American Academy of Physical Medicine and Rehabilitation

aaPM&R

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June 16, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1632–P
P.O. Box 8013, Baltimore, MD 21244–1850

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program

Dear Mr. Slavitt:

On behalf of the more than 8,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAMP&R), we appreciate the opportunity to submit comments to the proposed rule: *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program; Proposed Rule* that was published in the Federal Register on April 30, 2015. Physiatrists are specialists in the field of physical medicine and rehabilitation (physiatry) and 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 persons with neurologic disorders or any other disease process that results in impairment and/or disability.

ICD–10 Coordination and Maintenance

Code Freeze

In the January 16, 2009 ICD–10–CM and ICD–10–PCS final rule (74 FR 3340), there was a discussion of the need for a partial or total freeze in the annual updates to both ICD–9–CM and ICD–10–CM and ICD–10–PCS codes. The public comment addressed in that final rule stated that the annual code set updates should cease l-year prior to the implementation of ICD–10. At the September 19, 2012 ICD–9–CM Coordination and Maintenance Committee meeting that a partial freeze of both ICD–9–CM and ICD–10 codes will be implemented until 1-year following the implementation of the code set.

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In the Proposed Rule, the Centers for Medicare and Medicaid Services (CMS) continues to maintain the total freeze in the annual updates to both ICD–9–CM and ICD–10–CM and ICD–10–PCS codes on October 1, 2016 (1 year after implementation of ICD–10), regular updates to ICD–10 will begin. **The Academy applauds CMS and the Coordination and Maintenance Committee for recognizing the necessity for freezing the code set until one year following its implementation.**

Recalibration of the Proposed FY 2016 MS–DRG Relative Weights

Solicitation of Public Comments on Expanding the Bundled Payments for Care Improvement (BPCI Initiative)

In CY 2016 IPPS/LTCH PPS proposed rule, CMS is seeking a better understanding of potential policy and operational issues related to an expansion of the Bundled Payments for Care Improvement (BPCI) initiative in the future. AAPM&R supports CMS's effort to develop and test models of bundling that will result in higher quality and more coordinated care for Medicare patients. In this Proposed Rule CMS is not proposing an expansion of any models or policy changes associated with the BPCI Initiative given that further evaluation of the initiative is needed to determine its impact on both Medicare cost and quality of care. **The Academy agrees with CMS's proposal to delay expansion of the BPCI initiative until there has been an analysis of the available information from the demonstration project.**

Data needs

CMS currently provides monthly episode claims data to BPCI initiative participants for purposes of health care operations and periodic monitoring reports. **AAPM&R believes that when considering expansion of the BPCI initiative publishing of de-identified data may help stakeholders determine whether or not to participate in an expanded initiative or to propose new versions of the models to be used**.

Models for expansion

AAPM&R believes that additional consideration should be given to models with further episode definition refinement, such as the example in this Proposed Rule, "episodes that begin with post-acute care to incorporate the findings from standardized patient assessments at post-acute care initiation, rather than tying the episode to the hospital discharge diagnosis."

Physiatrist provide services across all post-acute care settings. **As such, the Academy believes that further exploration of alternate ways of evaluating patients who go to post-acute care settings is important. AAPM&R is interested in working with CMS and other stakeholders to design a standardized method of assessment at the initiation of post-acute care.** The Academy believes that the key to a successful post-acute outcome is not dictated exclusively by the acute hospital diagnosis, but instead is

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tied to the patient's ability to function despite persistent residual deficits. As an example of why diagnoses alone are insufficient, consider a patient who is given the diagnostic category of "stroke." At the end of the patient's acute hospital stay, functional abilities may range from independent to totally dependent, depending on factors such as the severity of the stroke, the type of stroke, age, and swiftness of diagnosis and treatment. Rehabilitation can help patients regain their ability to function at their highest level possible by both strengthening their physical ability to perform activities of daily living and by teaching them compensatory means for accomplishing the same end when their body no longer functions as it did previously. Therefore, it is imperative that the initial assessment, upon entering the post-acute system, also be measured in functional terms. This sort of assessment requires a unique assortment of skills, and they are part of every physiatrist's training. We believe that physiatrists, when available, have uniquely specific training and expertise to make such determinations.

Roles of organizations and relationships necessary or beneficial to care transformation

AAPM&R believes that transitioning from one level of care to another level, or to home, is a time of increased vulnerability and confusion for patients. **Therefore, it is our recommendation that under an expanded model an experienced physician assist patients and/or families through the transition period and take responsibility for ensuring that complete and accurate communication occurs between the transferring and receiving entities.** Additionally, if the plan is for discharge to the home, with or without additional post-acute care, the physician may ensure that the patient and/or caregiver is aware of the patient's needs upon discharge from the episode, for example, follow-up appointments, medications, equipment, special precautions, and connections with appropriate community resources. The physician should be knowledgeable about both clinical and socio-economic realities for the patient.

We appreciate the opportunity to comment on this proposed rule. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Jenny Jackson, Manager of Finance and Reimbursement in the AAPM&R Division of Health Policy and Practice Services. She may be reached at jjackson@aapmr.org or at (847)737-6024.

Sincerely,

Phillip R. Bryant

Phillip Bryant, DO
Chair
Reimbursement and Policy Review Committee
American Academy of Physical Medicine and Rehabilitation