



Submitted Electronically

September 27, 2017

House Ways and Means Committee
1102 Longworth HOB
Washington D.C. 20515

House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Current Discussion Draft Language for Replacing the Medicare Outpatient Therapy Caps Exceptions Process

Dear Chairman Brady, Ranking Member Neal, Chairman Walden, Ranking Member Pallone, Chairman Hatch, Ranking Member Wyden and Members of the Committees:

The six organizations that comprise the Steering Committee of the Coalition to Preserve Rehabilitation (CPR) write to outline major areas of concern and highlight specific items that we would like for you to consider as you draft language for permanent repeal of the Medicare outpatient therapy caps. CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

First, we wish to stress how much we appreciated the opportunity to meet with committee staff on September 20 and to provide comment on issues that need to be considered in formulating a permanent repeal solution. We also want to reiterate how strongly we feel that the Medicare outpatient therapy caps must be permanently repealed *this year*. These caps are arbitrary limitations in benefits that impact beneficiaries at the very time that they need outpatient therapy the most. We also acknowledge

that Congress must find ways to minimize the long-term cost of therapy cap repeal, and we stand ready to work with Congress on this challenging issue.

The CPR Steering Committee suggests that the following issues be considered in the formulation of a permanent repeal policy:

Incorporations of Protections for Highly-Complex Patients under any Medical Review Process

- Highly complex, resource intensive cases, including but not limited to: those involving neurological or moderate to severe traumatic brain injury, in addition to paralysis through spinal cord injury (paraplegic or quadriplegic), moderate to severe stroke, or major multiple trauma/limb amputation, should be exempted from therapy caps altogether. These conditions, on their face, require significant outpatient therapy, and the treatment plan should be determined by the rehabilitation team subject to typical medical necessity review by CMS contractors. Specific protections for these patients from unnecessary delays in care and to ensure access to services need to be incorporated into any medical review policy.
- CMS should examine other conditions that have a high likelihood of extensive therapy requirements in an outpatient setting, and should apply these same protections to these highly complex patients under any medical review process.

Prior-Authorization

- CPR has significant concerns with the implementation of any prior authorization program, because prior authorization delays access to beneficiary care and puts Medicare contractors in the position of practicing medicine, supplanting the medical judgment of the rehabilitation physician and the rehabilitation team.
- However, if prior authorization is implemented as part of a policy solution to repeal the Therapy Caps, we ask that you consider the following:
 - Prior authorization should be used only as a last resort for providers that have demonstrated a repeated pattern of unacceptable billing practices.
 - CMS should be required to respond to prior authorization requests within a specified timeframe (CPR recommends within 48 hours), or payment cannot be denied. Delaying treatment for certain types of beneficiaries by even a few days can lead to severe harm to beneficiaries. For example, failure to deliver immediate, timely therapy services to an orthopedic surgery case can prevent a proper recovery. CPR believes that a ten-day timeframe, as is included in prior authorization impacting certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), is unacceptable and unreasonable.
 - Certain types of cases, including the above referenced list of highly complex, resource intensive cases, should be taken into account and have protections from prior authorization requirements. As mentioned previously, certain types of post-operative beneficiaries require immediate therapy services, and delaying the initiation of therapy by even a few days can lead to serious harm to a beneficiary.
 - CMS should be prohibited from auditing claims that have been approved by prior authorization. For example, in DMEPOS, claims that have been granted prior authorization are afforded reasonable protection from future Medicare medical necessity audits.

Post-Payment Review

- The above-referenced list of highly complex, resource intensive cases must be taken into account when identifying what constitutes an “aberrant billing pattern.” These types of beneficiaries have been shown to have a wide-range of rehabilitation needs. Broadly flagging these cases as being “aberrant” without taking into account the diagnosis of the patient or the patient case-mix of the provider when compared to their peers may cause providers who treat these patients to be unfairly targeted for medical review, which could lead to patient access issues.

Pre-Payment Review

- As detailed above, a prior authorization requirement could harm beneficiary health and impede access to care. CPR believes that a pre-payment review process, rather than a prior authorization requirement, should be considered if a provider fails to rectify any billing issues identified on post-payment review.

Maintenance Therapy Standard of Coverage

- In identifying aberrant billers under a medical review process, it is imperative that patients receiving skilled maintenance care under the *Jimmo* settlement, which establishes coverage for skilled services to maintain or prevent deterioration of an individual’s function not only to improve it, are not inadvertently or unfairly targeted or impacted. Providers providing skilled maintenance care pursuant to *Jimmo* cannot be designated “aberrant” simply for providing these services. Any legislation that addresses outpatient therapy caps must be consistent with this standard of Medicare coverage.

Thank you for your willingness to consider our views. Should you have further questions regarding this information, please contact Peter Thomas or Steve Postal, CPR staff, at (202) 466-6550 or by emailing Peter.Thomas@powerslaw.com or Steve.Postal@powerslaw.com.

Sincerely,

CPR Steering Committee

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