July 1, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1448-P
Room 445-G, Hubert Humphrey Building
200m Independence Ave., S.W.
Washington, DC 20201

Submitted electronically

RE: CMS-1448-P; Medicare Program – Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2014

Dear Administrator Tavenner:

On behalf of the 84,000 physical therapist, physical therapist assistants, and students of physical therapy members of the American Physical Therapy Association (APTA), I respectfully submit comments regarding the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for Fiscal Year (FY) 2014. Physical therapy is the profession devoted to restoration, maintenance, and promotion of optimal physical function. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations. Physical therapists help patients maintain health by preventing further deterioration or future illness. In the inpatient rehabilitation facility (IRF) setting, physical therapy is critical to patients with a number of conditions.

In this proposed rule, CMS proposes to update the IRF PPS payments for FY 2014 by a market basket increase factor based upon the most current data available. After the applicable adjustments, the FY 2014 IRF market basket is 1.8 percent. APTA commends CMS on this proposed increase to ensure appropriate payment levels for services in the IRF, and we wholly support the finalization of this increase.

Proposed Refinements to the Presumptive Compliance Criteria Methodology

IRFs have been subject to a compliance percentage as part of their qualifying criteria since the implementation of the Inpatient Prospective Payment System (IPPS) in 1983. Under these criteria, originally, 75 percent of the IRF’s patient population must be treated for one or more of 10 delineated medical conditions that typically require the intensive inpatient rehabilitation
treatment provided in an IRF (there are now 13 qualifying conditions). Subsequently, following
the passage of legislation in 2008, the 75 percent threshold was lowered to 60 percent.

There is a list of diagnosis codes (ICD-9) that contractors use to determine whether the patient
has met the “60 percent rule” criteria if the codes appear on the patient’s IRF-PAI as either an
etiologic diagnosis or as a comorbid condition. After a close examination of the list, CMS has
found that evolution now necessitates the updating of the ICD-9-CM diagnosis code list. CMS
further states that certain ICD-9-CM codes currently on the list do not necessarily demonstrate a
patient’s meeting the requirements for inclusion in a facility’s 60 percent compliance threshold.
CMS proposes to delete 331 codes from the list.

The proposed deletions include the following:

- Non-specific diagnosis codes;
- Arthritis codes (because the codes themselves do not allow one to determine whether the
  required severity and prior treatment criteria are met);
- Some congenital anomaly diagnosis codes (because a patient with such serious
  conditions would be unlikely to be able to meaningfully participate in an intensive
  rehabilitation therapy program);
- Unilateral upper extremity amputations diagnosis codes (because CMS believes that it is
  impossible to determine from the codes alone whether such a patient would qualify for
  treatment in an IRF); and
- Miscellaneous diagnosis codes that CMS believes do not require intensive rehabilitation
  services for treatment (including tuberculous and tuberculoma of the meninges, brain, or
  spinal cord where a bacterial or histological examination was not done; postherpetic
  polyneuropathy; louping ill, which is an acute viral disease primarily of sheep that is not
  endemic to the United States; brain death; myasthenia gravis without (acute)
  exacerbation; other specified myotonic disorder; periodic paralysis; brachial plexus
  lesions; neuralgic amyotrophy; and other nerve root plexus disorders).

Although the original ten specified conditions have been expanded over the past 25 years to
thirteen conditions, the implementation of the now “60 percent rule” still remains archaic and
does not take into account the changing needs of IRFs and the patient population they serve.
Physical therapists working in rehabilitation facilities often treat patients with complex
orthopedic diagnoses, organ transplants, cancer, pain, and cardiopulmonary conditions that are
not included in the current list of specified conditions. Depending upon the complexity of the
condition, the rehabilitation hospital is the best setting for the patient to receive the level of
intense treatment needed for their condition.

We believe that a system should be based on patient severity and function and not on an arbitrary
and restrictive list of delineated diagnoses. IRF classification criteria should recognize the
totality of the patients’ condition (such as the patients’ impairment, age, co-morbidities, and
functional capabilities) in order to determine their need and the appropriate level of intense
rehabilitative services. In addition, we recommend that CMS invest more resources in the
analysis of the “60 percent rule”, specifically the affect that the rule has had on access to intense
rehabilitative services for patients with chronic pulmonary and cardiac conditions as well as various types of cancer.

Specifically regarding the proposed deletions, we caution CMS to carefully assess the deletion of the upper extremity diagnoses, such as 755.21 – Transverse deficiency of upper limb; and 755.23–755.27 and Brachial Plexus lesions (353.0) and Traumatic amputation of arm and hand (887.0–887.5), when coupled with other conditions. If the patient had bilateral lower extremity fractures and needed to transfer from the wheelchair to the bed because the patient was non-weight bearing on the lower extremities, then there would be a need for intensive rehabilitation to increase the patient’s independence due the patient’s functional limitations.

