

Via online submission to www.regulations.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: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Proposed Rule

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 population in skilled nursing facilities (SNFs). We appreciate the opportunity to comment on the proposed update to rates and policies affecting the SNF prospective payment system (PPS). The notice titled 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 (hereinafter "Proposed Rule") was published in the *Federal Register* on May 12, 2009 (74 Fed. Reg. 22208).

AOTA presents the following comments on the SNF PPS Proposed Rule:

I. General Comments

In the 2010 SNF PPS Proposed Rule, CMS proposes to cut \$1.05 billion in Medicare funding for skilled nursing care. AOTA is concerned about the impact such cuts will have on residents and the stability of the long term care work force. Currently, a therapy staffing shortage exists in the SNF setting. Quality of care in SNFs may further decline if additional cuts to therapy personnel and other staff result from reduced funding. Any cuts should be measured against the potential to harm outcomes for beneficiaries.

II. Staff Time and Resource Intensity Verification (STRIVE) Data Collection

AOTA requests that CMS provide the public with additional information about how STRIVE data was collected and analyzed. Certain data is not readily found at the CMS SNF PPS Web site indicated. For instance, it is our understanding that occupational therapists were asked to record their time and interventions with residents using HCPCS codes through personal data assistants (PDAs) and a paper-based tool. There are several problems with this methodology as we have noted in past comments

submitted by AOTA to the STRIVE project contractor. Namely, AOTA has voiced concern that therapists who are unfamiliar with HCPCS codes would be easily confused about how to reconcile Medicare Part B HCPCS coding policies (CCI edits, 8 minute rule, etc.) with the “click on/click off” mentality of the STRIVE data collection PDA tool. AOTA has not received any feedback to date from the STRIVE contractor as to how our concern in this area was remedied, if at all, and how the HCPCS code data was analyzed to draw conclusions about the types of interventions provided by therapists in SNFs.

In addition, in the Proposed Rule section, “*Adjustments to STRIVE Therapy Minutes*” CMS discussed difficulties experienced in collecting data using PDAs versus a paper-based tool. AOTA is concerned with CMS’ adjustment to the differential data reported between use of the PDA and the use of the paper-based tool over the 7-day period that therapy data was collected. This data indicates that therapy was being underreported and that there was less substantial data collection oversight during the time a paper tool was utilized (typically on weekends). As a result, CMS conducted a series of numerical adjustments and manipulations to make the data more consistent with the national RUG III distribution for rehabilitation groups. AOTA does not have sufficient information to comment on the statistical methodology at this time, but AOTA questions whether unstudied assumptions were made in adjusting the data that are worthy of further study to better understand the reasons for the data collection problems discussed in this section.

Finally, AOTA was concerned to hear from our appointed TEP representative that in the March 11, 2009 TEP meeting, when CMS and RTI were asked by TEP members about the data collected related to HCPCS codes, CMS stated that they could not answer the questions of the TEP because they were in the middle of rulemaking. As discussed further below, AOTA urges CMS to provide stakeholders with additional information about how the collection of therapy information with regard to individual, group, and concurrent supports proposed changes to concurrent therapy policy and to the Minimum Data Set (MDS) Section T in the Proposed Rule.

III. Concurrent Therapy

In the Proposed Rule, CMS states that concurrent therapy is a legitimate mode of delivering therapy, should be an adjunct to individual [1:1] delivery, and should represent an exception rather than the standard of care. CMS proposes to allocate the total minutes among the patients based on the therapist’s clinical judgment of how much therapist time was actually provided to each patient. CMS also invites public comment on whether there should be other restrictions relating to concurrent therapy such as a limit to the percentage of concurrent therapy minutes that may be counted in the MDS for any individual or the number of people that can be treated concurrently by the same therapist.

AOTA has concerns with the STRIVE data collection as a basis for the change in concurrent therapy policy. CMS states in the Proposed Rule that “[t]he STRIVE data shows that approximately two-thirds of all Part A therapy provided in SNFs is now being delivered on a concurrent basis rather than on an individual basis that we believe to be the most clinically appropriate mode of therapy.” However, AOTA is unable to locate the STRIVE data to support the two-thirds figure and requests further clarification from CMS as to how that figure was determined. On March 11, 2009, AOTA’s representative to the STRIVE TEP was provided with a power point slide showing a bar graph

depiction of the amount of individual, concurrent, and group therapy identified by STRIVE for Part A services, however, a portion of the data is attributed to a fourth mode of therapy called “group/concurrent.”¹ The data provided in the March 2009 TEP presentation slide does not sufficiently explain CMS’ conclusion regarding concurrent therapy. AOTA seeks further clarification of which mode of therapy this fourth category includes, as well as a breakdown of how CMS concluded that two-thirds of all Part A therapy provided in SNFs is now being delivered on a concurrent basis.

