission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.⁹

AOTA asserts that the appropriate amount of occupational therapy should be determined by patient need, capacity for improvement, tolerance, and the clinician's professional judgement as to the medically necessary amount of therapy.

AOTA believes that a patient's condition can change from day to day and that flexibility is necessary with regard to the level of intensity of services. AOTA agrees that limiting the duration of the break in service to "a brief period not to exceed 3 consecutive days"¹⁰ is generally a reasonable standard.

However, there are circumstances where a patient may only be able to withstand 1 or 2 hours a day of therapy, but may then grow strong enough with rest to withstand greater than 3 hours of therapy per day for one or more days. In such cases, we recommend language permitting IRFs to average a patient's participation in therapy per day over a multiple day period to meet the 3-hour rule criteria. Permitting an IRF to average therapy hours over a week will assure both patient and IRF needs are satisfied.

⁸ MBPM, Chapter 1, Section 110.1, Inpatient Hospital Stays for Rehabilitation Care- General.

⁹ MBPM, chapter 1, Section 110.2.1, Intensive Level of Rehabilitation Services (proposed section).

¹⁰ *Id.*

Finally, in the Proposed Rule, CMS states that the patient must “actively participate in at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week.”¹¹ AOTA supports the CMS proposal, but requests that CMS provide examples and additional clarifying language that will address what level of functional deficits might warrant more than three hours/day for five days a week. Examples will be educational and will assist therapy professionals to more accurately comply with the rule.

Measurable Improvement

AOTA urges CMS to permit the therapist (in consultation with the interdisciplinary team) to exercise their professional judgment to determine what a “measurable improvement that will be of practical value to improve the patient’s functional capacity or adaptation to impairments”¹² means for patients with differing levels of functional impairment, including cognitive issues, and differing rehabilitation needs. In the revised MBPM, Chapter 1, Section 110.2.3, CMS states the following:

Since in most instances the goal of an IRF stay is to enable a patient’s safe return to the home or community-based environment upon discharge, the patient’s treatment goals and achievements during an IRF admission should reflect significant and timely progress toward this end result. During most IRF stays, therefore, the emphasis of therapies would generally shift from traditional, patient centered therapeutic services to patient/caregiver education, durable medical equipment training, and other similar therapies that prepare the patient for a safe discharge to the home or community-based environment.¹³

While a return to the home or community environment is certainly the goal following IRF stays, the research on this topic indicates that patients may be discharged to any number of settings following IRF discharge, including skilled nursing facilities, long term care hospitals, and of particular concern, often an IRF patient may be re-admitted to the acute hospital.¹⁴ Occupational therapists must be given the flexibility to determine the most appropriate interventions and modes of treatment based on their patient’s functional status. Given that IRF stays are typically shorter stays compared to other post-acute care settings, patients may benefit from intense therapy right up until discharge if that discharge is to the SNF, for example. A patient’s readiness to transition from intense therapy to patient/caregiver training, for example, must be determined by the therapist.

Medical Stability

In the Proposed Rule, CMS would require that patients be medically stable upon admission to the IRF. AOTA supports this important distinction and believes that the proposal will lead to the availability of medically necessary therapy for patients who would benefit from 3 or more hours of therapy per day. However, AOTA respectfully requests that CMS add additional language to both the regulatory text and

¹¹ 74 Fed. Reg. 21080

¹² *Id.*

¹³ MBPM, Chapter 1, Section 110.2.3, Measurable Improvement (proposed section).

¹⁴ Gage, et al. (2009) *Examining post-acute care relationships in an integrated hospital system*. Review of research submitted to Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services.

the MBPM language to better define medical stability because the proposal can be interpreted to mean that the need for all acute issues must be resolved prior to consideration for IRF admission. A patient may have acute medical issues that are being managed by the IRF team with the primary focus being on rehabilitation, such as occupational therapy, to improve the patient's functional status. The concept of medical management in the IRF setting should include the reasonable management of acute medical issues as well as management of a patient's medical status in the context of functional recovery.

