AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

June 13, 2018

Lynne G. Johnson
Deputy Group Director, Partner Relations Group
Office of Communications
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244-1850
Location: S1-07-13

RE: June 2018 Meeting of the Centers for Medicare & Medicaid Service Advisory Panel on Outreach and Education

Dear Ms. Johnson:

On behalf of the American Speech-Language-Hearing Association, I would like to thank you and the Advisory Panel on Outreach and Education for the opportunity to provide recommendations for topics on additional Medicare provider and beneficiary outreach and education needs. We are recommending two topics for your consideration. First, there is an educational need related to changes in the Medicare medical review threshold process for outpatient therapy services including speech-language pathology, occupational therapy, and physical therapy, subsequent to the repeal of the therapy cap. Second, ongoing implementation concerns regarding the *Jimmo vs. Sebelius* settlement need to be addressed.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

Medicare Medical Review Threshold Process for Outpatient Therapy Services

In February 2018, as part of a continuing resolution, Congress included the permanent repeal of an annual financial limitation for outpatient therapy services (often referred to as the therapy cap) that had been in place since 1997. In its place, Congress permanently extended a targeted medical review policy for outpatient therapy services that exceed a $3,000 threshold per beneficiary, per year. Until this legislation became law, Medicare beneficiaries that exceeded a $2,010 financial limitation on speech-language pathology and physical therapy services combined in January and February of this year were forced to pay out-of-pocket for therapy services or make the difficult decision to forego medically necessary care. Clinicians serving these patients may have had claims rejected while others held claims in anticipation of Congressional action. Once permanent repeal of the therapy cap was achieved and enacted in a retroactive manner to January 1, 2018, the Centers for Medicare & Medicaid Services (CMS) had to reprocess claims that were rejected and provide instructions to clinicians on how to refund patients who paid out-of-pocket for services that exceeded the therapy cap and submit those

claims to the Medicare program for coverage. Very limited guidance on the reprocessing or resubmission of claims has been provided to Medicare beneficiaries or the clinicians who served them.

Additionally, the law provided specific guidance on how claims submission for therapy services and targeted reviews that exceed the financial threshold of $3,000 should be implemented but no guidance on these issues has been made available by CMS. For example, the law indicates that once a patient has spent an excess of $2,010 for occupational therapy and/or $2,010 for physical therapy and speech-language pathology services combined, the clinician needs to place the KX modifier on the claim. Clinicians need regulatory implementation guidance from CMS advising them of this requirement. The regulatory guidance should also indicate whether this dollar amount will be updated by the Medicare Economic Index (MEI) on an annual basis, which has been the case since the therapy cap was created in 1997. Clinicians also need clarity on whether CMS intends to modify the current targeting criteria used to determine which of their medical records will be reviewed once a patient has exceeded the $3,000 targeted medical review threshold.

Currently, CMS maintains information regarding the financial limitations associated with outpatient therapy resources on three separate webpages, which creates confusion and burden when attempting to find and understand information on the process. Of those three sites, only one appears to have been updated since the law was passed and the update is very minimal by only indicating that the law exists. It is possible CMS intends to outline this information in the annual physician fee schedule rulemaking process but if this is the case the final rule will not be issued until November, almost one year after the law was passed. That is too long to wait for guidance that is critical to ensure compliance with federal law and preserve access to outpatient therapy services for Medicare beneficiaries as Congress intended.

Implementation Concerns Regarding the *Jimmo vs. Sebelius* Settlement

Therapy providers working in every health care setting–with the exception of inpatient rehabilitation facilities–were dramatically impacted by the settlement in the 2013 *Jimmo vs. Sebelius* case that was reaffirmed in 2017. The settlement between the Center for Medicare Advocacy (representing a Medicare beneficiary) and the U.S. Department of Health and Human Services upheld the right of a Medicare beneficiary to have maintenance therapy services designed to maintain function or prevent further decline covered under Medicare when the services are medically necessary and require skilled care. For many years, payment policies, such as local coverage determinations and audit findings, would deny therapy services if the patient did not demonstrate improvement. CMS published some information regarding the settlement but due to confusion among Medicare stakeholders about the implications of the *Jimmo* settlement, the Center for Medicare Advocacy engaged the courts again to reaffirm CMS's obligation to implement and uphold the settlement agreement. The judge in the second round of litigation agreed that CMS had done a poor job implementing the requirements of the settlement. Additional guidance and transparency is necessary to ensure entitled access to care for beneficiaries and avoid additional litigation.

ASHA staff continue to field questions from our speech-language pathology members about the implications of the *Jimmo* settlement on their clinical practice, which is compounded further with the continued use of words like "improvement" and "progress" in local coverage determinations and negative audit findings. It is imperative that CMS inform its Medicare contractors that "improvement" cannot be used as a reason for denial and direct contractors to work with providers and beneficiaries to ensure access to maintenance therapy services. These services are particularly critical for the Medicare population as many suffer from progressive neurodegenerative conditions such as Parkinson's, multiple sclerosis, and dementia, and could maintain higher levels of function, quality of life, and independence with the benefit of medically necessary skilled care provided by speech-language pathologists and other therapists.

Thank you for the opportunity to provide recommendations on outreach and education resources that meet the specific needs of speech-language pathologists and the beneficiaries they serve. We stand ready to assist this advisory panel and CMS to achieve these objectives. If you or your staff have questions, please contact Sarah Warren, MA, ASHA's director for health care policy, Medicare, at swarren@asha.org.

Sincerely,

Elise Davis-McFarland, PhD, CCC-SLP
2018 ASHA President