The American Occupational Therapy Association, Inc.

Occupational Therapy: Skills for the Job of Living

Via express mail
Via electronic mail to IRFReporttoCongress@cms.hhs.gov and bgage@rti.org

February 9, 2009

Barbara Gage, PhD
Deputy Director of Aging, Disability, and Long-Term Care Studies
RTI International
1440 Main Street, Suite 310
Waltham, MA 02451-1623

Re: Medicare Classification Criteria for Inpatient Rehabilitation Facilities

Dear Ms. Gage:

The American Occupational Therapy Association (AOTA) represents the interests of over 140,000 occupational therapists, occupational therapy assistants, and therapy students, many of whom serve the Medicare populations in inpatient rehabilitation facilities (IRFs) and in other post-acute care settings including long-term care hospitals, skilled nursing facilities, acute care hospitals and home health agencies. We appreciate the opportunity to provide comments pursuant to the February 2, 2009 Centers for Medicare & Medicaid Services (CMS) Town Hall Meeting to gather public input on the classification criteria applicable to Inpatient Rehabilitation Facilities, commonly known as the "75 percent rule." AOTA hopes that these comments will assist RTI International (RTI) in its study of these issues and inform CMS in preparing the Report to Congress required by the Medicare, Medicaid and SCHIP Extension Act of 2007.

AOTA has significant concerns regarding the 75% rule (currently, the 60% rule). Occupational therapists and occupational therapy assistants provide key intensive rehabilitation services in IRFs. Consequently, occupational therapy practitioners are well aware that the 75% rule fails to accurately reflect the increasing need for patients with diagnoses outside of the existing 13 conditions to have access to inpatient rehabilitation hospital care. According to occupational therapy practitioners working in IRFs, many patients fall outside the 13 CMS conditions that might require IRF services, including: *orthopedic, joint/limb replacement, post transplant patients, patients with chronic pulmonary and cardiac conditions, and medically complex patients*. The decision of where services are best obtained for a patient must be based on the individual's total needs as assessed by a physician, clinician, and discharge planner and not based on arbitrary categorizations.

Using the 75% rule as a proxy for IRF admission prevents patients from receiving appropriate intensive, multidisciplinary rehabilitation services by setting impossibly narrow medical necessity criteria. Such narrow criteria are contrary to the purpose of IRFs, as noted in Chapter 1, section 110.1 of the Medicare Benefit Policy Manual (MBPM), where CMS explicitly recognizes that IRF care is necessary and reasonable for patients who require more coordinated, intensive, and interdisciplinary care than is available in other settings. CMS' manual states:

> *Medicare recognizes that determinations of whether hospital stays for rehabilitation services are reasonable and necessary must be based upon an assessment of each beneficiary's individual care needs. Therefore, denials of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms, "the three hour rule," or any other "rules of thumb," are not appropriate.* (MBPM, Ch.1, section 110.1).

The 75% rule is unnecessary and interferes with sound clinical decision making and, consequently, with patient access to medically necessary and appropriate services. The need to better clarify existing medical necessity criteria is of the utmost importance for the RTI project. The focus on diagnosis alone is not founded in any scientific research or sound medical judgment. In addition, the 75% rule fails to account for changes in medical technology and advances in rehabilitation made in the last 2 decades. Unlike in other areas of medical care, the need for IRF services is *not* driven by the presence or absence of a specific diagnosis. IRF medical necessity is multi-factorial and involves in-depth assessment of functional abilities (mobility, cognition, social participation etc.), potential for improvement, co-morbidities, care personnel skill set among other factors, must be considered when determining an individual's need for intensive inpatient rehabilitation services.

Additionally, according to anecdotal information from occupational therapy practitioners, a number of states over the past several years have seen a decrease in patient access to medically necessary inpatient rehabilitation services because of interpretations made by regional Medicare entities. According to our members, the recent problems in patient access to IRFs in California have been caused by the inappropriate application of existing medical necessity criteria, as outlined in the Medicare Benefit Policy Manual, Chapter 1, Section 110, by Medicare reviewers. Though the vast majority of the claims in question are upheld in subsequent review (typically Administrative Law Judge), the expensive and time-consuming appeal process has led many facilities to limit admissions of certain patients they believe may be subject to review. The impact of the 75% rule, combined with the impact of arbitrary claims review and denials (e.g., Recovery Audit Contractors and/or Medicare Administrative Contractors) taken together can inappropriately restrict patient admission decisions.

AOTA supports a repeal or modification to the 75% rule that reflects patient need for intensive rehabilitation services. IRFs should be required to demonstrate that patients admitted for care meet medical necessity criteria as set forth in the Medicare Benefit Policy Manual (MBPM), Chapter 1, section 110. Determinations of medical necessity would include an examination of functional factors rather than diagnosis alone. Expansion of the existing requirement for pre-admission screening and appropriate revisions or modifications to the inpatient rehabilitation facility patient assessment instrument could be components of this process. However, AOTA urges that any changes to existing screening and placement criteria be balanced against the possible delay in patient transfer out of the acute setting while clinicians are gathering the necessary data and interacting with the medical director and others in the care team at the IRF.

IRFs should be required to demonstrate compliance with existing criteria governing IRF classification in the MBPM, Chapter 1, beginning at section 110, including: preadmission screening, qualified personnel, physician management of individual patient plans of care, and a coordinated multidisciplinary team approach to care (See MBPM, Ch. 1, sections 110.2, 110.3 and 110.4). For example, the Medicare

Benefit Policy Manual provides detailed coverage criteria regarding need for intensive rehabilitation specifically related to need for a physician with special training in rehabilitation:

> *A patient's condition must require the 24-hour availability of a physician with special training or experience in the field of rehabilitation. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct, and medically necessary physician involvement in the patient's care; i.e., at least every two to three days during the patient's stay. (Emphasis added).* (MBPM, Ch.1, section 110.4.1).

AOTA argues that the Medicare Benefit Policy Manual spells out in great detail the medical necessity criteria, which appropriately focuses on patient functional abilities, goals, and outcomes in determining IRF admission. An approach built on these criteria would be far superior to the arbitrary 75% rule.

AOTA urges RTI to review Medicare Manual sections closely and consider a new framework for classification using criteria described therein; the criteria rightfully are based in the need for reasoned joint physician and clinician judgment regarding medical necessity for admission into an IRF. AOTA asserts that any standards developed must be client–centered and transparent in nature. In addition, AOTA recommends that RTI and CMS compile a group of experts from among the professionals on the IRF care team to discuss new IRF coverage criteria. This group of experts should be permanently established as an advisory group that can continue to reconvene as CMS considers future changes to IRF policies. Finally, additional research must be done regarding comparative effectiveness and outcomes in the various post-acute care settings.

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AOTA requests that due consideration be given to these comments. Thank you, again, for the opportunity to comment on the "75 percent rule", the classification criteria commonly applicable to Inpatient Rehabilitation Facilities. AOTA looks forward to a continuing dialogue with CMS and RTI on the coverage and payment policies that affect the ability of occupational therapists to provide quality care to Medicare beneficiaries.

Sincerely,

Sharmila Sandhu, Esq.
Regulatory Counsel

cc: Julie M. Stankivic, CMS Health Insurance Specialist