Pre-Admission Screening

AOTA supports the regulatory language proposed in connection with the pre-admission screening, however, we request that CMS allow for an exception to modify the within 48-hour time frame in those cases where IRF admission is delayed. AOTA suggests including an addendum to the admission paperwork to provide an update to those cases in which IRF admission was delayed. This would document the fact that the pre-admission screening has occurred greater than 48 hours prior to IRF admission.

In addition, AOTA requests that CMS clarify the following statement in the MBPM with regard to a "qualified clinician" to avoid confusion:

Individual elements of the preadmission screening may be evaluated by any clinician or group of clinicians designated by a rehabilitation physician, as long as the clinicians are licensed (to the extent possible under State licensure laws and requirements) and qualified to perform the evaluation within their scopes of practice and training."¹⁵

The above language "to the extent possible" is rather confusing and unclear. AOTA requests that CMS reference 42 CFR § 484.4 for the exact definition of qualified occupational therapist. Occupational therapists are qualified to perform evaluations under state law.

Individualized Overall Plan of Care

AOTA supports the plan of care requirement, but requests that CMS clarify the time frame requirement that the individualized overall plan of care be developed "within 72 hours of the patient's admission to the IRF."¹⁶ For example, if a patient is not admitted to the IRF until Friday night and is unable to obtain therapy services until the following Monday, the therapist would be unintentionally out of compliance with the 72-hour rule. AOTA urges CMS to make the individualized overall plan of care requirement consistent with the IRF patient assessment instrument (PAI) requirement (plan of care must be completed by day 4 of the IRF stay)¹⁷ to avoid confusion and the additional unnecessary administrative burden of requiring therapists to begin counting hours from the point of admission to assure compliance.

Discharge Planning

AOTA recommends that CMS add a section to the revised MBPM section 110 to provide additional guidance for IRF personnel with regard to discharge planning. The additional language should be

¹⁵ MBPM, Chapter 1, Section 110.1.1, Required Preadmission Screening.

¹⁶ 74 Fed. Reg. 21081.

¹⁷ MBPM, Chapter 1, Section 110.3, Inpatient Assessment of Individual's Status and Potential for Rehabilitation.

reasonable in terms of administrative burden and could build upon the language in current MBPM, section 110.5, which states in relevant part:

Since discharge planning is an integral part of any rehabilitation program and should begin upon the patient's admittance to the facility, an extended period of time for discharge action would not be reasonable after established goals have been reached, or a determination made that further progress is unlikely, or that care in a less intensive setting would be appropriate.¹⁸

CMS appears to have deleted most language in the Manual with regard to discharge planning and it is unclear if this was intended or unintended. Guidance will be helpful for therapists to understand the parameters set for patient discharges in an IRF setting as they work on skilled interventions to achieve goals set in a patient's plan of care.

Effective Date of MBPM Changes

CMS does not specify in the IRF Proposed Rule, nor anywhere within the draft MBPM, the effective date of the changes to the IRF screening and medical necessity policies. AOTA urges CMS to make public an effective date that is reasonable and provides sufficient time for facilities to educate staff and change systems internally to be in compliance with the changes. AOTA recommends that these policies should be effective earlier than 6-months following publication of the final section 110 MBPM changes.

Furthermore, AOTA requests that in the interim CMS conduct educational teleconferences (for example, a Special Open Door Forum) and publish provider education materials such as a MedLearn Matters article to update and educate facilities as well as practitioners about IRF policy changes.

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AOTA requests that due consideration be given to these comments. Thank you, again, for the opportunity to comment on the revisions to Section 110 of the Medicare Benefit Policy Manual. 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,



Sharmila Sandhu, Esq.
Regulatory Counsel

¹⁸ MBPM, Chapter 1, Section 110.5, Length of Rehabilitation Program.