Talking Points for AAPM&R Regarding CMS Town Hall Meeting on the Congressionally Mandated Study of the 75% / 60% Rule

On behalf of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), a medical society of more than 7,500 physicians specializing in physical medicine and rehabilitation, we offer these comments in connection with the Town Hall Meeting being held by CMS and its contractor, RTI, to solicit comments on the congressionally mandated study of the so-called “75% Rule,” more recently known as the “60% Rule.”

As one of the stakeholders specifically listed in the statute that created this study, the AAPM&R is interested in actively engaging with both CMS and RTI as they embark on this study to identify alternatives to or improvements of the 75%/60% Rule. Overall, we are concerned with the deterioration of CMS's reliance on the medical judgment of the physicians and other practitioners involved in the rehabilitation of patients in this setting of care. As such, we take a dim view of rules that attempt to establish bright lines in an area where there are often multiple shades of gray. With this in mind, we offer the following comments and intend to submit more formal written comments in the near future.

• **I. Separate IRF Classification from Medical Necessity:** AAPM&R believes that CMS has inappropriately commingled the 75% Rule/60% Rule with standards for medical necessity of individual patients. The Rule was historically intended to serve as one method of determining whether a rehabilitation hospital or unit should be classified differently than an acute care hospital for payment purposes, not to assess whether particular patients should be admitted to the inpatient rehabilitation hospital setting. Over the years, CMS has melded the concept of medical necessity with the 75% Rule, contributing to significant confusion in the field and arbitrary denials of access to inpatient rehabilitation care for individuals who, based on the totality of their circumstances, are completely appropriate for inpatient rehabilitation hospital services. CMS should refrain from melding the two concepts of medical necessity and the classification criteria of the 75% Rule and treat these as two separate and distinct issues.

• **I. Use Function Rather than Diagnosis:** The AAPM&R has long opposed diagnosis-based rules to determine the classification of inpatient rehabilitation hospitals and units for purposes of payment under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). Diagnosis-based rules of this nature are blunt tools that ultimately result in the inappropriate denial of access to care for people with disabilities, chronic illnesses, and severe injuries who require the intensive services provided in an inpatient rehabilitation hospital or unit. AAPM&R would prefer a function-based system to a diagnosis-based system and is open to discussing different options during the course of this study. For instance, reliance on the FIM measures to assess the functional status of typical patients would be far preferable to a diagnosis-based system. However, AAPM&R is concerned with the approach taken by the GAO in their 2005 report on the 75% Rule. In this report, GAO suggested that functional status might be an additional criterion after a
diagnostic-based set of criteria is used. AAPM&R believes that functional deficit criteria should be used in lieu of diagnosis-based criteria.

- **I. Improvements to the Existing 75%/60% Rule:** If CMS is inclined to continue to use the existing diagnosis-based rule or some variation of it, the Academy would strongly support a number of improvements to the Rule to modernize it. These modifications might include the following:
  - a. **Modernize the CMS-13:** Since the original list of conditions were developed in the early 1980’s, the typical patient mix in the IRF setting has evolved. The changes made in 2004 to the category previously described as “polyarthritis” did little to address the need to modernize the list of “qualifying conditions” to reflect contemporary practice. There are a number of conditions that the Academy would suggest are appropriate conditions to add to this list and would be happy to engage CMS and RTI as they conduct this study.
  - a. **Clarify Treatment of Comorbid Conditions:** The current treatment of comorbid conditions for purposes of qualifying under the Rule makes little sense in that a comorbid condition can only qualify a patient under the Rule if that condition would independently qualify that patient for coverage under the Rule. This fails to acknowledge the interplay of comorbid conditions on the totality of clinical circumstances of each patient and the medical judgment that comes into play when determining whether a particular patient needs to be admitted to an inpatient rehabilitation hospital or unit.
  - a. **Create a “Tiered” System of Review for Compliance with the Rule:** If RTI is inclined to recommend, and CMS is inclined to continue to use, a diagnosis-based system much like the existing Rule, the Academy would support a creation of a “tiered” system where the issue of IRF classification ultimately rests on a much more intimate examination of how the IRF functions than a simplistic assessment of the diagnoses of the IRF’s patients over a given period of time. For instance, once a Medicare Administrative Contractor (MAC) determines that a particular rehabilitation hospital or unit is not in compliance with the Rule, a more refined review of the operations of the facility in question should be conducted. This type of review lends itself well to an accreditation model, where surveyors would be sent on-site to review records, examine programs, assess patient mix, severity, functional deficits, and comorbidities, and gain a more intimate understanding of whether the facility is functioning as an inpatient rehabilitation hospital or unit. The accreditation agency (e.g., CARF, JCAHO) could be given “deemed status” by Medicare to make the final determination as to whether the facility should be treated as an IRF for payment purposes. There may be other alternatives for this second tier review, such as a newly appointed expert panel.

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