July 16, 2010

Donald M. Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Hubert Humphrey Building, Room 314G
200 Independence Ave, S.W.
Washington, DC 20201

Dear Dr. Berwick:

The undersigned organizations representing physicians, physical therapists, occupational therapists, speech language pathologists, hospitals, nursing homes, and other entities that serve the elderly and disabled Medicare population for a vast number of conditions, are writing with regard to a provision included in the 2011 proposed physician fee schedule rule that would result in significant, unjustified cuts in payment for outpatient therapy services.

In particular, we are writing in regard to the proposal to expand the application of the multiple procedure payment reduction (MPPR) policy to outpatient therapy services. Specifically, CMS proposes to make full payment for the therapy service or unit with the highest practice expense relative value units (PE RVUs) and payment of 50 percent of the PE RVUs for the second and subsequent procedures or units of the service furnished during the same day for the same patient. CMS assumes that duplicate clinical labor and supplies are included in the practice expense relative value units (PE RVUs) when multiple services are furnished to a patient in a single session. This basic assumption is incorrect since the development of the PE RVUs for the therapy services already took into account the fact that certain efficiencies exist when multiple therapy services are provided in a single session.

The proposed multiple procedure payment reduction policy would apply to both the services paid under the physician fee schedule (PFS) that are furnished in the office setting and those services paid at the PFS rates that are furnished by outpatient hospitals, home health agencies (Part B), skilled nursing facilities (Part B), comprehensive rehabilitation facilities, and other entities that are paid by Medicare for outpatient therapy services.

If implemented, CMS estimates that the MPPR policy would result in significant reductions in payments in 2011 to physical and occupational therapists in private practice of approximately 11%. This cut could be further exacerbated by the projected reductions in the SGR and the annual financial cap on therapy services. Under the budget neutrality provisions of the Medicare physician fee schedule (PFS), the money associated with these payment reductions will be redistributed to all other services paid under the MPFS. CMS also estimates that this proposal would reduce (not redistribute) payments in settings outside of the PFS (e.g., outpatient hospital departments, skilled nursing facilities) by approximately 13 percent in CY 2011. If this proposal stands, access to vital outpatient therapy services will be at grave risk.

Considering the magnitude of these cuts, it is essential for CMS to ensure that the process it uses to develop policies is transparent and decisions are based on accurate information. In order for the undersigned organizations to prepare meaningful comments regarding the MPPR proposal, we are requesting that CMS provide us the data files used by CMS to draw conclusions that there should be a 50% reduction in practice expense values for outpatient

therapy services. We understand the need to strip these data of any potential patient identifiers so we are not asking for any information that might allow a given patient to be identified. While the rule contains some information regarding the CMS analysis, this information is limited and does not enable the public to replicate or refute the CMS analysis. In addition, the limited data sets that are made available to the public do not provide sufficient information to allow us to identify the specific services that are provided by the same practitioner/provider to the same patient on the same date of service.

In addition to our request for the de-identified data files used by CMS, we request that you respond to specific questions (below) related to the data that was used during your analysis. Answers to these questions are essential to enable us to prepare our comments on the CMS proposal.

Questions

1) It is stated in the proposed rule that the CY 2009 PFS claims data show that when multiple therapy services are billed on a claim for the same date of service, the median number is four services per day. Were the CMS analyses limited to claims submitted by physicians, physical therapists and occupational therapists (office-based) or did the analyses include claims for services provided by outpatient hospitals, home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities (CORFs)? This is a critical question since the proposed CY 2011 MPPR policy would apply to services paid under the PFS that are furnished in the office setting as well as services paid at the PFS rates that are furnished by these other entities.
2) In the proposed rule, CMS states that when multiple therapy services are billed on the same date of service, the median number of services is four per day. In determining the median, did CMS exclude all claims submitted with only one service? What was the mean number of claims and can you provide a frequency distribution showing the number and percent of all claims on a given date of service with 1, 2, 3, 4, 5, etc. paid therapy services.
3) CMS proposes to apply the policy regardless of professional discipline. In reviewing the claims data, did CMS combine the services delivered by the professions (occupational therapy, physical therapy, and speech language pathology) in determining the number of services furnished per day? This information is important because in certain settings, such as skilled nursing facilities, it is common for a resident to receive services from one professional (e.g. physical therapist) in the morning and another professional (e.g. occupational therapist) in the afternoon. In other settings where multidisciplinary outpatient therapy is provided in an inpatient hospital or IRF, a patient may require rests or meals between disciplines, disciplines may be located in a different campus, or in a different part of the hospital. A patient receiving treatment by multiple disciplines may be required to check out and then check back in. During the break between disciplines, medication levels may be different and neuromuscular performance and vital signs may vary significantly. In such situations, the application of the MPPR is illogical since there can be no economies of scale when the patient sees different individuals on the same date of service.
4) In the proposed rule, it is stated that a sample of the most common therapy code pairs were reviewed and that one fourth of the code pairs were not valued based on two services. Which code pairs were examined by CMS in making these statements? Of these code pairs, which pairs were included in the one fourth?
5) In the proposed rule, it is stated that over 500 therapy service code pairs were billed for the same patient in a single session and that high volume code pairs with more than 250,000

combined services per year represented more than half of the occurrences of therapy services billed together. What were these high volume code pairs?

6) In the proposed rule, CMS estimates that for five high volume therapy code pairs the resulting reduction in the practice expense payment for the lower paying code would range from 28 to 56%. How did CMS come up with this range? If the range is from 28-56%, how did CMS come to the conclusion that there should be a 50% reduction?
7) When developing the proposed MPPR policy and conducting the analysis of data, did CMS seek the input of clinicians who are physical therapists, occupational therapists, and speech language pathologists?

Clearly, the proposal to extend the MPPR policy to outpatient therapy services will result in significant reductions in payment for these services. Our organizations are very concerned about the impact that these reductions will have on providers and the Medicare beneficiaries needing these services. If CMS is considering such large cuts, it is essential for CMS to provide information and analysis used to derive these conclusions. The proposed rule does not include sufficient information regarding the data used to develop this policy. As you are aware, comments in response to the proposed physician fee schedule are due August 24, 2010. Therefore, we request that you respond to this letter soon so that we have adequate time to prepare sound comments. Please contact Gayle Lee at 703-706-8549 or gaylelee@apta.org with your response to this letter. We look forward to hearing from you soon. Thank you.

Sincerely,

Alliance for Quality Nursing Home Care
American Health Care Association
American Hospital Association
American Medical Rehabilitation Providers Association
American Occupational Therapy Association
American Orthotic and Prosthetic Association
American Physical Therapy Association
American Society of Hand Therapists
American Speech Language Hearing Association
Easter Seals
Federation of American Hospitals
National Association for the Support of Long Term Care
National Association of Rehabilitation Providers and Agencies

cc: Jonathan Blum, Amy Bassano, Carol Bazell, MD, MPH