

1111 North Fairfax Street  
Alexandria, VA 22314-1488  
703 684 2782  
703 684 7343 fax  
www.apta.org

June 26, 2017

Seema Verma, MPH; Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G  
Attn: CMS-1671-P  
Hubert Humphrey Building  
200 Independence Ave, SW  
Washington, DC 20201

*Submitted electronically*

**RE: CMS-1671-P; Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018**

Dear Administrator Verma:

On behalf of the more than 95,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) respectfully submits comments regarding the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for Fiscal Year (FY) 2018 proposed rule. Physical therapy is an integral service within the IRF setting, where physical therapists furnish medically necessary services to Medicare beneficiaries to improve their overall health and function, and to optimize their quality of life.

The estimated IRF market basket update to payments for FY 2018 is 1.0%, or an increase of \$80 million after applicable adjustments. APTA commends the Centers for Medicare and Medicaid Services (CMS) for proposing this increase to ensure appropriate payment levels for services in the IRF setting. While we support the overall proposed policies included in this rulemaking, we respectfully request that you carefully consider the comments that we have provided below. We also appreciate your consideration of our comments in response to your request for information to improve the health care delivery system.

**Changes to Presumptive Compliance Conditions**

CMS has proposed changes to the list of ICD-10-CM codes that the agency uses for its presumptive compliance methodology to evaluate IRF compliance with the “60 percent rule.”

Under this rule, at least 60% of a facility's total inpatient population must require treatment in an IRF for at least 1 of the 13 medical conditions listed on the presumptive compliance list.

### ***Multiple Trauma Codes***

Physical therapists in IRFs often provide varied levels of rehabilitative care to patients with multiple traumas. APTA supports CMS' proposal to address certain codes that changed during the conversion from ICD-9-CM to ICD-10-CM, particularly the agency's proposal to include multiple trauma codes within the presumptive compliance list that did not translate properly during the ICD-10 transition. APTA agrees that rehabilitative services provided in IRFs to patients with multiple traumas should be counted toward the facilities' compliance with the 60 percent rule.

### ***Unspecified Codes***

APTA generally supports CMS's proposal to remove "unspecified codes" from the presumptive compliance list. Within the rule, CMS explains that by removing the nonspecific codes from the presumptive compliance list, providers will be encouraged to identify codes included on the list that better describe patients' conditions. APTA agrees with CMS's statement that there is a need for descriptive coding and documentation to demonstrate the appropriateness of a patient's admission to an IRF. However, we strongly encourage CMS to monitor the coding practices of providers who refer patients to IRFs and ensure that *referring* providers' use of unspecified codes does not prevent patients from being considered in CMS's calculation of the 60 percent rule.

### ***13 Conditions for Presumptive Compliance***

In its proposed rule, CMS has requested comments on the 13 conditions that are used to evaluate facilities' compliance with the 60 percent rule. The 13 conditions are as follows:

- Stroke
- Spinal cord injury
- Congenital deformity
- Amputation
- Major multiple trauma
- Fracture of femur
- Brain injury
- Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneurotherapy, muscular dystrophy, and Parkinson disease
- Burns
- Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies
- Systemic vasculidities with joint inflammation, under specified conditions
- Severe or advanced osteoarthritis, under specified conditions
- Knee or hip joint replacement, or both, if the replacements are bilateral, if the patient is 85 or older, or if the patient have a body mass index of at least 50

APTA supports the use of these conditions and associated diagnosis codes to satisfy the 60 percent rule. APTA recommends that CMS seek comments on an annual basis from stakeholders regarding the list of conditions and associated diagnosis codes to ensure that this list continues to reflect the diverse patient population of IRFs and the services furnished to these patients.

### **IRF Quality Reporting Program**

The Secretary established the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) in accordance with Section 1886(m)(5) of the Social Security Act, as added by Section 3004 of the Affordable Care Act. The Improving Post-Acute Care Transformation (IMPACT) Act also requires that the Secretary specify quality measures as well as resource-use and other measures with respect to certain domains not later than the specified application date that pertains to each measure domain and post-acute care (PAC) setting.