Lastly, we request that CMS avoid arbitrarily deleting codes from the presumptive compliance based solely on the designation “unspecified” as there may be clinical justification for these codes to be included on the list. Additional, deletions should be given a complete clinical analysis before making random decisions to remove these codes. APTA firmly believes that there are medically necessary services provided to patients outside of the delineated 13 conditions of the “60” percent rule” that should be treated in the IRF.

**Proposed Revision to the Regulations at §412.29**

CMS proposes to amend §412.29(d) to clarify that the IRF’s preadmission screening procedure must ensure that the preadmission screening for a Medicare Part A fee-for-service patient (not all patients) is reviewed and approved by a rehabilitation physician prior to the patient’s admission to the IRF. In other words, this requirement would apply only to patients for whom the IRF is seeking payment directly from Medicare.

APTA supports this clarification as other payers operate under different criteria and it eases the administrative burden posed on the IRF to be able to distinguish which requirements are mandated solely for reimbursement under Medicare. In addition, APTA strongly urges CMS to recognize the critical role that physical therapists play in contributing to those key admission decisions. Physical therapists are uniquely qualified and trained to assess the functional limitations of the patient and determine the appropriate amount, duration and frequency of rehabilitation services necessary to treat the patient’s condition.

CMS proposes to retain the current language under which an IRF must have a preadmission screening procedure under which each prospective patient’s condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program. APTA also supports this proposal as we believe that in order to accurately place patients into the appropriate post-acute care setting, the need for the intensive level of rehabilitation services provided in the IRF must be established at the onset of the episode to minimize risk of denials.

**Proposed Non-Quality Related Revisions to IRF-PAI Sections**

To minimize possible confusion due to the use of different sets of status codes on the
IRF-PAI and the CMS-1450 (also referred to as the UB-04) claim form, CMS proposes to change the IRF-PAI status codes to mirror those used on the CMS-1450 claim form. APTA commends CMS for periodically assessing the IRF-PAI for areas of refinement. We believe these revisions are warranted and should be adopted in the final rule. Streamlining claims submission requirements and easing the administrative burden for providers is a key tenant under the Paperwork Reduction Act (PRA) and the agency’s efforts to reduce regulatory burden. APTA strongly believes that any steps necessary to alleviate administrative hardship in order to focus more on quality care should be taken.

**Proposed Revisions and Updates to the Quality Reporting Program for IRFs**

Section 3004 (b) of the Act requires CMS to implement a quality reporting program for IRFs that would result in a 2% reduction in its payment increase factor in 2014 if the IRF does not report quality data. APTA applauds the Centers for Medicare & Medicaid Services (CMS) for including quality measures in the IRF PPS FY 2012 proposed rule. APTA strongly supports initiatives to improve the safety and quality of patient care. We are committed to encouraging physical therapists to participate in quality improvement and patient safety programs that are implemented through the Affordable Care Act (ACA) and have supported the growth of these quality programs.

The IRF PPS FY 2014 proposed regulations detail three quality measures for FY 2016: (1) All-cause unplanned readmission measure for 30 days post discharge from inpatient rehabilitation facilities, (2) Percent of residents or patients who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680), and (3) the NQF endorsed version of percent of residents or patients with pressure ulcers that are new or worsened (Short-Stay) (NQF #0678). APTA is supportive of these measures overall, but does have some concerns about the readmission measure, which are discussed below.

Our major concern with the readmissions measure is with respect to measure attribution. As we see this measure being implemented in this and likely other additional settings, attribution for the success or failure of these transitions must be clearly defined as a patient could conceivably be transitioned through a variety of care settings within a 30 day period prior to a readmission. In that event, will the last facility be held accountable? See the below illustrative examples.

**Scenario 1**
Patient X is admitted to an acute care hospital on June 1, following an acute stroke. He is stabilized and transferred to an inpatient rehabilitation hospital on June 5. He is discharged to home on June 20. He is readmitted to the acute care setting on June 25. *Is this readmission attributed to the IRF?*

**Scenario 2**
In the same scenario, if on June 20 after discharge from IRF, the patient is seen by the home health agency and then on June 29, is readmitted to the acute care setting, *is the home health agency accountable for the readmission?*
Again we support the implementation of the readmission measure in the IRF setting but emphasize that we feel strongly that measure attribution must be resolved in order to make this measure meaningful.

In closing, APTA is encouraged by the incremental steps that CMS is taking to better classify patients and clarify polices in the Medicare rules regarding inpatient rehabilitation facilities. We believe that it is imperative that CMS, on an ongoing basis, review its policy and classification criteria for IRFs to ensure that the IRF Prospective Payment System is current, comprehensive in coverage, and reflects the most recent data regarding patient admissions and treatment in the IRF setting. APTA thanks CMS for the opportunity to comment on this proposed rule, and we look forward to working with the agency to craft patient-centered reimbursement policies that reflect quality health care. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Director of Regulatory Affairs at (703) 706-8547 or roshundadrummond-dye@apta.org or Heather Smith, Program Director of Quality at (703) 706-3140 or heathersmith@apta.org.

Sincerely,

Paul Rockar, Jr.
President

PR: rdd, hls