Kentucky Hospital Association
Representing Kentucky Health Care Organizations

June 26, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Re: CMS 1608; Medicare Program; Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2015; May 7, 2014.

Dear Ms. Tavenner:

On behalf of Kentucky Hospital Association (KHA) member hospitals, including inpatient rehabilitation facilities (IRFs), the KHA appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2015 proposed rule for the IRF prospective payment systems (PPS). In addition to explaining our concerns related to the proposed narrowing of cases that qualify under the IRF "60% Rule" presumptive test, this letter discusses the proposed group therapy reporting requirements, and makes several recommendations regarding the agency's proposed changes to the IRF quality reporting program.

The KHA strongly opposes any further proposals to restrict the codes that qualify for the 60% Rule presumptive test, including those in the FY 2015 proposed rule. The additional proposed reduction of NUMBER codes from the presumptive test, coupled with the already finalized reduction of 259 ICD-9-CM codes that will begin Oct. 1, 2014, would inappropriately narrow the 60% Rule compliance criteria. This would have the immediate effect of decreasing the presumptive compliance rate for many facilities, which in turn would impact IRFs' ability to admit other diagnoses having a significant negative impact on access for rehabilitation patients.

We urge CMS, respectfully, to refrain from changing the technical code specifications defining the parameters of the 60% Rule's "presumptive testing" methodology in a manner that would prohibit any impairment group categories ("IGCs") other than osteoarthritis and rheumatoid and other arthritis from counting toward or otherwise being used as a part of that methodology.

Our detailed comments follow.

PROPOSED CHANGES TO THE '60% RULE' PRESUMPTIVE COMPLIANCE METHODOLOGY

The 60% Rule requires that 60 percent of an IRF's cases for a prior 12-month period fall within 13 qualifying conditions or have qualifying comorbidities. Compliance with the 60% Rule is assessed through a two-step process. The first step is the presumptive assessment – a software audit by a CMS contractor that analyzes ICD-9-CM diagnosis codes submitted for each patient. IRFs that fail to demonstrate 60% Rule compliance using this initial presumptive test may then elect a second step involving a comprehensive assessment in which a contractor audits a sample of the facility's medical records to assess compliance with this policy.

REDUCTION OF ICD-9-CM CODES FROM PRESUMPTIVE TEST

In the FY 2014 final rule, CMS finalized a policy to remove 259 ICD-9-CM codes from those that qualify under the 60% Rule presumptive test, beginning Oct. 1, 2014. CMS stated that this change was intended to account for changes and variation over time in hospital coding, clinical practice, condition frequencies and 60% Rule enforcement by CMS contractors. CMS finalized this policy despite the KHA's significant concerns that several of the coding changes were unwarranted and inappropriate. Specifically, we were, and continue to be, concerned that the coding changes do not reflect clinically relevant distinctions, are administratively unrealistic, and do not further CMS's ability to ensure that IRFs are treating medically appropriate patients. We also expressed concern that these changes would have the immediate effect of decreasing the compliance rate for many IRFs, reducing IRFs' ability to admit diagnoses outside of the 60% Rule qualifying conditions, and potentially decreasing access for patients that would benefit from specialized IRF services.

The Proposed Rule seeks "to revise Appendix B: Impairment Group Codes That Meet Presumptive Compliance Criteria by revising the diagnosis codes listed as exclusions on the table and by revising the title of the table."[1] In making this proposal, CMS references action it took in the Final Rule for the FY 2014 IRF PPS (referred to herein as "FY 2014 Final Rule") to "remov[e]...certain ICD-9-CM codes from the list of codes" [2] that are used in the 60% Rule's "presumptive testing" procedure, most of which pertained to the use of "comorbidities" for "presumptive testing" procedures. In the FY 2015 Proposed Rule, CMS proposes "to exclude these diagnosis codes [i.e., the codes excluded as part of the FY 2014 Final Rule] from counting if they are the patient's Etiologic Diagnosis (that is, the etiologic problem that led to the condition for which the patient is receiving rehabilitation). That is, a given IGC that would otherwise meet the presumptive compliance criteria will not meet such criteria if the patient has one of the 'excluded' Etiologic Diagnoses for that IGC."[3] In examining the relevant table referenced in the Proposed Rule containing "Appendix B's" codes (ICD-9 version), we have noticed that certain IGCs would no longer be included in the 60% Rule's "presumptive testing" procedures, by virtue of their association with etiological diagnosis codes. Moreover, many of these IGCs would not count toward "presumptive testing" *even if* they are associated with cases that have a qualifying co-morbid condition or meet other

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[1] Id. At 26328
[2] Id
[3] Id. At 26329

qualifying criteria under the 60% Rule, such as those specified for lower extremity joint replacement (LEJR) cases. We believe a number of the IGCs and other codes that would be removed from Appendix B may be erroneous and unintended, including those pertaining to LEJR.

