

Via email to [Debra.Fulfer@trailblazerhealth.com](mailto:Debra.Fulfer@trailblazerhealth.com)

December 14, 2009

Debra Fulfer  
8330 LBJ Freeway  
Dallas, Texas 75243

**Re: Draft LCD for Physical Medicine and Rehabilitation, Outpatient  
Draft 4Y-26AB (DL30533)**

Dear Ms. Fulfer,

The American Occupational Therapy Association (AOTA) represents the interests of 140,000 therapists, assistants and students, many of whom provide services to Medicare beneficiaries under Parts A and B of the Medicare program. We appreciate the opportunity to provide comments on Trailblazer Health Enterprises' (Trailblazer's) draft local coverage determination (LCD) for Physical Medicine and Rehabilitation, Outpatient (referred to hereinafter as "draft LCD") for therapy services paid under Medicare Part B.

**Utilization Guidelines include Rule of Thumb Prohibited by Medicare**

The draft LCD includes the following language under "Utilization Guidelines":

This LCD establishes frequency limitations of 5 (15-minute) PT or OT services per day and 60 (15-minute) PT or OT services per month. Providers of PT/OT services must be aware however, that any service reported to Medicare, even when reported at a frequency within the following stated covered guidelines, may be denied if done so in association with medical review of the patient's record. Likewise, providers of PT/OT services must understand that though Medicare will allow the following units of service, each service must be medically reasonable and necessary for the specific patient and his or her condition. Additionally, Medicare expects that the patient's medical record will clearly demonstrate that medical necessity. Further, Medicare does not expect that maximum allowable services will be routinely necessary, necessary for multiple week periods, or necessary for the entirety of the patient's course of treatment.

We believe the language in the first sentence of the above excerpt amounts to an overreaching "rule of thumb" and request removal of the sentence. AOTA has commented on other draft LCDs regarding our concerns about the use of "rules of thumb" to predetermine a patient's need for therapy service. CMS, through its Medicare Manuals, has stated that the use of rules of thumb on the frequency or duration of therapy and other services is not permitted by CMS and is not an option for contractors. Please see the following sections for guidance on the

prohibition on the use of restrictions on frequency and durations under various Medicare Part A and B services:

Medicare recognizes that determinations of whether hospital stays for rehabilitation services are reasonable and necessary must be based upon an assessment of each beneficiary's individual care needs. Therefore, denials of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms, "the three hour rule," or any other "rules of thumb" are not appropriate.<sup>1</sup>

"Rules of thumb" in the MR [medical review] process are prohibited. Intermediaries must not make denial decisions solely on the reviewer's general inferences about beneficiaries with similar diagnoses or on general data related to utilization. Any "rules of thumb" that would declare a claim not covered solely on the basis of elements, such as, lack of restoration potential, ability to walk a certain number of feet, or degree of stability is unacceptable without individual review of all pertinent facts to determine if coverage may be justified. Medical denial decisions must be based on a detailed and thorough analysis of the beneficiary's total condition and individual need for care.<sup>2</sup>

Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate.<sup>3</sup>

We believe these principles apply to Part B occupational therapy services as well. Medicare law allows for coverage of services which meet medical necessity criteria and does not limit daily, weekly or monthly need except as related to the patient's condition and state medical necessity criteria.

Medicare rules also support qualified professionals using their clinical judgment to ensure that each Medicare beneficiary is receiving services that are medically necessary and tailored to their individual condition. Medicare guidelines for the therapy cap exception process set forth that by including the KX modifier on a claim, the clinician "attests" that the services they provided "are medically necessary and justification is documented in the medical record."<sup>4</sup> Further, the guidelines establish that by including the KX modifier "the provider is attesting that the services billed are reasonable and necessary services that require the skills of a therapist, are justified by appropriate documentation in the medical record, and qualify for an exception

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<sup>1</sup> Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 1, § 110.1 (General).

<sup>2</sup> Program Integrity Manual (CMS Pub. 100-08), Ch. 6, § 6.1 (Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills).

<sup>3</sup> Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 7, § 20.3 (Use of Utilization Screens and "Rules of Thumb").

<sup>4</sup> Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 5, § 10.2(C)(1) (The Financial Limitation; Exceptions to Therapy Cap – General).

using the automatic process exception.”<sup>5</sup> We feel Medicare’s reliance on the therapist’s clinical judgment is well expressed in the draft LCD’s provision that “each service must be medically reasonable and necessary for the specific patient and his or her condition. Additionally, Medicare expects that the patient’s medical record will clearly demonstrate that medical necessity.” Allowing providers to use their clinical judgment based on the condition of each specific patient still requires that providers demonstrate that their skilled therapy services are reasonable and necessary to improve a patient’s impairment or functional limitation, and therefore meet the requirements for Outpatient Rehabilitation Therapy Services set forth in the Medicare Benefit Policy Manual.<sup>6</sup>

AOTA argues that the minute/unit limitation in this LCD is attempting to impose a cap on access to therapy services for Trailblazer beneficiaries similar to the cap imposed by the Balanced Budget Act of 1997, but which Congress has seen fit to override with the implementation of an exception process that assures access to medically necessary, appropriate and skilled services beyond the arbitrary limit of the annual cap. Trailblazer is attempting to make a decision that is not within its purview but rather in the purview of Congress.

The exception process has the added important element of supporting and promoting the value of the therapist’s judgment in determining the medical necessity of therapy. The therapist must attest to the fact that the beneficiary’s situation meets all of the Medicare coverage criteria when billing for additional therapy. Although it was always the case that the therapist confirmed that the patient met the coverage criteria, the emphasis in the exception process is a salute to the importance of the therapist’s clinical judgment and professional behavior.

Trailblazer fails to provide any evidence or scientific studies to support the arbitrary frequency limits on therapy services referenced in the draft LCD. AOTA is opposed to the use of “rules of thumb” because positive outcomes can result only from the therapist’s clinical evaluation of all factors affecting a person’s progress in rehabilitation and the development of an individualized plan of care based on these clinical factors.

**For the reasons listed above, AOTA urges the removal of the following sentence under “Utilization Guidelines” in the draft LCD:**

**This LCD establishes frequency limitations of 5 (15-minute) PT or OT services per day and 60 (15-minute) PT or OT services per month.**

\* \* \*

We hope that these comments are helpful and greatly appreciate the opportunity to comment on the draft LCD. We look forward to a continuing dialogue with Trailblazer on these issues as they apply to occupational therapy. Should you have any questions or comments, please contact me at (301) 652-2682 ext. 2017 or via email at [jbogenrief@aota.org](mailto:jbogenrief@aota.org). Thank you once again for

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<sup>5</sup> Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 5, § 10.2(C)(6) (The Financial Limitation; Use of the KX Modifier for Therapy Cap Exceptions).

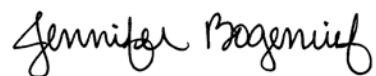
<sup>6</sup> Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 15, § 220.2 (Reasonable and Necessary Outpatient Rehabilitation Therapy Services).

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considering the comments submitted above, and for your continued work on the behalf of Medicare beneficiaries.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Bogenrief". The signature is written in a cursive style with a large initial "J" and a long, sweeping underline.

Jennifer Bogenrief  
Senior Regulatory Analyst, Reimbursement and Regulatory Policy