February 16, 2009

Julie M. Stankivic
Health Insurance Specialist
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C5-06-27
Baltimore, Maryland 21244

RE: Medicare Classification Criteria for Inpatient Rehabilitation Facilities in preparation for the Report to Congress required by the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).

Dear Ms. Stankivic:

On behalf of Aurora Health Care inpatient rehabilitation facilities in southeastern Wisconsin, we appreciate the opportunity to comment on the Medicare Classification Criteria for Inpatient Rehabilitation Facilities in preparation for the Report to Congress required by the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).

We have several concerns about the "75% Rule" as it stands today and we have some thoughts on alternative criteria or refinements to the "75% Rule" that could be used to determine IRF classification. Both of these areas will be addressed in this letter.

First, we would like to address the virtual extinction of the joint replacement category from inpatient rehabilitation facilities (even for joint replacements that fall under the "CMS 13" list of acceptable diagnoses). While we agree that most joint replacements do not require inpatient rehabilitation, there are some that do. Aurora IRF's are not "the rule" nationally when it comes to joint replacement admissions, we have decreased our admission of joint replacements from approximately 18% in 2004 to less than 1% in 2008. We have a thorough pre-admission screening process at all of our IRFs. As a result of our pre-admission screening process, if it is found that a joint replacement beneficiary has active or potential medical needs or risks as a result of their hospitalization and associated complications that cannot adequately or safely be expected to be provided for (in the case of medical needs), or the outcome of which cannot be treated (in the case of risks) in a setting less intense than an acute care hospital, then we do admit them to our IRF, regardless of the diagnosis. Further, if the beneficiary is able to tolerate the rigors of IRF care for their post-joint replacement rehab, then that rehabilitation should be done in an IRF because it has been proven that IRF's are more effective at post-joint replacement rehabilitation than SNF care (and for that reason, since it is clearly the standard of care, the beneficiary should be admitted to the IRF). During the CMS Town Hall meeting on February 9th, 2009 it was requested that we provide a list of conditions that may warrant a patient with a joint replacement to require an IRF level of care. Some conditions that may warrant an inpatient level of care include bilateral joint replacement, morbid obesity, 85 years or older, history of infected joint, history of DVT, history of pulmonary embolism, associated neurological condition (such as CVA, Parkinsons, GB Syndrome, MS), and blood loss anemia (requiring a blood transfusion). It should be noted that subacute/skilled nursing facilities in our area do **not** perform blood transfusions.

Based on the denials we have received for joint replacements (which it should be noted that we have appealed 28 joint replacement denials over the past two years and have successfully had 100% of these cases overturned), we can't help but wonder if the recommendation for a less

intense setting is not purely financially and diagnostically driven (which of course is not a consideration at all as outlined by HCFA 85-2 or section 110 of the Medicare Beneficiary Policy Manual) because we know that patients who receive their post-joint therapy in an IRF get better faster than those that receive their care in a SNF. For some reason, there is an ongoing movement in regards to inpatient rehabilitation care, directed by payers only, which states something like, "joint replacement beneficiaries do not need 3 hours of therapy" or "close medical supervision." It is difficult for us to understand why. There is certainly no logic for this philosophy other than the care in a skilled nursing/subacute facility is perceived as being cheaper than an IRF, which is really no logic at all – we should be governed by the logic of best practice. Joint replacement patients are in the best position to benefit from intensive physical and occupational therapy (i.e. 3 hours) because they are highly motivated and we know they benefit greatly from intensive PT and OT, resulting in rapid progress. This is a fact that has been proven and reported on in the 2006 study in American Journal of Rehabilitation, Volume 85, issue 1, pages 1-5. In this study, it was found that total joint replacement patients treated in an IRF (vs. skilled nursing facility/subacute) achieved superior functional outcomes in a shorter period of time. The mean LOS of IRF-treated patients was 10.3 ± 3.3 days, compared with 20.0 ± 10.8 days for SNF-treated patients ($P < 0.005$). A significantly higher percentage of IRF-treated patients were discharged directly home (IRF: 89.5%; SNF: 79.1%; $P < 0.029$). The mean discharge locomotion FIM score for IRF-treated patients was 5.71 ± 0.91 compared with 4.90 ± 1.92 for the SNF-treated patients ($P < 0.004$). At discharge, the mean ambulation distance of patients treated at the IRF was of 380 ± 168 feet compared with 289 ± 212 feet for patients treated at SNFs ($P < 0.005$). Significantly more of the SNF-treated patients required a walker (80.2%) for ambulation at discharge compared with patients treated at the IRF (38.3%, $P < 0.001$). Of the patients who were discharged home, 75% of the SNF-treated patients required homecare services compared with 41.2% of the IRF-treated patients ($P < 0.001$).
It seems to us that we, as an IRF provider, are morally, ethically, and legally bound to provide joint replacement beneficiaries with their rehabilitation on an IRF level based upon the results of this study because we know we can get them better faster. That means we can get them home faster, and reduce the likelihood of nosocomial complications. Beneficiaries that have joint replacements are also entitled to the most excellent rehabilitation care for their needs and skilled nursing facility/subacute care is not it. As we stated earlier, we agree that most joint replacements do not require IRF care, but we must not exclude those that do. When a beneficiary's health or life is on the line, we as an organization will not send a beneficiary to a lower level of care just because the lower level of care is "perceived" to be cheaper. We will do what is in the best interest of our patients. The virtual extinction of joint replacements from inpatient rehabilitation is one area of concern for many IRFs in the United States that CMS <u>must</u> address.