The 60% Rule is intended to ensure that IRFs concentrate on treating patient populations that are distinct from the populations treated in other post-acute settings. However, this goal has been met as a result of a variety of regulatory interventions by CMS. First, the long-standing requirement that IRF patients require and receive at least three hours of therapy a day results in an IRF patient mix that, as a whole, is unlike the mix treated in other settings. In addition, the agency's substantial redesign of the "75% Rule" (now the "60% Rule") in 2004 initiated a period of major volume reduction for the IRF field – a decrease of more than 123,000 cases from 2004 through 2011. Further, CMS implemented new regulatory requirements in January 2010 that required IRF physicians to apply even more stringent admission criteria when considering whether a patient was medically necessary for the IRF setting.

Collectively, these regulatory actions have resulted in a substantial reduction in IRF utilization and an IRF case-mix that is, on average, more acute than in prior years.[4] Thus, CMS's proposed changes are not only concerning because of the effect they would have on access, but are also unnecessary. The proposed additional narrowing of 60% Rule eligible codes as discussed below is inappropriate, and we are concerned they would further reduce access to IRF services for patients who would otherwise meet IRF admissions criteria.

PROPOSED REMOVAL OF AMPUTATION ICD-9-CM CODES FROM PRESUMPTIVE TEST

CMS proposes to remove an additional 10 ICD-9-CM codes for amputation cases from the codes that qualify under the presumptive test, beginning Oct. 1, 2014. CMS's rationale for this change is that these diagnosis codes (shown in Table 7 of the rule) cannot, on their own, indicate whether a patient with an amputation status or with prosthetic fitting and adjustment needs has a condition for which IRF treatment is medically necessary.

We acknowledge that an ICD-9-CM "status" code *alone*, such as V49.75, below knee amputation status, does not provide specific enough information to determine whether the patient has a condition for which he or she would qualify for treatment at an IRF. Specifically, the ICD-9-CM code alone does not specify how long ago the amputation occurred (immediately before the IRF admission or years before), the underlying condition which precipitated the amputation, or which side of the body was affected. However, the loss of a limb is a major medical event and, at a minimum, it is a complicating co-morbidity. Rehabilitation care and treatment will be different for a patient who has sustained an amputation in the past compared to other patients. These patients will have impairments related to their ability to conduct activities of daily living, significantly different safety concerns and challenges related to their ability to balance themselves.

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[4] Medicare Payment Advisory Commission Report to Congress. March 2013. Pages 224-225.

Therefore, we urge CMS to retain the amputation status codes as qualifying codes, but consider them in conjunction with other related information in the inpatient rehabilitation facility-patient assessment instrument (IRF-PAI), as well as the imminent implementation of the more granular ICD-10-CM diagnosis codes. Specifically, the status codes can be used in combination with the etiologic diagnosis (the primary reason that led to the condition for which the patient is receiving rehabilitation), which will reflect recent injuries, in the IRF-PAI, and other co-morbidity diagnosis codes to provide a more complete clinical picture of the patient. For example, a patient who has suffered multiple major traumas affecting the right leg, but also had a left-sided, below-the-knee amputation in the distant past, will have additional challenges requiring intensive rehabilitation to regain strength and mobility of the right limb – the remaining leg. We acknowledge that the ICD-9-CM codes for traumatic injury do not specify which side of the body was affected, but the more granular ICD-10-CM diagnosis codes do specify whether the right or left side was injured, while the "status post amputation" codes specify whether it is the right, left or unspecified limb. The additional information provided by the ICD-10-CM diagnosis codes will help support amputation as a qualifying condition under the presumptive test.

