

June 27, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1608-P
Room 445-G, Hubert Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Submitted electronically

RE: CMS-1608-P; Medicare Program – Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2015

Dear Administrator Tavenner:

On behalf of the 88,000 physical therapist, physical therapist assistant, 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) 2015. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations. 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 2015 by a market basket increase factor based upon the most current data available. After the applicable adjustments, the proposed FY 2014 IRF market basket is 2.1 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.

We ask that the Agency carefully consider the comments that we have articulated below regarding pertinent sections of the proposed rule. In summation, APTA recommends the following:

- 1) CMS provide further clinical data to justify refinements to the presumptive compliance list and the 60 percent rule. Specifically, we oppose the deletion of the amputation and prosthetic status codes and the broad based assumptions regarding the importance of admission and treatment of amputees in the IRF setting.**

- 2) **CMS not finalize the proposed definition of group therapy and conduct a thorough data analysis to ensure that a final definition is crafted that is based on sound clinical evidence. In addition, we urge CMS not to mandate any limitations of group therapy within the “three-hour rule” as we believe that therapists and IRFs should have the flexibility to utilize group therapy as needed based on the patient’s unique clinical condition and the skills and judgment of the therapist.**
- 3) **CMS not finalize its proposal to add a new section to IRF Patient Assessment Instrument (PAI) to record the amount of and type of therapy. Alternatively, CMS should undertake a research study and convene a technical expert panel to gather the appropriate information regarding modes of therapy.**
- 4) **CMS ensure that reporting requirements regarding arthritis severity and prior treatment do not pose undue administrative burden on IRFs. Additionally, CMS should provide safeguards to ensure that IRFs are not unfairly targeted for review based on the percentage of patients admitted to the IRF with arthritis conditions.**
- 5) **CMS move expeditiously to adopt functional outcome measures into the current IRF PPS quality reporting program with adequate consensus and input from the provider community.**

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.

The presumptive compliance methodology list represents particular diagnosis codes that would more than likely show that the patient required intensive rehabilitation services for treatment in the IRF as mandated by the Medicare regulations. In this proposed rule, CMS announces plans to delete 10 amputation status and prosthetic codes because the Agency states that it is not possible by these codes alone to determine whether a patient qualifies for IRF treatment.

APTA believes 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 recommend that CMS provide further clinical data that justifies the removal of these codes from the presumptive compliance list before finalizing this proposal. While we understand CMS’ rationale that patients with amputations alone do not meet the criteria for intensive rehabilitation in the IRF setting, we strongly urge

CMS to guard against blanket policies that unfairly discriminate against IRF admission for this patient population. Amputations in older adult populations are generally the byproduct of multiple co-morbidities such as diabetes, peripheral vascular disease, and cardiovascular disease. With these co-morbidities, there is a risk of post-surgical complications such as risk of non-healing surgical incision. Additionally, a person with cardiovascular disease could likely have had a previous stroke but the amputation may be new due to the impaired cardiovascular system.

Inpatient rehabilitation is also clinically justified for bi-lateral amputees. It is important to keep the residual limb in good condition (i.e., appropriate wrapping to prevent dog-ears and facilitate prosthetic fitting.) Additionally, the patient requires upper extremity and trunk strengthening, and environmental accommodations to enable mobility to function in his/her living environment.

Furthermore, if these codes are removed or revised on the current presumptive compliance list, APTA recommends that CMS ensure that medical review contractors such as the Recovery Auditors understand the importance of IRF care to patients with amputations and comorbidities. We strongly believe that this proposal should not be used as a stop gap measure to prohibit care based on cost considerations rather than medical necessity of care for amputees in the IRF setting.

In short, we request that CMS avoid arbitrarily deleting codes from the presumptive compliance list based solely on the designation of amputation or prosthetic status as there may be clinical justification for these codes to be included on the list. Additionally, deletions should be given a complete clinical analysis before making random decisions to remove codes.

Proposed Data Collection of the Amount and Mode (Individual, Group and Co-Treatment) of Therapy Provided in IRFs According to Occupational, Speech and Physical Therapy Disciplines

To better determine future IRF payment policies, CMS proposes to define and collect data on individual therapy, group therapy and co-treatment provided by the physical therapy, occupational therapy and speech-language pathology disciplines. CMS proposes to define individual therapy as the provision of therapy services by one licensed or certified therapist (or licensed therapist assistant under the appropriate direction and supervision of the licensed therapist) to one patient at a time. The proposed definition of group therapy is the provision of therapy services by one licensed or certified therapist (or licensed therapist assistant under the appropriate direction and supervision of the licensed therapist) to 2 to 6 patients at one time, regardless of whether the patients are performing the same or different activities. Lastly, the proposed rule defines co-treatment as the provision of therapy services by more than one licensed or certified therapist (or licensed therapist assistant under the appropriate direction and supervision of the licensed therapist) from different therapy disciplines to one patient at the same time.

