June 29, 2009

Ms. Charlene Frizzera  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1538-P  
P.O. Box 8012  
Baltimore, MD 21244-8016

RE: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010 (CMS-1538-P)

Dear Acting Administrator Frizzera:

On behalf of the American Physical Therapy Association (APTA) and its 73,000 member physical therapists, physical therapist assistants, and students of physical therapy, I appreciate the opportunity to comment on the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Fiscal Year (FY) 2010 proposed rule. Physical therapy is an integral service within the IRF setting, and therefore we are very concerned about the proposed changes.

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 the Medicare, Medicaid, and S-CHIP Extension Act of 2007, it was mandated that a zero percent increase factor be applied to IRF payments in 2008 and 2009. In this proposed rule, CMS states that it is not confined to this restriction and therefore proposes to use the most current data and methodology formulated in the FY 2006 IRF PPS final rule to compute the market basket increase factor and labor-related share for FY 2010. Accordingly, the proposed FY 2010 IRF market basket would be 2.4 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 proposal.
In addition, we applaud CMS on its efforts, in this proposed rule, to begin focusing on the rehabilitation needs of patients in the IRF, rather than arbitrary delineated lists of diagnoses and comorbid conditions as mandated in the current policy (known as the “75 Percent Rule”). Specifically, the three new criteria for coverage emphasize the patient’s rehabilitation and functional needs. Currently the basis for admission to the IRF is incompletely based on medical instability. While classified as stable, there are a number of patients with conditions, such as total knee arthroplasty, who would greatly benefit from the complex, intensive rehabilitative services. We believe the proposed coverage rules should, if implemented, prevent contractors from denying coverage to patients who are stable but would greatly benefit from the intense rehabilitation provided in the IRF.

In addition to the above mentioned aspects of the proposed rule, we are concerned about the impact of several other provisions included in the rule. Our comments articulated below address those specific concerns with our recommendations on how these policies can be further refined.

§ VII Inpatient Rehabilitation Facility (IRF) Classification and Payment Requirements (74 FR 21070)

A. Analysis of Current IRF Classification and Payment Requirements

In the proposed rule, CMS summarizes the congressionally-mandated work that it is being conducted related to alternatives to IRF classifications and payment requirements. APTA supports the work of the Agency and believes that it is critical to formulating coverage polices in the IRF setting that are patient-centered and based on best medical practices. One issue of significant importance to APTA is the criterion set forth in the 60 percent compliance threshold policy (formerly known and referred to as the “75 percent rule”). This policy establishes a minimum percentage of the facility’s total inpatient population that must meet one of thirteen medical conditions listed in the regulation in order for the facility to be classified as an IRF. APTA believes that the “60 percent rule” continues to reduce IRF admissions based on outdated, restrictive, and ineffective diagnosis-based criteria.

When Medicare first implemented the inpatient acute care hospital prospective payment system (PPS) in 1983, the regulation included a set of rules by which an IRF could exclude itself from the Inpatient Acute Care PPS. These rules included the original version of what we call the “60 percent rule”, today. The “75 percent rule” was a methodology adopted by CMS for the purpose of establishing that the IRF was primarily engaged in providing intensive rehabilitation services as opposed to general medical and surgical services that involved the provision of some ancillary rehabilitation services.

Although the original ten specified conditions have been expanded over the past 25 years to thirteen conditions, the implementation of this policy 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.

In light of CMS current activities in exploring alternatives to the “75 percent rule”, APTA respectfully requests that that the following recommendations be considered when constructing alternative classification criterion for IRFs.

1. We believe that a system should be based on 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.

2. We recommend that CMS clearly separate the classification of a facility (i.e. IRF, acute care hospital, disproportionate share hospital (DSH)) from the definition of medical necessity. It is wholly inappropriate for these two elements to be comingled and does a disservice to Medicare beneficiaries who are in need of critical care provided in an inpatient rehabilitation facility. In addition, we recommend CMS assess and revise the Medicare manuals for IRFs to ensure that appropriate facility requirements are met and that there is no overlap between medical necessity and facility distinctions or conditions of participation. As noted above, we believe that CMS is starting to make these strides as evidenced by this current proposed rule, but there is still more work to be done.

3. We recommend that CMS invest more resources in the analysis of the “75 percent (currently 60%) 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.