The result of this now apparent habit of retroactively denying IRF care to <u>all</u> joint replacement patients, whether their conditions place them on the 75% list, or not, is to, of course, limit their access the needed IRF care. When facilities see that every single one of their joint replacement cases are being retroactively denied, thus forcing the very burdensome, costly, and unnecessary appeals process, the final result is that each facility learns to not admit the patients in whatever diagnostic group is being discriminated against by the fiscal intermediary/MAC/RAC/whatever. That isn't right (and it isn't the intent of the 75% rule, either).

A second area we would like to comment on is the "CMS 13" diagnosis list, as it exists today. As we all know the "HCFA 10" was developed in the 1980's. The HCFA 10 evolved into the CMS 13. The fact of the matter is that the CMS 13 (as it exists today) is not reflective of the current medical population or of the advancements of modern medicine. We propose adding a 14th category to the CMS 13. We propose that this category would be a called the "Catastrophic Illness" category. For this category, a beneficiary will have had a continuous acute

hospitalization for at least 2 weeks or longer (just prior to admission to the IRF). Also, the beneficiary will have experienced one or more of the following complications during the 2 week (or longer) acute hospitalization:

- Stroke while hospitalized
- GI bleed requiring transfusion or ICU stay
- Respiratory failure requiring mechanical ventilation for support (this could be either intubation or CPAP/BiPAP)
- Sepsis
- Acute renal failure (not necessarily requiring dialysis)
- Multisystem organ failure
- IABP placement/use
- Acute MI during hospitalization (any cause)
- Newly documented EF less than 25%
- Chemotherapy induced pancytopenia
- Code IV (advanced cardiopulmonary resuscitation)
- Newly diagnosed FEV1 less than 35% of predicted (American Thoracic Society criteria for severe COPD)
- Be on TPN at the time of their admission to the IRF
- Organ transplantation as the reason for their immediate pre-IRF admission

In the catastrophic illness category, the beneficiaries would clearly require the ongoing availability of 24-hour medical supervision (both physician and nursing) as well as the other IRF criteria listed in section 110 of the Medicare Beneficiary Policy Manual. By adding this additional category, it would allow Medicare beneficiaries with complicated acute courses (with unusual ongoing medical needs) to have access to medically necessary rehabilitation services that this population often requires.

Once again, we appreciate your solicitation of our comments for this important topic. If you have any questions or require clarification of our comments, please feel free to contact Andrea Pfaffl at 414-649-5765.

Respectfully,

Scott Hardin, MD
Medical Director of Rehabilitation
Aurora St. Luke's Medical Center
Board Certified in PM&R
Fellow, AAPM&R

Gita R. Baruah, MD
Medical Director of Rehabilitation
Aurora Sinai Medical Center
Aurora West Allis Medical Center
Board Certified in PM&R
Fellow, AAPM&R

Andrea Pfaffl
Prospective Payment Supervisor
Inpatient Rehabilitation
Aurora Health Care