PROPOSED REMOVAL OF IMPAIRMENT GROUP CODES (IGCs) FROM PRESUMPTIVE TEST

For "presumptive testing" purposes, the code changes contemplated by Appendix B literally turns the 60% Rule's list of medical conditions, commonly referred to as "CMS-13," into "CMS-10." The effect of the arthritis change alone – without accounting for the effects of any other code changes contemplated by Appendix B – stands to result in some combination of, A) fewer patients with arthritis IGCs accessing IRF services; B) fewer patients with conditions not eligible for "presumptive testing" accessing IRF services; or, C) more "medical review" for IRFs. All of these outcomes have substantial drawbacks for IRFs and patients who need their services, though the potential for any of them makes it all the more important for CMS to carefully examine and re-consider the code changes that would be implemented under Appendix B, especially those that would preclude IGCs other than osteoarthritis and rheumatoid and other arthritis from "presumptively" counting toward the 60% Rule.

Though not within the immediate scope of our concerns with Appendix B and the effect it would have on the use of certain IGCs in the 60% Rule's "presumptive testing" procedures, CMS' proposal to create a new interim step in "presumptive testing" to allow results of a partial "medical review" of arthritis cases could alleviate some of the administrative costs and burdens, and subjectivity, of the "medical review" process generally. While reserving the right to comment further on the proposal later in the comment period, we are generally supportive of CMS's proposal in this area. Still, while the logic of conforming the code changes made by the FY 2014 Final Rule to arthritis IGCs may be understandable given how the 60% Rule defines arthritis cases, the code changes contemplated by the Proposed Rule's Appendix B would have an unintended and negative impact on a number of non-arthritis cases at the IGC level, including LEJR and hip fracture cases. **Apart from the arthritis category, other IGCs slated for preclusion from "presumptive testing" under Appendix B seem to be an unintended consequence of proposed Appendix B. We respectfully urge CMS to refrain from precluding any non-arthritis IGCs from being included in the "presumptive testing" methodology.**

PROPOSED EXCLUSION OF IGCs THAT ARE ETIOLOGIC DIAGNOSES

The proposed rule seeks to revise Appendix B: Impairment Group Codes That Meet Presumptive Compliance Criteria by revising the diagnosis codes listed as exclusions on the table and by revising the title of the table. The proposed rule would exclude 24 IGCs from qualifying under the presumptive test because they correspond to etiologic diagnoses that already have been excluded from the presumptive test by CMS.

We request that CMS specifically confirm that the changes to the "Impairment Group Codes That Meet Presumptive Compliance Criteria" list are a consequence of the removal of the 259 ICD-9-CM codes from those that meet the presumptive test, as finalized in the FY 2014 final rule – IRF providers have found the revisions and title of the table confusing. **And we urge CMS, in its clarification of the scope and intent of Appendix B, to explain how the IGCs in the appendix would not remove any further cases from compliance with the presumptive test, beyond those that were removed under the ICD-9-CM restrictions in the 2014 final rule.**

Non-specific ICD-9-CM Diagnosis Codes. The KHA agrees that, whenever possible, IRFs should use the most specific code possible to describe a medical disease, condition or injury on the IRF-PAI. However, we continue to strongly object to CMS's indiscriminate proposed approach of uniformly removing non-specific codes whenever more specific codes are available. We note that the ability of IRFs to obtain more specific codes from the referring hospital, instead of using non-specific codes, is often administratively unrealistic. IRFs have to rely on the documentation provided by the referring general acute care hospital when assigning certain codes to describe the patient's status. It can be very difficult to obtain detailed medical documentation from the transferring facility, especially when the transferring facility itself may not have the level of specificity required by the proposed changes. The difficulty is compounded when the IRF admission is not directly from a general acute care hospital, for example, when a patient is discharged from a general acute care hospital, then treated in a long-term care hospital, and then transferred to an IRF.

Therefore, we urge CMS not to exclude non-specific etiologic diagnosis codes from the IGCs. Also, we disagree with CMS's estimate that this change will not have any significant financial effects on IRFs, as "IRFs will be able to switch to using the more specific codes that are available for the Etiologic Diagnoses instead." As alluded to above, we do not believe that IRFs will be able to actually find and/or use more specific codes for etiologic diagnoses in every case. First, while many hospitals are working with their physicians to improve the quality and specificity of their medical documentation in preparation for ICD-10-CM and ICD-10-PCS implementation and to mitigate the risk of payment denials due to audits by Medicare contractors, improvements in the specificity of the documentation will take time. It is therefore, again, administratively and clinically unfeasible to require IRFs to obtain the more specific codes, as illustrated below with the hip fracture and joint replacement and TBI examples.

In addition, there is no clinical rationale for excluding these codes. Unspecified codes do not reflect either poor documentation or poor coding. We urge the agency not to finalize any of its proposals to

remove non-specific codes from the list of qualifying codes. The examples below illustrate that CMS's proposals do not further ensure that IRFs are concentrated on treating medically appropriate patients.

