National Association for the Support of Long Term Care

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NARA

The National Association of Rehabilitation Providers and Agencies

Via email

April 9, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services

Re: Patients Over Paperwork Initiative

Dear Administrator Verma:

Our two organizations, National Association for the Support of Long Term Care (NASL) and the National Association of Rehabilitation Providers and Agencies (NARA) submit these comments for consideration for Patients Over Paperwork. **With COVID-19, current regulations are putting patient's and rehab therapist's health and safety at risk.**

The National Association for the Support of Long Term Care is a trade association representing providers and suppliers of ancillary services and providers to the long-term and post-acute care (LTPAC) sector. NASL members include rehabilitation therapy companies that employ physical therapists, occupational therapists, and speech-language pathologists who furnish rehabilitation therapy to hundreds of thousands of Medicare beneficiaries in nursing facilities as well as to beneficiaries in other long-term and post-acute care settings. NASL members also include vendors of health information technology (IT) that develop and distribute clinical electronic medical records (EMRs), billing and point-of-care IT systems and other software solutions that serve the majority of LTPAC providers of assisted living as well as skilled nursing and ancillary services. In addition, NASL members include providers of clinical laboratory services, portable x-ray and other specialized supplies for the LTPAC sector. NASL is a founding member of the Long Term and Post-Acute Care Health Information Technology Collaborative (LTPAC Health IT Collaborative), which was formed in 2005 to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers, and other stakeholders.

The National Association of Rehabilitation Providers and Agencies represents over 80,000 physical therapists, occupational therapists and speech language pathologists through our member organizations who provide rehabilitation services throughout the United States. NARA's members provide therapy in all settings across the care continuum including outpatient clinics, skilled nursing facilities, assisted living facilities, hospital outpatient facilities, hospital inpatient settings, in patient's homes, and in retirement and assisted living communities. As a member-driven organization, NARA promotes accessible and high-quality physical therapy, occupational therapy, and speech-language pathology services through education, support, and advocacy. NARA's membership demographics give it a unique insight into the full breath of the continuum of care for patients and, given the nature of the services its members furnish, NARA has special insight into the needs and risks of the senior population.

The patients our members treat in nursing facilities, assisted living facilities and other settings where Medicare beneficiaries receive long-term care-related services are the most susceptible to COVID-19. Our highest priority is to the patients we serve and the rehabilitation therapists we employ who treat these patients. As important background information, current regulations for Part B Outpatient Therapy require that rehabilitation therapists assess the therapy program being delivered a minimum of once every 10 visits AND require the therapist to personally provide at least one unit of service during each reporting period. **The effect of COVID-19 has placed rehabilitation therapists in an untenable position where we cannot meet compliance with Part B Outpatient Therapy regulations and comply with screening guidelines from the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control (CDC) at the same time. We are committed to the Part B Outpatient Therapy progress report period clinician active participation requirement and we are fully confident we can monitor the patient's progress, supervise and provide guidance to therapy assistants, complete required documentation and make clinical determinations to continue or discontinue skilled services -- we just cannot do it face to face while complying with the safety requirements of COVID-19.**

CMS and CDC guidelines restrict and otherwise discourage traffic into facilities in order to reduce the spread of COVID-19 for the safety of patients and staff. See April 2nd guidance at https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf Facilities have set up screening protocols to put these guidelines into practice. Some states or health departments have required more stringent screening protocols than what is recommended by CMS or the CDC. As part of the screening protocols, facilities are understandably concerned about healthcare personnel who have to travel from facility to facility to treat patients. Even with careful infection control and screening, facilities are restricting rehabilitation therapists that treat at multiple facilities or sites. Generally, only allowing one therapist into that one building at all. Some rehabilitation therapists are under quarantine due to exposures and so

they cannot treat for 14 days or longer. Unfortunately, some rehabilitation therapists have contracted COVID-19 which threatens their health and they are of course not able to treat patients for some time. Some facilities face such shortages of PPE that they must restrict clinicians because the facility can't provide enough PPE for safe treatment. Because of these conditions and others, it is extremely challenging under these conditions to meet compliance with the Medicare requirement for onsite active participation by a clinician once every 10 treatment days and maintain safe conditions for patients and staff. Compliance with the supervisory requirement requires a supervising therapist to enter the facility in addition to a therapist assistant who is providing the ongoing treatment which threatens the health and safety of the patients, the rehabilitation therapists and the rest of the staff in the facility.