We urge CMS to conduct research regarding outcomes of individual therapy v. group and/or concurrent therapy. 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 and to improve the accuracy of RUG categorization. In addition, a review of SNF 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.

AOTA commends CMS’ continued support of the occupational therapist’s professional judgment as the foremost consideration in making the determination as to the most appropriate mode of delivery of occupational therapy services to individual patients based on the therapy plan of treatment. At the same time, AOTA appreciates CMS’ concerns that “there has been a shift from one-on-one therapy to concurrent therapy that may not represent optimal clinical practice.”² We do not share CMS’ conclusion that use of concurrent therapy represents sub-optimal practice; in fact, in some cases concurrent therapy may be the preferable mode of therapy. AOTA is highly concerned about efforts to interfere with clinical judgement – whether it is by CMS rulemaking or by employer or facility requirements. AOTA is concerned that some occupational therapy professionals may be placed in ethically compromising positions where high SNF productivity requirements are set. We reiterate that therapist judgement and patient needs must guide the provision of therapy and RUG categorization.

AOTA opposes CMS’s proposal to change the manner in which concurrent therapy minutes are allocated among the patients based on how much time the therapist spends in direct contact with each patient. AOTA understands that patients receiving therapy concurrently do, in fact, interact with and learn from one another. Patients treated concurrently often share information and experiences with each other and build relationships as they are working on their individual tasks. For this reason, allocating minutes in the manner proposed by CMS fails to reflect the amount of therapy the patient actually received from working in a concurrent therapy situation.

For administrative ease, AOTA recommends that CMS consider only two limitations on concurrent therapy at this time. First, we recommend that concurrent therapy be restricted to no more than 2 patients at a time based on the therapist’s clinical judgment of efficacy. For a number of years, AOTA has been informally advising members that the number of patients should be limited to 2 as a best practice standard. Thus, AOTA’s recommendation is consistent with the organization’s advice to occupational therapy professionals. In addition, the limit to two patients also derives from a Part A

¹ March 11, 2009 Power point Presentation, Staff Time and Resource Intensity Verification Technical Expert Panel Meeting, Slide # 34 titled, “Individual, Concurrent & Group Time” (Retrieved June 30, 2009 from download at: http://www.cms.hhs.gov/SNFPPS/10_TimeStudy.asp).

² 74 Fed. Reg. 22222.

example of concurrent therapy practice provided in the Resident Assessment Instrument (RAI) Manual Version 2.0 that identifies only two patients being treated concurrently, as follows:

A licensed therapist starts work directly with one resident beginning a specific task. Once the resident can proceed with supervision, the licensed therapist works directly with a second resident to get him/her started on a different task, while continuing to supervise the first resident. The treatment ends for each resident 30 minutes after it begins. For each resident, record 30 minutes therapy time for each resident at Item P1bB. This delivery of therapy is often referred to as supervisory treatment, dovetailing, or concurrent therapy.³

While the example does not explicitly limit the number of patients to two, it suggests that the model scenario of concurrent therapy involves a maximum of two patients.

CMS makes the following statement in the Proposed Rule:

We believe it is in the beneficiary's best interest that concurrent therapy should never be the sole mode of delivering therapy care to any individual in a SNF setting; rather, it should be used as an adjunct to individual therapy when clinically appropriate, as determined by the individual's current medical and physical status based on a therapist's clinical judgment.⁴

Accordingly, AOTA suggests CMS consider a second limitation on the amount of time that a patient can receive concurrent therapy, similar to the limitation of 25% of total weekly minutes in group therapy

Finally, CMS solicits comments concerning whether therapy data need to be reported separately by therapy mode on the MDS. AOTA supports the recordation of the mode of therapy (individual, concurrent, or group) on the MDS as an assurance that no abuse of concurrent therapy is occurring and to monitor outcomes achieved by mode of therapy delivery. However, under current SNF policy, occupational therapists are already subject to significant documentation and paperwork requirements. AOTA urges CMS to consider methods of recordation for concurrent therapy that will not increase the administrative burden and be as simple and straight-forward as possible for therapy professionals to comply.

