



American Therapeutic Recreation Association

August 9, 2019

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: **CMS-6082-NC; Request for Information: Reducing Administrative Burden to Put Patients over Paperwork**

Dear Administrator Verma:

The American Therapeutic Recreation Association (ATRA) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (“CMS”) request for information (“RFI”) regarding reducing administrative burden through the Patients over Paperwork initiative. ATRA is the largest professional association representing recreational therapy practitioners. Recreational therapists are nationally certified, and where applicable state-licensed, to provide activity-based treatment services for individuals with a range of disabling conditions across the lifespan. **Recreational therapy is active treatment, medically necessary, and prescribed by a physician as part of a patient’s plan of care.**

ATRA shares CMS’ goal of reducing unnecessary administrative burden for patients and providers, and we appreciate the Centers’ commitment to achieving this goal. Our comments will focus on one major regulatory issue facing recreational therapists and other rehabilitation providers who practice in inpatient rehabilitation hospitals and units (IRF’s). We believe that the proposal outlined below will have a **significant impact on the ability of the recreational therapists we represent to provide truly patient-centered care to Medicare beneficiaries with disabling and chronic conditions.** We urge CMS to consider our comments and to continue pursuing policies that decrease regulatory barriers to access and empower providers to tailor their care to the needs of individual Medicare beneficiaries.

Summary of the Issue

Current regulations narrowly restrict the types of skilled therapy countable towards the intensity of therapy requirement (otherwise known as the so-called “three hour rule”) for Medicare beneficiaries admitted to inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals. CMS should modify the rule to **restore physician judgment to select other skilled therapies that can be counted toward the intensity of therapy requirement in order to better meet the unique rehabilitation needs of Medicare patients.**

Background on the IRF Intensity of Therapy Requirement

In order to qualify for coverage in an IRF, a Medicare beneficiary with an injury, illness, disability, or chronic condition must require a “relatively intense” course of rehabilitation therapy. Beneficiaries must be able to participate in at least three hours of rehabilitation therapy per day, five days per week (or fifteen hours within a consecutive seven-day period in certain cases), the so-called “three hour rule.” Prior to 2010, CMS regulations for IRFs explicitly stated that skilled therapies such as physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), and/or orthotics and prosthetics (O&P) could be counted toward the “intensity of therapy” requirement. CMS regulations also stated that “other therapeutic modalities” that were determined by the physician and the rehabilitation team to be needed by the patient “on a priority basis” would qualify toward satisfaction of the rule.

This language allowed the physician and the rehabilitation team to tailor the mix of therapies provided to each IRF patient as they progressed through their IRF stay. For instance, typically when IRF patients begin to recover and become more functional, they may need recreational therapy to help facilitate community reintegration and independent living upon discharge from the rehabilitation hospital. The recreational therapist typically provides this service. This is one instance where recreational therapy is often critical to ensuring a smooth transition to independent living and a reduction in the likelihood of a hospital readmission.

In addition to recreational therapy, this flexibility of the three hour rule also allowed neuropsychology services, psychology services, respiratory therapy and other skilled services to count toward satisfaction of the three hour rule for patients who required therapies other than those explicitly listed in the regulation. **The mix of therapies was determined by the professional judgment of the treating physician and the rehabilitation team.**

The 2010 IRF Regulation Restricts Access to Care

Deference to the treating physician’s judgment was removed by regulations issued by CMS in 2010, resulting in restricted access to skilled services other than PT, OT, SLP, and O&P. For the past nine years, PT, OT, SLT, and O&P have been the only skilled modalities that IRFs can count toward the provision of three hours of therapy per day to Medicare patients. As a result, some IRFs eliminated their capacity to provide other skilled services, including recreational therapy, which patients often need during their IRF stay. While the costs of recreational therapy were built into the IRF prospective payment system and IRFs continue to be paid to provide them, many IRFs do not make these services available to Medicare patients due to the current regulatory restrictions, even if the physician and the rehabilitation team believe the services are medical necessary for particular patients.

The current three hour rule regulation replaces flexibility and physician judgment with a one-size-fits-all, bureaucratic approach to therapy prescription. **Ensuring access to the appropriate mix of services in the IRF setting is essential to optimizing care** for people with brain injuries, spinal cord injuries, individuals who have sustained strokes and amputations, individuals living with neurological disorders, and other beneficiaries with a wide range of medical conditions.

Recommendation: ATRA recommends that CMS update the three hour rule regulation to state that in addition to PT, OT, SLT, and O&P services, the rehabilitation physician and the rehabilitation team may determine that additional skilled modalities may be prescribed based on patient needs and may be counted toward the three hour rule during the course of an IRF stay. Restoring physician judgment will allow the treating rehabilitation professionals to determine the appropriate mix of skilled therapy services that best meet the patient’s needs as they progress through their IRF stay and are ultimately discharged. The current regulation is overly proscriptive and prevents physicians from fully implementing a patient-centered, intensive, interdisciplinary treatment program tailored to the needs of the individual patient.

Rehabilitation organizations, including ATRA, have requested in the past that CMS modify the regulations to provide greater flexibility in meeting the intensity of therapy requirement, but thus far the agency has not done so. Revising the overly restrictive regulation currently in place would have a significant impact on the availability of rehabilitation services for patients who need them, and reduce burden on providers who face obstacles in prescribing and offering a treatment plan best suited to individual patient’s circumstances.

Related Legislation

There are ongoing bipartisan efforts in Congress to address the burdensome three hour rule requirement legislatively, but CMS can and should reform the regulation under the agency’s own authority. The Access to Inpatient Rehabilitation Act (H.R. 626 in the 115th Congress, and soon to be reintroduced) has received support from a diverse group of organizations, including the American Medical Rehabilitation Providers Association, the American Academy of Orthotists and Prosthetists, the Association of Rehabilitation Nurses, the Brain Injury Association of America, the Commission on Accreditation of Rehabilitation Facilities, the Christopher & Dana Reeve Foundation, the Council on Brain Injury, the United Spinal Association, and ATRA. The legislation would restore physician judgment to determine which skilled therapies should be considered for purposes of the intensity of therapy requirement for IRF admission. ATRA supports all efforts to reduce the unnecessary barriers to access inherent in the current regulatory language involving the three hour rule.

Reducing the Three Hour Rule Burden

We urge CMS to return to the pre-2010 interpretation of the rule, which allowed the rehabilitation physician and the rehabilitation team to determine which skilled services should be countable toward the three hour rule (i.e., intensity of therapy requirement) in order to provide the best outcomes for Medicare beneficiaries in IRFs.

We greatly appreciate your attention to our comments. Should you have any further questions, please contact Dr. Dawn DeVries, ATRA Federal Public Policy Chair, at devridaw@gvsu.edu or by phone at 616-331-5553.

Sincerely,

Handwritten signature of Dawn DeVries in cursive script.

Dawn DeVries, DHA, DFRT, CTRS
ATRA Federal Public Policy Chair
Distinguished Fellow in Recreational Therapy

Handwritten signature of Tim Passmore in cursive script.

Tim Passmore, Ed.D., DFRT, CTRS
President, ATRA Board of Directors
Distinguished Fellow in Recreational Therapy