IGCs 08.11, Unilateral Hip Fracture, and 08.12, Bilateral Hip Fracture. CMS proposes to eliminate ICD-9-CM codes 820.8 and 820.9 for hip fractures, which generally correspond to IGCs 08.11 and 08.12, from the list of 60% Rule Etiologic Diagnosis qualifying codes. However, these codes specify the fracture of the neck of the femur – they are not unspecified codes – and CMS does not set forth a clinical rationale for their elimination. Our member IRFs indicate that they use the combination of IGCs 08.11 or 08.12 and Etiologic Diagnosis ICD-9-CM codes 820.8 or 820.9 to code hip fractures. ICD-9-CM diagnosis codes 820.8 and 820.9 still represent a hip fracture that is listed as a qualifying condition in 42 CFR 412.29(b)(2) which only specifies "fracture of femur (hip fracture)" and not a specific segment of the femur. It is unlikely that more information will be readily available or provide meaningful additional specificity. For example, it is unlikely that the physician documentation would reflect anything more specific without a copy of the X-ray report, yet the X-ray may have been taken in an emergency department at a general acute-care hospital, in a nursing home or some other location, and therefore not available as part of the IRF record. Further, any additional specificity indicating which portion of the neck of the femur is affected would not impact the type or intensity of rehabilitation services the patient requires and therefore would not further CMS's ability to ensure IRFs are treating medically appropriate patients.

Hip and Knee Replacement IGCs (08.51–08.72). CMS proposes to refine hip and knee replacement IGCs by excluding various ICD-9-CM diagnosis codes for osteoarthritis as etiologic diagnoses. This proposed refinement seems to exclude knee replacement, hip replacement or both during an acute hospitalization immediately preceding the IRF stay from the list of qualifying codes. However, it does not consider the three clinical criteria specifically identified as qualifying conditions in 42 CFR 412.29(b)(2):

- The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission;
- The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF; and
- The patient is age 85 or older at the time of admission to the IRF.

We believe that compliance with these three clinical criteria can be demonstrated with a combination of diagnosis codes (either ICD-9-CM or ICD-10-CM) and either adding new data items to the IRF-PAI or using existing data items in the IRF-PAI, as follows:

- *The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute care hospital admission immediately preceding the IRF admission* – This information would require a new IRF-PAI data item to identify this criterion has been met. While the addition of a new item, such as this one, creates additional administrative work, we believe that it would result in considerably less burden than requiring audit review.

- *The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF* – This information can be reported using existing ICD-9-CM codes (V85.43, V85.44 or V85.45), or ICD-10-CM codes (Z68.43, Z68.44 or Z68.45).
- *The patient is age 85 or older at the time of admission to the IRF* – Given that the patient's date of birth is an existing field in the IRF-PAI, this information can be easily calculated.

IGC 02.22, TBI, Closed Injury and IGC 02.21, TBI, Open Injury. CMS proposes to remove approximately 90 ICD-9-CM codes for traumatic brain injuries from the list of 60% Rule etiologic diagnosis qualifying codes, which generally correspond to IGCs 02.22 and 02.21, including codes for skull fractures, cerebral lacerations and concussions, seemingly because these codes do not identify the duration of the patient's loss of consciousness (LOC). **We oppose this proposal, as the elimination of these codes is administratively and clinically unrealistic.** For example, when the LOC is of short duration, the LOC information may be typically recorded at the scene of the injury by the emergency medical technician or the ambulance driver, and often is not available to the receiving IRF. As another example, a patient may sustain a fall at home. The patient's family may notice that the patient does not appear "right" and mobility is declining, prompting a visit to the emergency department where a diagnosis of subdural hematoma is made. After treatment in a general acute-care hospital, the patient is then transferred to the IRF to address mobility issues associated with a traumatic brain injury. In this example, neither the family nor the discharging general acute-care hospital possess or relay this information to the receiving IRF regarding the original LOC that precipitated the initial trip to the emergency department. Yet, despite the absence of this information, at the point of discharge from the general acute-care hospital, the patient's medical necessity for IRF services can be assessed without this information.

