The American Occupational Therapy Association, Inc.

January 23, 2003

Via First Class Mail and Facsimile

Michael Rapp, MD
Chair, Practicing Physician Advisory Committee
Centers for Medicare and Medicaid Services
Department of Health and Human Services
???
Baltimore, Maryland 21244-8013

Re: Medicare Program Fee Schedule Issues

Dear Dr. Rapp:

The American Occupational Therapy Association (AOTA), representing over 40,000 occupational therapy professionals, appreciates the opportunity to submit issues for the Practicing Physician Advisory Committee (PPAC) to consider that are related to the Medicare Physician Fee Schedule (MPFS). These issues are as follows:

I. Disclosure of Departure from Current Methodology to Compute PE RVUs for Occupational Therapy Services (See 67 Fed. Reg. 79966, 79970 (December 31, 2002) and 67 Fed. Reg. 67 Fed. Reg. 43846, 43848 (June 28, 2002)

The methodology CMS utilizes to compute the practice expense (PE) relative value units (RVUs) for the CPT 97000 series is inconsistent with the methodology used for all other families of CPT codes and fails to meet CMS' own "top down" approach. In short, CMS crosswalks therapy services in that series of codes to the occupational therapy and physical therapy practice expense pool under the assumption that most therapy services billed by physicians are performed by therapists.

However, this assumption fails to recognize that many physicians, including orthopedic surgeons, physical medicine and rehabilitation physicians and internists, report their services using the CPT 97000 series. Consequently, CMS should apply the "top down" approach to the CPT 97000 series in a manner that is consistent with computing PE for all other CPT series. This means that CMS first should determine the utilization of each service in the CPT 97000 series by occupational therapists and physical therapists in private practice (OTPPs/PTPPs) and apply the PE per hour for OTPPs/PTPPs. Then, CMS should determine the utilization of each service in the series by each physician specialty, and use the PE per hour for each specialty. Finally, CMS should apply this information to Step 4, and determine the final procedure code allocation for each service in the CPT 97000 series by taking a weighted average of allocations for all the specialties

that perform each procedure. Failure to follow the top-down approach will continue to result in inequitable PE values.

II. 30 Day Physician Visit For Outpatient Occupational Therapy Services and 30 Day Physician Recertification

The Medicare Part B requirement that individuals receiving outpatient occupational therapy services see a physician every 30 days should be eliminated. In the Medicare program manuals, CMS has broadly interpreted the regulatory requirement that occupational therapy services be furnished while the beneficiary is "under the care of a physician, nurse practitioner, clinical nurse specialist or physician assistant" to further require that the physician physically see the beneficiary every 30 days. The 30 day physician visit is required for patients who obtain Part B therapy services across the following settings: outpatient hospital, skilled nursing facility, home health agency, rehabilitation agency, and private practice. This requirement is not grounded in regulation, has been implemented inconsistently among Carriers and Fiscal Intermediaries, and is confusing and burdensome to beneficiaries, particularly to those in rural areas. In addition, it would appear that the requirements that occupational therapists promptly inform the treating physician of beneficiary's change in status or change in plan of care and that physicians review and recertify the plan of care sufficiently ensures that therapy services are medically necessary. Given these other regulatory requirements, a return visit is duplicative and costly.

While there are several important public policy reasons to ensure that physicians review the therapy plan of care and attest to a continuing medical need for therapy services, the length of time for recertification (30 days) is arbitrary and not based upon patient outcomes. This Medicare Part B regulation should be modified. Rather, it should be left up to the physician's discretion to determine when and how often it is necessary for each patient under his care who is receiving occupational therapy services to be reassessed. Such a change would put medical decision making back into the hands of the treating physician and would allow for variation among patients' needs.

The AOTA respectfully requests that the PPAC consider these concerns which mutually impact physicians and occupational therapists.

Sincerely,

Leslie Stein Lloyd, Esquire
Regulatory Counsel

cc: Tom Grissom
Terry Kay