The *Medicare Benefits Policy Manual* (Pub. 100-01, Ch 15) Section 220.3(D), allows for a delayed report in 7 calendar days if the clinician has not written a progress report before the end of the progress reporting period, it shall be written within 7 calendar days after the end of the reporting period. We are finding that this allowance while helpful in normal times, falls short of a solution during these extreme situations. We believe the COVID-19 pandemic will be with us for some time, perhaps months. Even though the delayed report provision is meant to provide some help when the progress report period requirements of progress report completion and active participation by a clinician cannot be met, we find a flexibility for only 7 days will not relieve our current situation for the same reasons that rehabilitation therapists are having trouble entering facilities to comply with the requirement for active participation via delivery of at least one unit of service. The *Medicare Benefits Policy Manual* (Pub. 100-01, Ch 15) Section 220.3(D) states, "…If the clinician did not participate actively in treatment during the progress report period, documentation of the delayed active participation shall be entered in the treatment note as soon as possible." There is no guidance as to timeframes associated with these delayed active participation notes. We anticipate that this challenge for therapists to enter facilities will extend across many consecutive reporting periods. We ask for relief with both of these requirements.

We are very appreciative that CMS has halted Medicare Administrative Contractor (MAC) medical review activities like Target Probe and Educate (TPE). Rehabilitation therapy providers must divert available staff that otherwise would answer these reviews to supporting care activities at this time as clinical staff are limited and so this relief is greatly appreciated. We ask for instruction to the MACS not to deny claims with respect to the 10th supervisory visit report requirements and requirements for direct involvement as rehab providers struggle under this new environment to comply with rules. Right before CMS halted review activities, at least three MACs were shifting their focus to Part B Outpatient Therapy. We believe it would be unfair for MACs to disregard the COVID-19 situation and deny claims both now and when a normal situation resumes, hopefully in a few months. We ask that CMS instruct the MACs to take into

consideration that providers are currently having to weigh compliance with the 10th visit rule against safety guidelines from CMS and the CDC which currently conflict. We ask that CMS instruct the MACs to follow Benefit Policy Manual guidance and take into consideration when making a clinical judgment whether continued treatment by assistants or qualified personnel is reasonable and necessary when the clinician has not actively participated in treatment for longer than one reporting period that providers are currently having to comply with the safety guidelines from CMS and the CDC and ensure that patients receive the medically necessary care.

We have written previously to ask that CMS waive the every 10th treatment day clinician active participation for the duration of the emergency period. We continue to ask for this provision to be waived as CMS has provided many waivers for Medicare providers under its 1135 authority during a Public Health Emergency (PHE). Asking for a waiver of this requirement during the PHE does not diminish our support for the supervisory requirement. The issue is that CMS and CDC guidelines conflict with this requirement being conducted face-to-face by a patient and therapist.

In the alternative, we are proposing that compliance with the need to determine if continued justification for skilled therapy exists could also be attained through the use of "remote supervision" (we define remote supervision as virtual presence through audio/video real-time communications technology) where the supervising clinician, therapy assistant and the patient connect through audio/visual real-time communications technology in order to provide the necessary supervision and determination to either continue skilled care or discharge as well as provide guidance to the assistant continuing care. As stated earlier, the *Medicare Benefits Policy Manual* (Pub. 100-01, Ch 15) Section 220.3(D) states, "…If the clinician did not participate actively in treatment during the progress report period, documentation of the delayed active participation shall be entered in the treatment note as soon as possible. The treatment note shall explain the reason for the clinician's missed active participation. Also, the <u>treatment note shall document the clinician's guidance to the assistant or qualified personnel to justify that the skills of a therapist were required during the reporting period…</u>" Emphasis added. We believe that virtual supervision could comply with the requirement that the treatment note shall document the clinician's guidance to the assistant or qualified personnel, to show evidence of involvement in directing the plan of care and to justify that the skills of a therapist were required during the reporting period

In the recently released, *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Interim Final Rule with Comment* CMS has provided many new authorizations that allow for communications very similar to our proposal

of remote supervision. We ask the same for this requirement in order to preserve the safety of our staff and patients while maintaining compliance.

Nursing facilities and other long term care facilities are on the front lines of the battle against the COVID-19 and we fear that the situation could become worse for our vulnerable patients. We want to work with CMS to try to temporarily mitigate these requirements so that we can proactively help reduce spread, provide medically necessary care and also meet regulatory compliance. The current emergency situation with COVID-19 is a barrier to these regulatory requirements and compliance to the tenth visit rule may significantly increase the potential for COVID-19 spread.

It is our intent and responsibility to ensure that patients under our care continue to receive medically necessary rehabilitation therapy services with proper oversight while we attempt to comply with regulation and manage through the limitations from the COVID-19 pandemic.

We wish to discuss this with you at your earliest convenience. We can be reached at Cynthia@nasl.org or KCooney@therapyspecialists.net . Thank you for your consideration.

Sincerely,

Cynthia K. Morton, MPA
Executive Vice President
National Association for the Support of Long Term Care (NASL)

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President,
The National Association of Rehabilitation Providers and Agencies (NARA)