While APTA agrees with CMS' definitions for co-treatment and individual therapy, we firmly disagree with the proposed definition of group therapy. In the proposed rule, CMS provides no clinical evidence or sound rationale for the proposed definition. Therefore, we recommend that

CMS refrain from finalizing this arbitrary definition without conducting further data gathering and analysis from clinical experts on an appropriate definition.

In addition to the proposed definitions, CMS proposes to collect this information in a new Therapy Information Section on the IRF-PAI which would be effective for discharges on or after October 1, 2015. This new section would be completed as part of the patient's discharge assessment. In this new proposed section, the IRF would record how many minutes of individual, group, and co-treatment therapies the patient received, according to each therapy discipline (PT, OT, and SLP), during the first week (7 calendar day period) of the IRF stay; how many minutes of individual, group, and co-treatment therapies the patient received, according to each therapy discipline, during the second week (7 calendar day period) of the IRF stay; and the average number of minutes of individual, group, and co-treatment therapies the patient received, according to each therapy discipline, during all subsequent weeks (7 calendar day periods) of the IRF stay, beginning with the third week. For co-treatment, each therapist would record the amount of time spent with the patient.

APTA is concerned that the inclusion and mandate to complete this section on the IRF-PAI will cause significant administrative and financial hardship on IRFs to maintain compliance. CMS estimates that for fiscal year 2016, it will cost IRFs \$1.2 million to report under this new requirement. This is quite significant and we assert that this may even be a low estimation. Electronic medical record software will require major overhauls to incorporate the proposed new therapy section of the IRF-PAI. Also, it will take significant staff to monitor the modes of therapy and ensure that all group therapy sessions are meeting the delineated definition.

CMS expressly states that they would like to collect this information to analyze the types of therapy services Medicare is currently paying for under the IRF PPS. CMS plans to utilize these proposed changes to monitor the amount of therapy furnished to patients in the IRF and to track the use of different therapy modes to support future rulemaking.

IRFs are currently making tremendous strides to implement the IRF quality reporting program as well as the multiple changes to the 60 percent compliance threshold policy and IRF coverage criteria. Therefore, we urge CMS not to impose one more requirement on a provider community that is currently dealing with multiple regulatory and statutory mandates. In the alternative, we believe further information regarding the amount and type of therapy can be gathered through further data analysis and review of the medical record. As CMS has done with similar topics, most notably the Alternative Therapy Project for the Skilled Nursing Facility (SNF) PPS, we recommend that the Agency launch a formal research project that can further explore therapy utilization patterns in the IRF. As part of this project, CMS should convene a technical expert panel comprised of clinicians, such as physical therapists, to gain insight on best practices.

Lastly, the Agency reflects its intent to use this data to propose limits on the amount of group therapy that may be provided in IRFs, such as a limit of no more than 25 percent of an IRF patient's total therapy treatment time in group therapy, similar to the limit that currently exists in the skilled nursing facility (SNF) setting.

APTA strongly opposes any limitations placed on group therapy in the context of the “three-hour rule”. We believe individual, group and co-treatment are all integral to the care provided to a patient in the IRF setting. Each mode of therapy is carefully selected by the therapist based on the individual needs of the patient. When clinically indicated in the plan of care, group therapy can serve as an appropriate mode in which to deliver therapy to a particular patient. The patient benefits of group therapy are numerous. They include functional improvements, greater psychological and social awareness, and educational opportunities. In addition, group therapy promotes social interaction and motivation among IRF patients.

For example, in one study, patients with Parkinson disease exhibited improvements in gait measures such as standing, walking, and transfers when participating in group therapy. In another study, it was shown that patients participating in groups advanced to walkers and crutches, when patients receiving individual therapy remained in the parallel bars for a longer period of time. Overall, patients in the group setting may often achieve their goals much faster than patients being individually treated.

Physical therapists are more than competent to make these decisions and should be afforded the flexibility to use their clinical judgment to determine the appropriate amount and frequency of group therapy for their patients.

