American Academy of Physical Medicine and Rehabilitation

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Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
CMS 1488-P
7500 Security Blvd.
Baltimore, Maryland 21244

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2014; CMS-1448-P.

Dear Administrator Tavenner:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) appreciates this opportunity to comment on the proposed 2014 prospective payment rule for inpatient rehabilitation facilities (IRFs). The AAPM&R is the national medical society representing more than 8,000 physiatrists, physicians who are specialists in the field of physical medicine and rehabilitation. Physiatrists treat adults and children with acute and chronic pain, persons who have experienced catastrophic events resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, rheumatologic conditions, musculoskeletal injuries, and individuals with neurologic disorders or any other disease process that results in impairment and/or disability. Many of our members practice exclusively in the Inpatient Rehabilitation Facility (IRF) setting and several serve as IRF medical directors.

Use of Co-morbidities to Adjust Case-Mix Group Relative Weights

The presence of certain co-morbidities can significantly increase the intensity and cost of inpatient rehabilitation care. We appreciate that CMS recognizes this through its list of co-morbidities that, when coded on discharge, provide for increased payment. However we note that this list does not include several co-morbidities that can significantly increase the cost of care. These include certain thrombophlebitis codes, osteomyelitis, chronic pressure ulcers and urinary tract infections. We understand that these codes are not on the list because CMS believes they are preventable conditions and, as such, should not be a basis for increased reimbursement. We understand this concern but would note that many of these conditions may be present at the time the patient is admitted to the IRF and thus do not necessarily reflect on the quality of care provided by the IRF. We would urge that CMS review its list of co-morbidities and consider adding those that correlate with increased costs of care.

Changes to the Presumptive Compliance Criteria

The Academy strongly objects to CMS' proposal to eliminate a number of ICD-9-CM diagnostic codes from the presumptive compliance methodology. We believe this would result in a circumvention of the congressionally mandated 60 percent threshold and will cause IRFs to alter their admissions policies in a way that restricts access to medically necessary services. We strongly urge that the proposal be withdrawn or significantly modified.

In particular, we question whether CMS has the legal authority to remove codes from the presumptive compliance list that describe any of the 13 conditions in the CMS regulations at 42 CFR §412.29. That regulation provides that an admission for any of the 13 listed conditions must count towards the 60 percent rule. Removing codes that describe these conditions from the list would seem inconsistent with the regulation and also contravenes the statute and Congressional intent.

Section 5005 of the Deficit Reduction Act (DRA), passed by Congress in 2005, enacted a phase-in of the compliance percentage over a three-year period. As part of that law, Congress stated that the criteria set forth in the CMS May 7, 2004 Final Rule must be used in determining an IRF's compliance with the applicable percentage. That 2004 Final Rule established the current 13 conditions that count toward satisfying the threshold. Two years later Congress amended the DRA through the Medicare, Medicaid, and SCHIP Extension Act (MMSEA, P.L. 110-73) to prohibit the Secretary from requiring a compliance rate for IRFs that is greater than 60 percent. Congress reaffirmed, at that time, that compliance should be measured based on the 2004 Final Rule. Thus the DRA and the MMSEA essentially codify into the law the conditions listed in the 2004 Rule as the basis for assessing whether an IRF meets the 60 percent threshold. CMS does not have discretion to modify or limit those conditions. As such, CMS cannot legally remove codes from the presumptive compliance list and subject those admissions to additional scrutiny.

CMS has implemented the 60 percent test primarily through the presumptive review methodology and IRFs have come to rely on this approach to demonstrate their compliance. The alternative to presumptive compliance is medical record review – a burdensome administrative process for both IRFs and the agency. If this proposal is finalized, the Academy is concerned that IRFs will begin restricting admission to individuals with arthritis and other conditions proposed for elimination (e.g., upper extremity amputations, congenital anomalies) in an effort to continue to meet the presumptive compliance test and avoid the onerous medical record review process. This will limit access to IRF care to patients who need it – especially the many patients admitted with various arthritis diagnoses. Other IRFs will be unable to meet the presumptive compliance test and be subject to the burdensome medical record review. This will increase costs for both IRFs and the Medicare program. For these reasons, the AAPM&R strongly urges that CMS withdraw its proposal.

If the proposal is not withdrawn, with respect to the arthritis conditions which require specific severity and prior treatment requirements, it is imperative that CMS assign modifiers that could be used to indicate on the IRF Patient Assessment Instrument (PAI) that the patient meets the requirements. This would allow those cases to continue to count under the presumptive compliance methodology.

Proposed Revisions and Updates to the Quality Reporting Program

The Academy is wary of the recently proposed performance measures to the quality reporting program. Specifically, these measures are important but are not central to the activities that occur during rehabilitation. Regarding the influenza measures for healthcare workers that are proposed for 2016, there are concerns about the proposed threshold which requires all healthcare personnel to receive mandatory vaccinations, as national survey data have demonstrated that vaccination coverage levels are only approximately 60% [1].

The Academy would recommend the threshold be consistent with the Healthy People 2020 goal of 90% for HCP influenza vaccination [1]. Regarding the influenza measures for patients that are being proposed for 2017, there are questions regarding how to handle situations where patients are vaccinated in other settings, since this measure is required for other settings as well. An important variable to consider is whether or not a vaccination history will be provided, in order to eliminate the possibility that patients might be vaccinated multiple times.

The American Academy of Physical Medicine and Rehabilitation thanks the Committee for the opportunity to share its thoughts on meaningful and balanced Medicare payment reforms. Despite the challenges that the practice of PM&R encounters with respect to quality and outcomes measures, we continue to work hard on developments in this area and we certainly recognize the importance of measuring and paying for outcomes. We remain committed to being part of the solution in any way we can. We hope these comments provide meaningful perspective in your deliberations over possible reforms. If you have any questions or require more information, please contact Sarah D'Orsie, Manager of Government Affairs, at sdorsie@aapmr.org, or (202) 349-4277.

Sincerely,

Peter Esselman, MD
Chair, Health Policy and Legislation Committee
American Academy of Physical Medicine and Rehabilitation

[1] http://www.cdc.gov/nhsn/PDFs/HPS-manual/vaccination/HPS-flu-vaccine-protocol.pdf