The IMPACT Act requires that PAC providers use risk-adjusted standardized assessment tools that are endorsed by the National Quality Forum (NQF) as the data source for quality measures. APTA strongly recommends that CMS incorporate the standardized assessment tools into the existing setting-specific assessment tools (OASIS, IRF-PAI, and MDS).

For FY 2018, CMS has also proposed changes to existing IRF quality measures, including measures for pressure ulcers and all-cause unplanned readmissions. Additionally, CMS has requested feedback on the survey-based experience-of-care measures for the IRF QRP.

#### ***Pressure Ulcer Quality Measure***

CMS has proposed to replace the existing pressure ulcer quality measure, Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (NQF #0678), with a modified pressure ulcer measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. The new measure would be included in the IRF QRP beginning in FY 2020. The modified version, unlike its predecessor, includes new or worsened unstageable pressure ulcers, including deep tissue injuries, in the measure numerator. The proposed measure also contains updated specifications that are intended to eliminate redundancies in the assessment items needed for its calculation, as well as reduce the potential for underestimating the frequency of pressure ulcers. The modified version of the measure would satisfy the IMPACT Act domain of skin integrity and changes in skin integrity. APTA supports these changes.

#### ***All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs***

CMS originally adopted the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs measure in the FY 2016 IRF PPS final rule. This measure assesses all-cause unplanned hospital readmissions from IRFs. Subsequently, in the FY 2017 IRF PPS final rule, CMS adopted the Potentially Preventable 30-Day Post-Discharge Readmission and Potentially Preventable Within Stay Readmission measures. CMS proposes to remove these measures in response to public comments expressing concern over the redundancy of readmission measures and the overlap between the All-Cause Readmission and Potentially

Preventable Readmission 30-Day Post-Discharge measures. APTA supports the removal of the All-Cause Readmission measure.

### **Feedback on Survey-Based Experience of Care Measures**

CMS is seeking feedback on the use of survey-based experience-of-care measures for the IRF QRP. CMS notes the survey has been field tested and explores experience of care across 5 main areas: (1) beginning stay at the rehabilitation hospital/unit; (2) interactions with staff; (3) experience during the rehabilitation hospital/unit stay; (4) preparing for leaving the rehabilitation hospital/unit; and (5) overall rehabilitation hospital/unit rating. APTA supports the implementation of survey-based experience-of-care measures. We recommend that CMS follow similar implementation processes to that of other survey-based measures in Medicare quality reporting programs.

CMS also is considering a measure focused on pain that relies on the collection of patient-reported pain data. APTA supports the future inclusion of a patient-reported pain measure in the IRF QRP.

APTA also supports CMS's proposal to modify the discharge-to-community measure in the future, such as including an assessment of the feasibility and impact of excluding baseline nursing facility residents from the measure through the addition of patient assessment-based data. We believe such modifications would increase the accuracy of the measure.

### **Accounting for Social Risk Factors**

APTA recognizes that adjusting for social risk factors in certain outcome measures is a complex issue. We appreciate that the lack of adjustment for social risk factors in outcome measures utilized in value-based payment programs and models negatively impacts providers and facilities in certain geographic areas where the incidence of specific social risk factors are highest. Currently, outcomes measures are not adjusted for social risk factors, which has led to reduced payments for providers and facilities caring for large numbers of disadvantaged patients. In addition to financial repercussions, these publically reported outcome measures can be misleading to consumers. We also acknowledge, however, that implementing social risk factor adjustments may increase health disparities by essentially masking these factors.

APTA is an active member in NQF. We have followed the social risk factor adjustment project as well as reviewed the work performed by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine regarding social risk factor adjustment. APTA supports the overarching strategies outlined in the ASPE report, including: Measure and report quality for beneficiaries with social risk factors; Set high, fair quality standards for all beneficiaries; and Reward and support better outcomes for beneficiaries with social risk factors. We also support testing of social risk factor adjustment models as well as the reporting of stratified outcomes measures to providers to enable them to better understand the effects social risk factors have on their performance. APTA encourages

CMS to take immediate action on ASPE's recommendations. Moreover, once the risk stratified data has been shared with providers, we recommend that CMS work with stakeholders to share this data with the general public.