4. We recommend that CMS reexamine the IRF prospective payment system to ensure that payment is adequate and comprehensive to cover the level of intense rehabilitative services being furnished in the IRF setting, beyond the 13 conditions delineated in the “75 percent policy”.

5. In the interim, while CMS is analyzing the “75 percent rule”, CMS should establish a temporary exceptions process that can be utilized by IRF providers so that patients outside of the 13 qualifying conditions can be treated without fear of an audit or penalty.

6. In the immediate future, CMS should conduct extensive educational outreach efforts to state surveyors, as well as health care providers, on auditing probes regarding the “60 percent rule”, “three hour rule”, and other policies. There is much confusion on the proper implementation of these policies and regulations, and as a result, IRFs are facing undue restrictions and penalties from survey and certification bodies.
7. We strongly urge CMS to review IRF policies in concert with other Medicare post-acute care policies and initiatives (e.g. post-acute care demonstration, CARE tool, revisions to MDS and OASIS, etc) and not in isolation, to ensure that patients are being seen in the best setting for their condition.

8. Lastly, we recommend that CMS convene a group of experts (from across the spectrum of post-acute care) to, on a regular basis, review and revise policies related to inpatient rehabilitation facilities, as well as, other post-acute care settings. We strongly contend that the group experts include physical therapists and APTA and would be more than willing to participate and provide content expertise as needed.

E. Proposed Changes to the Requirements for the Interdisciplinary Team Meeting

In the proposed rule, CMS specifically states:

“Another critical aspect of IRF care is that rehabilitation therapy services are generally provided to each patient by a licensed or certified therapist working directly with the patient, more commonly known as one-on-one therapy. Anecdotally, we have heard that some IRFs are providing essentially all ‘group therapy’ to their patients. We believe that group therapies have a role in patient care in an IRF, but that they should be used in IRFs primarily as an adjunct to one-on-one therapy services, not as the main or only source of therapy services provided to IRF patients. While we recognize the value of group therapy, we believe that group therapy is typically a lower intensity service that should be considered as a supplement to the intensive individual therapy services generally provided in an IRF. To improve our understanding of when group therapy may be appropriate in IRFs, we specifically solicit comments on the types of patients for which group therapy may be appropriate, and the specific amounts of group instead of one-on-one therapies that may be beneficial for these types of patients. We anticipate using this information to assess the appropriate use of group therapies in IRFs and may create standards for group therapies in IRFs.”

APTA strongly disagrees with CMS’ statement regarding group therapy, specifically the Agency’s position that group therapy is an adjunct service of lower intensity. Group therapy is a clinically relevant mode of intensive rehabilitation services that is often integral to the patient’s plan of care. In addition, we believe that it is clinically appropriate for group therapy minutes to count towards the three-hour rule and therefore, urge CMS to retract its statement that these services are “adjunct” or “supplemental to individual therapies.
First, APTA asserts that 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, whereas in the alternative 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. ¹

Secondly, CMS should not presume that group therapy is a lower level of intensity. Depending on CMS’ definition of group therapy, we assert that the group intervention can be as intensive as one on one therapy. For instance, while in group therapy, the patient is receiving multiple levels of stimulation from interaction with other patients within the group as well as the instruction and guidance of the therapist. In addition, the patient must learn to focus his or her attention and control and physical movements while facing a demanding set of objectives. In this instance, the intensity of the service could be high from the patient perspective. In addition, group therapy requires a high level of skill and work on the part of the therapist as he or she is faced with managing the multiple issues associated with the group dynamic. We recommend CMS convene a group of rehabilitation experts from the IRF community to develop a consensus understanding of the definition of group. APTA would welcome the opportunity to provide expertise in this area.

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 two weeks 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. Therefore, the patient begins to participate in group physical therapy as part of their 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 psychosocial activities 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 a periodic 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 her individualized care, help to effectively and safely transition the patient to this social setting.

2) Patient A, B, C, and D have suffered a spinal cord injury and are participating in circuit training upper body strengthening exercises in their wheelchairs. In the course of the group session, Patients A and B are performing upper extremity resistive strengthening exercises using Theraband® and Patient C and D are performing push/pull exercises using the Total Gym® equipment. The goal of the exercises is to increase muscle strength as well as improve posture, body positioning and balance in the wheelchair. During the exercises the patients have to perform sacral 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 wheelchair, balance and posture during the exercises and the frequency and technique of pressure releases. After assessing each patient’s maximum exertion levels, the therapist rotates the group exercises which allow the patients to strengthen a different muscle group. The therapist maintains positive encouragement, oversight, ensures a safe environment, and fosters interaction between patients.

