April 15, 2014

The Honorable Glenn Thompson

124 Cannon House Office Building

U.S. House of Representatives

Washington, DC 20515

Re: **Support for Introduction of Legislation to Modify Medicare’s Intensity of Therapy Requirement for Inpatient Rehabilitation Hospitals and Units**

Dear Congressman Thompson:

The undersigned rehabilitation and disability organizations join the AAPM&R in strongly supporting your efforts to introduce legislation to provide needed flexibility to the “intensity of therapy” requirement that the Centers for Medicare and Medicaid Services (“CMS”) uses to help determine which Medicare beneficiaries are appropriate for treatment in an inpatient rehabilitation hospital and unit (“IRF”).

In order to qualify for treatment in an IRF, Medicare beneficiaries must meet an intensity of therapy requirement which requires the patient to be able to participate in three hours of rehabilitation therapy per day, five days per week. This requirement is referred to in Medicare regulations as the “three hour rule.” For many years, the specific therapies that counted toward satisfaction of the three hour rule were somewhat flexible and subject to physician judgment.

Prior to 2010, CMS regulations explicitly stated that physical therapy (“PT”), occupational therapy (“OT”), speech therapy (“ST”) and/or orthotics and prosthetics (“O&P”) were counted toward the three hour rule on an as-needed basis. In addition, the regulation 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. (See, HCFA Ruling 85-2.) This language allowed recreational therapy services to count toward the rule for patients who needed these services on a priority basis in the IRF setting.

CMS revised these regulations in 2010 by significantly restricting the three hour rule to only four therapies (i.e., PT, OT, ST, and O&P) and removing the discretion of the physician and the rehabilitation team to count therapeutic services needed by the patient—other than these four services—toward satisfaction of the three hour rule.

As a result, some rehabilitation hospitals and units eliminated their capacity to provide recreational therapy services and are no longer capable of offering these services to patients who need them. This hamstrings physicians and rehabilitation teams from providing the appropriate mix of therapy services specifically tailored to the patients’ medical and functional needs in a timely and efficient manner. In addition, lack of recognition of these important services under the three hour rule may result in certain patients being inappropriately diverted to less intensive settings, even though their medical and functional condition justifies an inpatient rehabilitation hospital stay.

Rehabilitation organizations have requested CMS to modify the regulations to provide greater flexibility in meeting the intensity of therapy requirement but CMS has not done so. At a meeting hosted last summer by the American Academy of Physical Medicine and Rehabilitation (AAPM&R), key rehabilitation stakeholders achieved consensus that, at a minimum, the intensity of therapy requirement should be modified. Therefore, the undersigned organizations recommend that the intensity of therapy requirement of IRFs be revised to include “recreational therapy” among the therapies to be counted toward the three hour rule.

By including recreational therapy under the three hour rule, Medicare beneficiaries in inpatient rehabilitation hospitals and units will regain access to important therapies deemed medically necessary by their treating physicians and therapists. This will also reduce the risk that patients will be inappropriately diverted into less intensive post-acute care settings. As such, the undersigned organizations strongly support your efforts to restore needed flexibility to the intensity of therapy requirement in the IRF setting for the benefit of Medicare beneficiaries with illnesses, injuries, disabilities and chronic conditions.

Please contact Sarah D’Orsie, AAPM&R Vice President of Government Affairs, at SD'Orsie@aapmr.org for more information.

Sincerely,



Phillip R. Bryant, DO

Chair, Reimbursement and Policy Review Committee (RPRC)

American Academy of Physical Medicine and Rehabilitation (AAPM&R)

On behalf of the following national organizations:

American Medical Rehabilitation Providers Association

American Academy of Orthotists and Prosthetists

American Therapeutic Recreation Association

Brain Injury Association of America

CARF, International (Commission on Accreditation of Rehabilitation Facilities)

Council on Brain Injury

United Spinal Association