APTA believes that the understanding of social risk factors and their impact on the health care system will continue to evolve over time. We encourage CMS to be responsive to future developments and strategies that provide solutions for the adjustment of social risk factors in outcomes measures.

### **Response to CMS' Request for Information**

APTA appreciates CMS's efforts to transform the health care delivery system, including the Medicare program, by emphasizing a strong focus on patient-centered care. We are encouraged by CMS's efforts to solicit ideas from stakeholders on policies and practices to help the Medicare program achieve transparency, flexibility, program simplification, and innovation. In response to the request for information, APTA recommends the following:

#### ***Telehealth***

As Medicare payment shifts to innovative, valued-based payment methods, it is important to recognize the use of telehealth as a valuable tool for providers to improve the quality of care. Telehealth offers patients increased access to providers that might not be available otherwise, as well as medical services without the need to travel long distances. Telehealth consists of electronic communications to deliver a host of health related information and health care services including, but not limited to, physical therapy-related information and services, over large and small distances. Telehealth encompasses a variety of health care and health promotion activities ranging from education, advice, reminders, interventions, and monitoring of interventions. Telehealth is projected to reach 12 million users in 2022, according to the World Market of Telehealth.

With the increasing reliance of technology to improve access to quality care, APTA urges CMS to revisit its policies that address coverage of telehealth services to include services provided by physical therapists. Applications of telehealth in physical therapy expand throughout patient care and consultation, as it allows physical therapists to effectively communicate with patients and provide more flexible care. Expanding Medicare coverage of telehealth services to include physical therapy will ultimately allow physical therapists to provide services to patients in a greater capacity.

Moreover, as CMS pursues the development of future alternative payment models that emphasize both quality and multi-disciplinary service delivery, CMS should address gaps in its policies to provide increased Medicare coverage for telehealth services. Expansion of telehealth coverage to include physical therapy and other specialized health services within such models would allow for more flexible care delivery to Medicare beneficiaries in need of comprehensive care from a team of providers. In addition, coverage for telehealth across a variety of providers can improve patient outcomes, decrease families' out of pocket spending, and promote greater

adherence to rehabilitation programs. Telehealth can also promote increased collaboration among providers and social service institutions to better address the specific needs of patients across the complete care continuum, from the primary care visit, to the rehabilitation services necessary to promote and maintain positive outcomes.

Physical therapy provided via telehealth can reduce costs, increase access to necessary care, enhance the patient's rehabilitation experience in the home environment, and prevent hospital readmissions. Although physical therapy is not included as a covered telehealth service under Social Security Act Section 1834(m), we believe CMS has the authority to allow coverage and reimbursement for these telehealth services under new alternative payment models. Therefore, as CMS continues to develop new and innovative models, we encourage the agency to maximize the ability of multiple types of providers, including physical therapists, to have the flexibility to use telehealth services to effectively manage patient care.

Congress has also expressed an interest in allowing coverage under Medicare for physical therapy services delivered through telehealth. We are hopeful that Congress will pass legislation in the near future that permits coverage of telehealth services furnished by physical therapists, speech-language pathologists, occupational therapists, audiologists, and respiratory therapists to Medicare beneficiaries.

### ***Therapy Cap***

APTA strongly believes that hospitals should be appropriately reimbursed for the services they provide during the inpatient and observation periods. The decision to admit should be based solely on the clinical condition of the patient and the setting in which their medical needs can be safely and effectively addressed. However, one policy that continues to impact this decision-making is the therapy cap. Per statutory requirements, CMS places an annual per-beneficiary Medicare financial limitation on outpatient therapy services (therapy cap). Each year this annual amount is updated, and the 2017 therapy cap amount is \$1,980 for physical therapy and speech language pathology services combined.