3) Patients A, B, C, and D have suffered a stroke and are all engaging in group therapy as part of their plan of care established by the physical therapist. 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 retraining through exercises that challenge the patients’ postural stability over their base of support. Patients C and D are performing reaching activities to facilitate weight shifting and balance in sitting. All patients in the group are continuously monitored by the therapist for safety, proper technique and advancement of the exercise as indicated.

Thirdly, we assert that group therapy should only be permissible when it meets the goals and objectives identified for the patient as documented in the plan of care and should not in any way be solely based on the staffing needs or resources of the facility. Therefore, we recommend that group therapy should contain no more than four patients to one therapist. We believe that this ratio will allow the patient the opportunity to benefit from all that group therapy provides, while ensuring that the therapist is delivering a level of care that is skilled and intensive as delineated in the Medicare requirements. In addition, we believe that group therapy should represent a limited portion of the therapy minutes provided within the “three-hour rule” consistent with Medicare polices established in the skilled nursing facility. In addition, we also believe that group therapy should be recognized as an important element of skilled care as opposed to an adjunct service. Setting forth a policy that recognizes the value of group therapy, while also specifying that group therapy should not constitute the majority of therapy minutes required under the “three-hour rule, will address concerns regarding the potential overutilization of group therapy while allowing therapists to provide skilled therapy services based on their clinical judgment.
Lastly, we strongly urge CMS to provide clear and concise policies that RAC auditors and other Medicare contractors can follow to mitigate conflicts and confusion regarding group therapy in the context of the “three-hour rule,” the 60 percent compliance threshold, and definitions of medical necessity and admission. As CMS is well aware, IRFs have been faced with a high number of burdensome audits related to these policies over the past couple of years due to the broad and interpretive nature of these polices as they currently stand. With the commencement of the RAC audits, and the exponential increase in OIG and Medicare and Medicaid fraud activities, APTA is very concerned that IRFs will again be unfairly targeted.

§VIII. Proposed Revisions to the Regulation Text to Require IRFs to Submit Patient Assessments on Medicare Advantage Patients for Use in the “60 Percent Rule” Calculations (74 FR 21071)

Inclusion of Medicare Advantage Patients in Calculations for IRF Compliance Thresholds

Federal law mandates that in order to be classified as an IRF, a facility must meet a minimum percentage requirement that at least 60 percent of the IRF’s population has one of thirteen medical conditions delineated in §412.23(b)(2)(ii) as a primary condition or comorbidity. This is known as the “compliance threshold” or is generally referred to as the “60 Percent Rule”. In the methodology for calculating and meeting the compliance threshold, IRFs are not allowed to factor in the number of Medicare Advantage (MA) patients in their facilities. In this proposed rule, CMS states that it agrees with stakeholder views that MA patients are beginning to represent a significant percentage of IRF populations and should be counted toward the compliance threshold.

Therefore, CMS is proposing to require that IRFs submit IRF-PAI data on all of their MA patients to facilitate better calculations under the 60 percent rule. CMS is specifically seeking comments on whether requiring IRFs to submit IRF-PAI data on all of their MA patients is the best way to ensure the integrity of the compliance review process. Additionally, CMS proposes that, where an IRF fails to submit all MA IRF-PAIs, CMS will not count the MA patients toward the compliance threshold for that IRF.

We agree with CMS’s rationale and encourage the Agency to finalize its proposal to add these patients in its calculations for the 60 percent compliance threshold. In addition, we believe that it is fair and equitable that the IRF submit data on the IRF-PAI on all of these patients so as to avoid cherry-picking and unfair advantages among IRFs. Lastly, although we commend the Agency on making this distinction that helps to improve the compliance threshold policy, we would like to reiterate the inherent flawed methodologies of the 60 Percent compliance threshold policy formerly known as the “75 Percent Rule” as articulated above.

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, Associate Director, Payment Policy and Advocacy at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,

[Signature]

R. Scott Ward, PT, PhD
President