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

[Date]

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Attention: CMS—1751-P

PO Box 8016

Baltimore, MD 21244-8016

**Re:** **Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.**

Dear Administrator Brooks-LaSure:

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 86 Federal Register 39104 on July 23, 2021.

1. **Occupational Therapy Assistant Modifier**

I appreciate CMS’ updated interpretation of the de minimis standard to take into account the 8-minute rule. However, the proposed change in guidance comes at a very late date and means we will have 60 days or less after the final rule is issued to fully implement the finalized policy. Vendors of electronic health record (EHR) systems need time to program, test, and finalize their systems for therapy services. Medicare Administrative Contractors (MACs) will also need to interpret CMS’ guidance, and program and update their systems. History has shown that hastily implemented policy has been a conduit for costly mistakes during implementation that can harm beneficiary access to therapy services. I therefore request that CMS delay implementation of the therapy assistant modifier payment reduction policy until calendar year 2023 to give practitioners time to adopt the final policy changes.

Additionally, occupational therapy assistants (OTAs) serve a major role in providing care to rural and underserved areas. The implementation of the payment cut could be extremely detrimental to access to care in these areas, as personnel shortages make the hiring of OTs difficult. OTAs deliver high-quality care under the supervision of an OT and can have a profound impact on a patient’s condition and progress. This is particularly true in the Medicare population, in which many beneficiaries suffer from multiple chronic health conditions. The higher use of OTAs in rural and underserved communities means the payment differential will disproportionately challenge therapy practices in these communities, and both OT practitioners and their patients will suffer the consequences. Therefore, I urge CMS to exempt rural and underserved areas from the payment differential.

1. **Direct Supervision via Audio Visual Communication**

I appreciate the flexibility of CMS to allow for direct supervision via audio visual communication during the pandemic. As most states only require general supervision for occupational therapy assistants (OTAs), the requirements of direct supervision in outpatient private practice are an unnecessary burden and are inconsistent with the supervision requirements for other settings. Permanently allowing direct supervision via audio visual communication would immediately relieve that burden without causing any undue harm. As general supervision is allowed for OTAs in all other settings, I believe CMS should go one step further and allow general supervision for OTAs in private practice to further relieve practitioners from undue burden and ensure timely access to therapy services for Medicare beneficiaries.

1. **E/M Policy and Continued Cuts for 2022**

I understand that due to budget neutrality in the Medicare program, when increases are made to some codes reductions must be made to others. However, an additional decrease to therapy services would be highly detrimental to the profession of occupational therapy, especially coupled with the other reimbursement cuts that therapy services will continue to take with the OTA payment reduction.

For the profession of occupational therapy, the cumulative nature of last year’s E&M cut, on top 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 an additional payment cut will impact you personally and will impact access to occupational therapy for the Medicare beneficiaries that you serve]

I urge CMS to tell Congress that the current budget neutrality system is not sustainable and ask that additional funding be added once again to fund the changes made to the fee schedule as a result of the E&M policy. Congress and CMS must collaborate to implement a responsible, permanent solution to rectify this unsustainable neutrality policy.

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. 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 telehealth 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 occupational therapy, physical therapy, and/or speech-language pathology via telehealth during the duration of the PHE that they will not suddenly be discontinued from an effective and safe modality of treatment in the middle of their therapy plan of care. 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 Category 3 Telehealth Services List**

I appreciate CMS’ willingness to add relevant Physical Medicine and Rehabilitation CPT codes therapy services as Category 3 codes, as it 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.

However, I believe the exclusion of 97530, 97150, 92526, 92610, 97542. 97129, and 97130 from the Category 3 list is a significant oversight that needs to be corrected in the final rule.

97530

Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

97150

Therapeutic procedures, group (2 or more)

92526

Treatment of swallowing dysfunction and/or oral function for feeding

92610

Evaluation of oral and pharyngeal swallowing function

97542

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

Occupational therapy practitioners help patients reach optimal functional performance through the use of activities that enhance skill sets. Therapeutic activities, identified under CPT code 97530, are universal, used by occupational therapy practitioners in all settings, for all conditions. [Give an example where you would perform 97530 using telehealth.]

97129

Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes

97130

Each additional 15 minutes (List separately in addition to code for primary procedure.)

In addition, occupational therapy practitioners treat cognitive impairments because these impairments have the potential to compromise patient safety and long-term well-being, especially for frail and chronically ill elderly patients. Early identification of cognitive impairments that relate to performance of activities of daily living (ADLs), identified under CPT codes 97129 and 97130, allows for the timely implementation of an occupational therapy care plan. The plan can include implementing the supports, including training and modifications, necessary to prevent harmful events that commonly happen during routine everyday activities for patients with cognitive impairments; for example, falls due to problematic sequencing of activities during a bathing or dressing activity.

[Give an example of where you would perform 97129, 97130 using telehealth.]

I believe that leaving off 97542 is an oversight. Patients often need assistance with existing wheelchairs. Occupational therapy practitioners evaluate patients using existing wheelchairs through the course of treatment and assuring the proper alignment and use of the wheelchair is essential. Not allowing for wheelchair management is leaving the patient and his/her caregivers without appropriate support throughout the course of treatment.

[Give an example of where you would perform 97542 using telehealth.]

Occupational therapy practitioners often treat patients with swallowing and feeding dysfunction. Interventions performed can include individualized compensatory swallowing strategies; modifying diet textures to ensure safe swallowing and eliminate or minimize the risk of aspiration; enhanced feeding skills including strategies to create feeding independence and provision of appropriate adapted utensils; preparatory exercises prior to a meal to facilitate the oral and pharyngeal motions required for eating; reinforcement of strategies for clients to enhance and improve swallowing safety to prevent aspiration, including adapted swallowing techniques; and training for caregivers in individualized feeding and swallowing strategies, all of which can be completed using telehealth technologies.

[Give an example of where you would perform 92526 or 92610 using telehealth.]

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. We continue to urge CMS to collaborate with Congress to support the development of common-sense legislation to permit occupational therapy practitioners to provide therapy services via telehealth.

1. **Remote Therapeutic Monitoring**

I respectfully disagree with CMS’ determination that occupational therapists are not permitted to bill remote therapeutic monitoring codes. Although the services may be “incident to” when billed by physicians, they would not represent “incident to” services when billed by therapists. My comments are supported by the process undertaken by the American Medical Association CPT and RUC in developing the remote therapeutic monitoring code descriptors and values for billing by occupational therapists. I encourage CMS to reevaluate their interpretation of these codes to permit therapists to bill and be paid for these services.

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]