To further illustrate our points regarding the benefits and medical necessity of group therapy, consider the following clinical scenarios:

- 1) Patient A had a stroke 10 days ago and has been admitted to the IRF setting. In the plan of care, the therapist, after a comprehensive evaluation of the patient, has determined that this patient would benefit from group therapy in addition to individual therapy. Therefore, the patient begins to participate in group physical therapy as part of her care to improve function and aerobic capacity. Group therapy provides the opportunity for the patient to perform therapeutic exercises to help improve aerobic capacity, balance, coordination, flexibility, neuromotor development, and strength. The group setting further provides the patient an opportunity to engage in peer support and social interactions that both motivate and provide an environment for shared empathy. The group intervention meets Medicare’s definition of skilled therapy and allows the therapist to work with the patient on an individualized basis as well as in a group setting. After discharge, the patient is placed in a home and community-based setting and the lessons and skills learned during group therapy, in addition to their individualized care, help to effectively and safely transition the patient to this social setting.
- 2) Patients A, B, C, and D have suffered a spinal cord injury and are receiving rehabilitation in the IRF setting. Each patient has a plan of care that includes individual therapy and group therapy. They are participating in circuit training upper body strengthening exercises in their wheelchairs. In the course of the group session, Patients A and B are working with Theraband on resistive strengthening exercises and Patients C and D are working with the Total Gym on push/pull exercises. The focus during the exercises is on strengthening in combination with posture, body positioning and balance in the chair. During the exercises the patients have to perform pressure releases on a regular basis

which they have been taught in advance. The therapist checks each patient on the appropriate form of the exercises as well as monitoring safety, proper contraction of the muscle groups, positioning in the chair, balance and posture during the exercises as well as the regular pressure releases. When the therapist decides that the patients have their maximum exertion levels, he or she rotates the group exercises which allow the patients to strengthen a different muscle group. The therapist maintains positive stimulation and a safe environment for all participants and fosters interaction between patients.

- 3) Patients A, B, C, and D have suffered a stroke and are all engaging in group therapy. The therapist has each patient sitting on the edge of a mat table and the therapist works with Patients A and B on balance and coordination through picking up cones on their left side and putting it down on their right side. Patients C and D are performing weight shifting exercises in the parallel bars on both ends with the chair behind them for safety reasons. All patients are continuously monitored during their exercises and individual corrections are provided to all participants in the group.
- 4) 4) Patient A was involved in a car accident with resultant bilateral amputations (a below knee and an above knee) and has diabetes, a BMI of 39, osteoarthritis and had a CABG X2 two years ago. Patient B is post op above knee amputation with previously diagnosed Parkinson's disease, COPD and peripheral vascular disease. They are admitted to the IRF for intense rehabilitation. Each patient has a plan of care that includes individual therapy and group therapy. The therapist works with patient A and B on the mat table with instruction of proper wrapping of the residual limbs for edema control. The patients then perform sitting push-ups using functional grip push-up blocks to develop upper body strength while the physical therapist assists with balance and verbal cues for proper alignment. The group treatment provides peer motivation and support while accomplishing necessary aspects of treatment to reach functional goals.

Proposed Revision to the IRF-PAI to Add Data Item for Arthritis Conditions

CMS proposes to add an item to the IRF-PAI, for IRF discharges occurring on or after October 1, 2015, for an IRF to record the specific arthritis diagnosis code(s) for each patient that meets the severity and prior treatment requirements that allow a patient to be counted toward an IRF's compliance percentage under the presumptive compliance method. CMS also proposes to perform a brief medical review on a statistically valid random sample of the cases documented under the new item to ensure that the severity and prior treatment requirements were actually met. If the number of compliant cases documented under the new item does not result in the IRF's presumptive compliance percentage meeting or exceeding the 60 percent compliance threshold, then the normal medical review procedures for IRFs not meeting the compliance threshold will apply.

As CMS has indicated, we believe that it is important to ensure that information regarding diagnosis and severity are accurately captured on the IRF-PAI in order to determine compliance with the 60 percent rule. Specifically, we believe that there is a significant portion of patients with severe arthritic conditions that should have access to care in the IRF. As with the previous

proposed additions to the IRF-PAI, APTA is concerned about the administrative burden and financial impact this proposal will have on IRFs.

