Via online submission to <https://www.regulations.gov>

[Date]

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Attention: CMS—1734-P

PO Box 8016

Baltimore, MD 21244-8016

**Re:** Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy

Dear Administrator Verma:

I am an [occupational therapist/occupational therapy assistant/student of occupational therapy] residing in [state]. [Explain your area of practice]. I appreciate the opportunity to comment on this proposed rule published at 85 Federal Register 50074 on August 17, 2020.

1. **Proposed E/M Policy and Related Cuts for 2021**

I understand that due to budget neutrality, when increases are made to some codes, reductions must be made to others. However, the proposed 9% decrease to therapy services would be highly detrimental to the profession of occupational therapy, especially coupled with the other reimbursement cuts that therapy services have taken in recent years, and will continue to take with the OTA payment reduction, which is effective in 2022.

The cumulative nature of MPPR, sequestration, and the OTA payment modifier is already substantial and hard felt, particularly by practitioners in rural and underserved areas. As a result, occupational therapy private practices and outpatient clinics may need to reduce operations or close their small businesses altogether. Moreover, the aging population is in greater need of occupational therapy practitioners than ever before. Access to these services is essential for Medicare beneficiaries who wish to age in place, particularly for the growing demographic with chronic conditions, but a single reimbursement cut of this magnitude may make practicing unsustainable for the profession.

For example, [Explain how a 9% payment cut will impact you personally and will impact access to occupational therapy for the Medicare beneficiaries that you serve]

While the work Relative Value Unit (RVU) increases to therapy evaluation and re-evaluation codes is appreciated, the increased value does not adequately off set the cuts to therapy intervention services. Therapy services all require management of the whole patient, including medically complex patients with multiple medical conditions. Therapy progress reports, which are required every 10 visits, involve the same assessment skills as a re-evaluation. The Medicare Benefit Policy Manual Chapter 15, Section 220.3.D states that “*progress reports shall include assessment of improvement, plans for continuing treatment, additional evaluation results, and treatment goals*.” All of these elements make progress reports analogous to evaluation and management services. Because progress reports are not billable by their own CPT® code, they are performed and included on days that therapy interventions are performed. Therefore, we respectfully request that the mostly commonly billed therapy interventions, 97530 and 97110, be granted RVU increases to reflect the assessment- and management-focused components required to complete the progress report, since these components are analogous in many respects to the OT evaluation and re-evaluation codes.

Other services provided by occupational therapists that have a clearly established assessment and management component and therefore should be considered for additional reimbursement through RVU increases in the CY 2021 MPFS Final Rule include:

**97542** Wheelchair management (e.g., assessment, fitting, training), each 15 minutes

**97755** Assistive technology assessment (e.g., to restore, augment, or compensate for existing function, optimize functional tasks, and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes

**97760** Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies), and/or trunk, initial orthotic(s) encounter, each 15 minutes

**97761** Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes

**97763** Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

I urge CMS to reconsider the distribution of payment reductions for budget neutrality and, at a minimum, grant additional RVU reimbursement consideration for the following therapy CPT codes to help offset the budget neutrality cuts: 97530, 97110, 97542, 97755, 97760, 97761, and 97763.

1. **Telehealth**

[Explain how you use telehealth to successfully reach functional outcomes, how the pandemic has impacted your practice and your use of telehealth services, and its impact on the future of your practice.]

**Expand Telehealth Flexibilities Permanently to Therapy Practitioners**

While I appreciate the consideration CMS gave to occupational therapy, physical therapy, and speech-language pathology practitioners to perform telehealth for the duration of the COVID-19 public health emergency (PHE), I have concerns about my patients’ ongoing therapy and rehabilitation issues after the PHE ends and the waivers are revoked or expire. I ask that CMS consider longer waiver coverage while the agency considers lifting the PHE. Until there is a vaccine, COVID-19 will continue to be present in our communities and health care facilities. Further, data currently indicates that the United States is likely to experience a second wave in the winter that could be followed by a third wave before a vaccine is developed. It is imperative for CMS to maintain all health regulatory protections for as long as possible for the safety of the vulnerable beneficiary population and to assure efficient access to timely health care services. One of those critical protections for outpatient practices and institutional settings is the extension of telehealth. I urge CMS to extend the therapy services telehealth waiver flexibility beyond the PHE so that beneficiaries are not left suddenly without viable and safe rehabilitation treatment options. The additional time will also allow Congress to assess the data from the PHE and make decisions on the permanence of telehealth for therapy professionals. In addition, a longer term extension will assure patients who have successfully been accessing OT, PT, and/or SLP via telehealth during the duration of the PHE that they will not suddenly be discontinued from an effective and safe modality of treatment. Such a sudden discontinuance of telehealth could result in Medicare patients experiencing further functional decline, potentially leading to hospitalizations or re-hospitalizations.

**Add Therapy Services to the Telehealth Services List**

I understand that CMS is concerned about the confusion adding therapy services to the Medicare telehealth list could cause because therapists are not Medicare-eligible telehealth providers outside of the PHE. However, the experiences of the PHE have demonstrated that therapists can effectively and efficiently provide services using audio visual technology. Our associations will continue to advocate with Congress to legislatively add therapists as telehealth providers. When those efforts succeed, it would be counterproductive to have to wait for the next CMS rule making cycle to get the codes added in order to perform telehealth services. Adding therapy services as Category III codes will allow CMS and Congress the necessary time to analyze the PHE data, which will undoubtedly show positive outcomes and increased beneficiary access to therapy, especially in rural areas.

Adding the above listed CPT codes to the Category III list, in combination with extending waiver flexibilities to allow therapists to perform telehealth beyond the PHE, is the best solution to ensure the best possible outcomes for Medicare beneficiaries.

**Communication Technology–Based Services**

I appreciate that CMS is allowing therapists to continue to bill G2061–G2063 after the end of the PHE for E-visit services. The addition to the fee schedule of G20X0 and G20X2 as permanent non-physician equivalent codes to G2010 and G2012 at the same reimbursement rate is also supported and appreciated.

1. **Therapy Assistants Performing Maintenance Therapy**

I thank CMS for proposing allowing occupational therapy assistants to perform maintenance therapy under the Medicare Physician Fee Schedule (MPFS). This change aligns the MPFS policy with CMS’ policy for all other settings and assures consistency and continuity of care across Medicare programs for patients receiving therapy services.

1. **Student Medical Record Documentation**

I support the CMS proposed policy allowing therapists to review and verify student documentation instead of therapists having to re-document notes made by students for Medicare Part B patients. This is a significant burden reduction that will allow for better use of therapists’ time.

I would like to thank CMS for the steps taken during the PHE to ensure safe beneficiary access to Medicare services. Accordingly, I urge CMS to continue to take thoughtful and innovative steps to ensure that beneficiaries have access to medically necessary therapy services in the future. Thank you again for your consideration of the comments outlined above.

Sincerely,

[Add name and employer affiliation]