In the Proposed Rule, CMS states, "We are concerned that placing limits on the use of concurrent therapy could result in an inappropriate substitution of therapy aides for therapists and assistants. Therapy aides are expected to provide support services to the therapists and cannot be used to provide (*sic*) skilled therapy services." 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:

³ Resident Assessment Instrument (RAI) Manual Version 2.0, Chapter 3, pgs. 3-187 and 3-188.

⁴ 74 Fed. Reg. 22222.

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.⁵

While CMS states that aides cannot be used to provide skilled therapy in the text of the Proposed Rule, the services of aides who are under the “line of sight” supervision of a treating therapist count toward the total therapy minutes on the MDS according to current policy.

According to the Changes to the December 2002 RAI Manual, Version 2.0, August 2003 (page 8):

Supervision (Medicare A only): Aides cannot independently provide a skilled service. The services of aides performing therapy treatments may only be coded when the services are performed under line of sight supervision by a licensed therapist when allowed by state law. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. When the therapist starts the session and delegates the performance of the therapy treatment to a therapy aide, while maintaining direct line of sight supervision, the total number of minutes of the therapy session may be coded as therapy minutes.

AOTA urges CMS to remind providers that state law supersedes Medicare policy with respect to the role of aides. Most state occupational therapy statutes and regulations are consistent with AOTA’s policy and prohibit aides from providing skilled therapy services, therefore services of aides should not be counted as therapy minutes on the MDS in those states with limitations on the services that may be provided by aides.

We believe that the minutes of therapy that are counted on the MDS toward RUG determination must be skilled therapy minutes. Despite state laws to the contrary, AOTA remains concerned about the potential substitution of aides and supports the continued monitoring of the use of aides in SNFs to assure correct MDS reporting, as needed.

Importantly, while the line of sight supervision requirement for aide services also exists with respect to the services of therapy students, AOTA asserts that occupational therapy students are fundamentally different from aides because students have completed their formal occupational therapy education and are continually learning and growing their therapy practice. State occupational therapy statutes exempt occupational therapy students from licensure requirements while fulfilling supervised fieldwork experience requirements needed to graduate from an accredited occupational therapy education program. This exemption allows therapy students to provide skilled therapy services under clinical supervision.

AOTA urges CMS to maintain the current policy of counting therapy minutes provide by students as articulated in:

(1) Federal Register on November 4, 1999 (page 60122):

⁵ To be published and copyrighted in 2009 by the American Occupational Therapy Association in the *American Journal of Occupational Therapy*, 63(November/December).

Providers should record the minutes of therapy provided by therapy students in accordance with the past practice established under the instructions in the *Long Term Care Resident Assessment Instrument User's Manual* and other HCFA guidelines.

(2) Changes to the December 2002 RAI Manual, Version 2.0, August 2003 (page 9)

Therapy students are recognized as skilled providers under Medicare A only. They must be “in line of sight” supervision (Federal Register November 4, 1999).

CMS and its contractors should provide more targeted educational outreach to SNF facilities. AOTA has received numerous questions from occupational therapy practitioners about what their rights and obligations are to report to CMS treatment and billing practices they view as inappropriate. As part of this outreach effort, occupational therapists, occupational therapy assistants and therapy students working in SNFs should be informed of mechanisms for reporting abusive practices. Contractors bear responsibility for claims and documentation review and to identify and hold accountable bad actor facilities when abusive practices are suspected. AOTA is also supportive of efforts to ensure the integrity of the Medicare program and believes that enforcement oversight through the Health and Human Services Office of Inspector General (HHS OIG) should continue.

In addition to the role of local Medicare contractors and the OIG, AOTA recommends that CMS implement a requirement through which SNFs can publicly report their staffing ratios (ratio of therapists and therapy assistants to patients). Potentially, this feature could be added to the Nursing Home Compare search capabilities. Such a reporting mechanism could serve as a way for CMS to monitor the therapy professional workforce shortage that serves as a barrier to meeting the rehabilitation need of SNF residents as well as give consumers information about access to skilled therapy in SNFs.

Taken together, AOTA believes that our recommendations will permit occupational therapists, assistants, and students to have the flexibility to exercise their professional judgment and to provide patients with meaningful skilled concurrent therapy without compromising their ethics and professional guidelines.

IV. ADL Scale

AOTA supports CMS in their initiative to create an ADL scale that is more sensitive to functional status and allows for a finer analysis of changes in functional status over time. AOTA also agrees with the introduction of an index, which will make the use and interpretation of the ADL scoring scale clearer for occupational therapy practitioners.