In addition, we assert that there are medically necessary cases that meet the IRF coverage criteria where admission to an IRF is indicated for diagnoses of arthritis. For example, patients with Rheumatoid Arthritis (RA) may have been diagnosed many years ago and have been on various medications to decrease the effects. However, because the course of RA is variable, progressive joint damage and deformity may occur causing significant disability, particularly in the areas of self-care and mobility. Because the progression of RA is variable, it requires individual review of function to develop a comprehensive treatment plan which generally involves interventions that are best treated by a multidisciplinary intensive rehabilitation approach. This may include interventions such as pain control, joint protection, assistive and adaptive devices, joint mobilization, muscle strengthening, exercise, gait training, self-management, and activities of daily living. Often there are other comorbidities that complicate the arthritis diagnosis such as decreased mobility due to pain, obesity, decreased cardiovascular conditioning/aerobic capacity, muscle atrophy, osteoporosis, balance deficits, and risk of falls.

Therefore, CMS must ensure that reporting requirements regarding arthritis severity and prior treatment do not pose undue administrative burden on IRFs. Additionally, CMS should provide safeguards to ensure that IRFs are not unfairly targeted for review based on the percentage of patients admitted to the IRF with arthritis conditions.

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 and have supported the growth of these quality programs.

The IRF PPS FY 2015 proposed regulation details four functional quality measures for consideration in future years: 1) IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients; (2) IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients; (3) IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients; (4) IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients; APTA is supportive of these measures overall, but does have some concerns which are discussed below.

APTA supports the goal of improving quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based practice and patient-centered practice. Furthermore, APTA feels that it is essential that we move towards a core set of functional items to assess patients across the continuum of care. APTA is pleased to see that these measures proposed for IRFs move in that direction. However, the APTA does have some concerns regarding the proposed measure methodology. These concerns are discussed below.

1. Quality Measure: IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients

APTA supports the measure but has specific concerns. APTA believes that the categories for Functional status before current illness/injury: indoor ambulation be further separated. We propose four categories: dependent, some help, independent and unknown. Furthermore, we would propose this categorization for prior functioning level stairs as well. Based on the same rationale, APTA would suggest that unknown be separated out into a third category (yes and no being the other two categories) for wheel chair use prior to current illness/ injury. APTA would also strongly suggest the inclusion of wheelchair mobility items in this measure as some patients in this setting may use a wheelchair as a primary method of mobility. APTA would suggest the inclusion of the following items with a conditional statement: “For patients who use a wheelchair, complete the following items: Wheel in room: Once seated, can wheel at least 10 feet (3 meters) in a room, corridor, or similar space, Wheel 50 feet with two turns: The ability to wheel 50 feet and make two turn, Wheel 150 feet (45 m): Once seated, can wheel at least 150 feet (45 meters) in a corridor or similar space”.

2. Quality Measure: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients

APTA supports the measure but has specific concerns. APTA believes that categorization of prior functioning level self-care should be further separated. We believe that combining “Independent or unknown” would not appropriately allow for the stratification of patients for whom pre-morbid functional status is unknown. Although we recognize this may be a small number of patients, we do not feel it is appropriate to categorize these patients with those patients who had a pre-morbid functional status of independent. Instead we propose four categories: dependent, some help, independent and unknown. Furthermore, we would propose this categorization for prior functioning level be utilized for indoor ambulation as well. Based on the same rationale, APTA would suggest that unknown be separated out into a third category (yes and no being the other two categories) for wheel chair use prior to current illness/ injury.

3. Quality Measure: IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients

APTA’s concerns for this measure are the same as those expressed for measure 2: IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients.

4. Quality Measure: IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients

APTA’s concerns for this measure are the same as those expressed for measure 1: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients.

5. Additional concerns about the Functional Outcome Measures

APTA is concerned about the introduction of these core items in the absence of appropriate staff training. The proposed items and rating system differ from those used in the IRF- PAI tool. In the IRF setting, these core items may be completed by therapists or nurses and we believe that there should be appropriate standardized training with the introduction of these new items to ensure that there is inter-rater reliability.

In closing, APTA is encouraged by the incremental steps that CMS is taking to better classify patients and clarify policies 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 on the proposed payment policies and revisions to the IRF-PAI, please contact Roshunda Drummond-Dye, Director, Regulatory Affairs at (703) 706-8547 or roshundadrummond-dye@apta.org . If you have questions regarding our comments on the IRF quality reporting program, please contact Heather Smith, Director of Quality at (703) 706-3140 or heathersmith@apta.org.

Sincerely,

A handwritten signature in black ink that reads "Paul Rockar Jr." in a cursive script.

Paul Rockar, Jr. PT, DPT, MS
President

PR: rdd, hls