It is also technically inconsistent to exclude ICD-9-CM diagnosis codes for head injuries that do not specify the duration of the patient's LOC when it appears that LOC is not required for IRF admission. Specifically, IGC 02.22 and 02.21 would qualify for the 60% Rule presumptive test in conjunction with these two correlated ICD-9-CM codes, which specify "no loss of consciousness": 850.0, concussion with no loss of consciousness; and 800.61, open fracture of vault of skull with cerebral laceration and contusion, with no loss of consciousness. Therefore, these two IGCs should not be exempted from the 60% Rule presumptive test.

PROPOSED GROUP THERAPY REPORTING

In the proposed rule, CMS expresses interest in learning more about how group therapy fits within the overall IRF scope of services. We support the agency's plan to collect more data on group therapy to facilitate study of the role that this therapy mode plays in treating IRF patients, but note with concern CMS's intent to use its findings as it weighs a future group therapy cap per patient. As the agency proceeds, we encourage CMS to recognize the clinical value and advantages group therapy provides over other therapy modes for certain patients.

Group therapy is the preferred treatment method for patients for whom medical improvement, restoration of functional independence and the achievement of patient education goals are advanced through the social interaction and motivation gained through the group dynamic. The following examples illustrate clinical scenarios for which group therapy is advantageous:

- Speech therapy for patients recovering from conditions such as strokes can be more efficacious in a group setting. Speech therapy in a group promotes advances in conversational abilities that are more difficult to attain in a non-social setting and, as an added benefit, enhances community reintegration – a core mission of IRFs.

- Feeding therapy provided by an occupational therapist to patients recovering from brain and spinal cord injuries and other conditions also can be more beneficial to the patient when delivered in a group setting, as patients gain the added benefit of observing and learning from therapy advances of other patients in the group.

While the proposed rule states that group therapy remains widely used, many KHA members report using group therapy in a limited fashion, often only after the patient has received three hours of individual therapy per day. **As such, to enable the agency to better understand the range of group therapy practices, we generally support CMS's plan to collect data on group therapy practices.** When using these new data, the agency should be able to acquire a clearer profile of group therapy practices, and we encourage the agency to share such findings with providers.

In addition, the agency proposes new definitions for individual, group and co-treatment therapies that would apply to the therapy data collection process, but fails to provide a clinical foundation for the specifics in the proposed definitions. **We are concerned that CMS has not shared the origin and clinical rationale of these definitions, and encourage CMS to share any data or other analyses that support the proposed therapy definitions prior to their finalization.**

Of particular concern are two issues pertaining to the proposed definition for group therapy. First, the proposed rule does not provide CMS's clinical bases for defining group therapy in IRFs as groups of two to six patients, when, as a point of comparison, group therapy in a SNF applies exclusively to groups with four patients. In addition, it is unclear why CMS has not also provided a distinct definition for concurrent therapy, when this common IRF modality is clinically and structurally distinct from group therapy. We discourage CMS from blending concurrent therapy (one therapist providing *different* therapy for two patients) into the group therapy (one therapist providing the *same* therapy to two or more patients) definition. **Instead, CMS should add a distinct definition for concurrent therapy.**

The proposed rule discusses a potential, future individual cap for group therapy of 25 percent of total therapy received during an IRF stay. **Given that CMS still lacks the insights that would be gained through the proposed new collection of group therapy information, it is premature for CMS to contemplate a specific group therapy cap per patient.** Rather, CMS should collect the new information on group therapy, assess and share the findings, and then, prospectively from that point, consider the need for any policy changes based on the new data.

Finally, while we support this proposed new data collection, we remain concerned about the overall burden IRFs would face under the new group therapy reporting requirements. We are particularly concerned with CMS's estimate that the collection of new group therapy data would require four

additional minutes per assessment, given the regulation's lack of explanation of the methodology used to calculate this estimate. We believe that implementation of electronic medical records across the IRF field is highly varied, and as such, the experience of adding new data collection and reporting duties would substantially vary by IRF. Further, when combined with existing reporting, the work that would be required to retrain staff to adapt to new 60% Rule guidelines and the growing IRF quality reporting program (QRP), the new group therapy reporting activities would represent a material addition to the administrative and reporting burden facing IRFs. **We urge CMS to respond to these concerns by explaining their burden estimate methodology, including sharing distinct estimates for IRFs using electronic medical records versus providers without.**

Thank you for the opportunity to comment on this proposed rule. If you have any questions, feel free to contact me or Steve Miller at (502) 426-6220 or ngalvagni@kyha.com or smiller@kyha.com.

Sincerely,

Nancy C. Galvagni

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Senior Vice President