Due to the confusion that still exists around inpatient admission criteria, APTA continues to be concerned about coverage for therapy provided on an inpatient basis that is later denied by auditors and rebilled under Part B. Often, due to the risk of denials when classifying patients for an inpatient stay, there are instances in which a patient's entire stay in the hospital(s), which sometimes spans as many 16 days, is classified as an outpatient hospital stay. Therefore, all physical therapy services received during this period are counted toward the cap. We believe this is unfair to these patients, as it may limit their access to physical therapy in the outpatient setting when in fact these services should have been billed as inpatient services.

We strongly encourage CMS to establish an exception to the outpatient therapy requirements, as outlined in the Medicare Benefit Policy Manual, for observation status patients.

An additional Part B payment policy that poses serious implications for patients and providers during an outpatient hospital stay is therapy functional limitation reporting. The Middle Class

Tax Relief Act mandated that as of July 1, 2013, CMS collect information on claim forms regarding beneficiaries' function and condition. All practice settings that provide outpatient therapy services must include this information on their claim forms. Specifically, the policy applies to physical therapy, occupational therapy, and speech-language pathology services furnished in hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, rehabilitation agencies, home health agencies (when the beneficiary is not under a home health plan of care), and in private offices of therapists, physicians, and non-physician practitioners.

Under the functional limitation reporting requirement for outpatient therapy services, non-payable G-codes and modifiers are mandated on the claim forms to capture data on the beneficiary's functional limitations at the outset of the therapy episode, at a minimum of every 10th visit, and at discharge. The ability to clearly discern whether the patient is receiving services under the outpatient therapy benefit or as part of the patient's inpatient stay is critical to compliance for hospitals under functional limitation reporting requirements, which makes reporting under observation status all the more complicated. Therefore, we strongly urge CMS to waive functional limitation reporting for observation status patients. CMS could establish this exemption with the use of a modifier when billing. This same modifier could be affixed to therapy services billed under observation status as well as when rebilled under Part B for denied admissions.

Policies such as the therapy cap and functional limitation reporting were intended for patients receiving therapy in the outpatient setting, and are nonsensical in their application to hospital patients in observation status. We believe that addressing payment and defining these categories will help to ensure patient access to outpatient therapy is not unreasonably limited, while also helping hospitals maintain continuous compliance with Medicare rules and regulations.

### ***SNF Three-Day Waiver***

APTA strongly recommends that CMS modify the SNF three-day inpatient stay requirement to allow days spent in observation be considered for satisfying the three-day inpatient hospital stay requirement for Part A coverage of SNF care. Congress also has expressed support for such a policy change, as members in both the House and Senate have introduced the Improving Access to Medicare Coverage Act of 2017 (H.R. 1421/S. 568). The legislation expands the definition of inpatient for purposes of the three-day inpatient stay requirement, and allows time spent in observation to count towards satisfying the requirement.

### ***Direct Access***

APTA recommends that CMS revisit its referral requirements for physical therapy services. The physician authorization requirements inadvertently create significant delays in the provision of physical therapy services to individuals who would benefit from treatment by a physical therapist. These delays often lead to higher costs, decreased functional outcomes, and frustration for patients. Physical therapists are qualified to furnish therapy independent of a referral based upon their extensive education and clinical training in the examination, evaluation, diagnosis, and intervention of patients with a variety of clinical conditions. Given physical therapists'

extensive training and education and ability to improve patient outcomes, we strongly encourage CMS to adopt a broad policy that eliminates physician referral requirements for physical therapy services to ensure patients have access to medically necessary care.

### **Conclusion**

APTA thanks CMS for the opportunity to comment on the FY 2018 IRF PPS proposed rule. We look forward to working with the agency to craft patient-centered payment policies that promote the delivery of quality health care for all Medicare beneficiaries. If you have any questions regarding our comments, please contact Sharita Jennings, JD, Senior Regulatory Affairs Specialist, at 703/706-3391 or [sharitajennings@apta.org](mailto:sharitajennings@apta.org).

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

Sharon L. Dunn, PT, PhD  
President  
SLD: sj