V. Elimination of “Look-Back” Period

In the Proposed Rule, CMS proposes to eliminate the look-back period for completion of items in the MDS because CMS states its use could trigger a RUG assignment based on services that occurred solely during the prior acute hospital stay and were no longer being furnished upon SNF admission. AOTA is concerned that the removal of the look-back period to the hospital stay would

negatively impact the quality of care for SNF beneficiaries. The look-back period for rehabilitation counts actual days and minutes of therapy back from the Assessment Rehabilitation Date (ARD) for the previous 7 days to determine the appropriate RUG category and treatment needs (i.e., number of days of treatment) for the beneficiary.

The look-back into the hospital stay provides valuable clinical information that influences the plan of care for therapy, including selecting intervention approaches, setting therapy goals, establishing therapy frequencies, intensities and duration, and expecting outcomes. This information is particularly necessary to ensure that beneficiaries' needs for rehabilitation services (including occupational therapy) are identified and made available to the beneficiaries. In fact, CMS itself has stated that "our expectation is that the occurrence of one of the specified events during the 'look-back' period, when taken in combination with the characteristic tendency for an SNF resident's condition to be at its most unstable and intensive state at the outset of the SNF stay, should make this a reliable indicator of the need for skilled care upon SNF admission in virtually all instances."⁶

The omission of the information that otherwise would be garnered from the look back period data could hinder the timely provision of occupational therapy and other skilled services to beneficiaries. AOTA understands that CMS has expanded the MDS 3.0 Special Treatments and Procedures items to include two columns to allow providers to code services provided prior to SNF admission, however, AOTA remains concerned that such additions will not adequately account for needed patient resources during the SNF stay and future care planning needs. Frequently, ill elderly beneficiaries have several comorbidities and have received extensive medical interventions prior to SNF admission. These factors can be good indicators of beneficiaries who require observation upon admission to a SNF to monitor their medical status. If these factors are not adequately considered, it could result in increased readmissions back to the acute care setting and ultimately higher costs to the Medicare program. For these reasons, AOTA recommends that CMS retain the current look back period in the MDS.

VI. Elimination of Projected Therapy Services (Section T of the MDS)

AOTA also is concerned that the elimination of the projection of anticipated therapy services during the 5-day PPS assessment would impact beneficiary access to quality care. The projection of anticipated therapy services during the assessment is used to determine the overall picture of the amount of therapy that a beneficiary will likely receive throughout the SNF stay. This evaluative step in the MDS is crucial, particularly for beneficiaries who during their first 14 days are only able to tolerate a small amount of therapy but later would be ready for significantly more therapy. Cutting this projection could result in a mismatch of the plan of care with the beneficiary's needs, a mis-allocation of the therapy resources that the beneficiary requires, and financial pressure to provide less care than the beneficiary needs. If the beneficiary's primary skilled need is receipt of rehabilitation therapy, then the inability to capture that in the RUG system during the first assessment could prevent facilities from placing a patient in the most appropriate RUG category.

Furthermore, the elimination of Section T, which allows for use of projected therapy services to establish the appropriate RUG level, will overwhelmingly disadvantage SNFs located in rural areas

⁶ Federal Register, Vol. 64, No. 146, at p. 41668-69.

and small SNFs (for instance, SNFs that typically have only a 4 or 5 patient caseload). These facilities typically staff one part time licensed occupational therapist, who may treat patients in collaboration with an occupational therapy assistant. For example, if a patient is admitted on a Friday and the occupational therapist does not return to the SNF to evaluate that patient until the following Tuesday, the SNF has potentially missed the window to categorize the patient into the most appropriate RUG based on the patient's medical and rehabilitation needs.

Overall, AOTA is concerned that any changes to CMS policy that would individually reduce or eliminate the projection of anticipated therapy services or the look-back period of the MDS would significantly impact beneficiary access to appropriate occupational therapy services. Each of these mechanisms operates to gather as much accurate and predictive data about beneficiaries as possible to ensure the appropriate allocation of SNF resources, particularly with regard to the provision of therapy services. In a payment system that relies heavily on predicting beneficiaries' anticipated needs for therapy services, limiting or removing these data gathering mechanisms puts beneficiaries at risk of ultimately not receiving the therapy and other skilled services that they require and risks the overall quality of the services provided to beneficiaries. AOTA asserts that the MDS Section T projection for the therapy RUG level serves a critical function and recommends that CMS retain the projection of anticipated therapy services during the assessment.

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