June 28, 2013

Marilyn Tavenner
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1448-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Ms. Tavenner,

UDSMR appreciates the opportunity to provide written comment on 42 CFR Part 412 Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2014; Proposed Final Rule (CMS-1448-P), published in the Federal Register on May 8, 2013.

UDSMR is the world’s largest, government-independent repository of rehabilitation outcomes and IRF-PAI data, representing more than 830 acute units and freestanding rehabilitation hospitals. Because of our longstanding leadership position in the industry, we are recognized as objective evaluators of the data that are used to measure the outcomes and quality of care, effectiveness, efficiency, timeliness, safety, patient centeredness, and equity in inpatient rehabilitation.

We trust that our comments will be given serious consideration by the Centers for Medicare and Medicaid Services.

UDSMR’s Comments on Specific Proposed Changes to the IRF PPS Final Rule for FY 2014

VII. Proposed Refinements to the Presumptive Compliance Criteria Methodology

We question the timing of the updates to the presumptive compliance criteria methodology list of compliant ICD-9-CM codes and ask for further explanation of how the updates will be implemented. Given the agency’s target date of October 1, 2014, for implementation of the ICD-10-CM codes, the timing of this update to the current presumptive methodology list may cause an undue burden for facilities. The presumptive compliance list will require an update with the advent of ICD-10-CM, and we therefore question the purpose of changing the list of ICD-9-CM codes for one year. In addition, no information has been shared as to exactly how compliance will be calculated for facilities that have a cost-reporting period that spans the implementation of the updated compliant list. Will those facilities have two separate compliance periods? From June to September 2013, there will be one list of compliant codes; for October 2013 to September 2014, there will be another. If a facility has a compliance reporting period from June 2013 to May 2014, will it have to comply with the 60% rule in those two periods separately?

Furthermore, we have examined our data in multiple time frames and have estimated that the update to the compliant ICD-9-CM code list could lead as many as 20% of the facilities subscribing to the UDSMR® database to fall out of compliance with the 60% rule, depending on their cost reporting period. In the analysis, the arthritis ICD-9-CM
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codes were the cause of the majority of the difference in the percentage of compliant facilities. It seems counterintuitive to allow arthritis to remain on the list of the thirteen presumptively qualifying conditions but to remove all arthritis ICD-9-CM codes from the remaining list that determines compliance, considering that their removal may result in the loss of compliant status for a large number of facilities.

VIII. Proposed Non-Quality Related Revisions to IRF-PAI Sections

We appreciate that CMS would like to minimize confusion with the use of different sets of status codes on the IRF-PAI and UB-04; however, if the proposed amended list of status codes is designed “to mirror those used on the CMS-1450 claim form,” we suggest the elimination of item 44E, Was patient discharged with Home Health Services?, and the addition of code 06, Home under care of organized home health service organization, to item 44D, Patient’s discharge destination/living setting. This code more accurately reflects the CMS-1450.

Regarding item 20, Payment Source, the current IRF-PAI form lists the available payment source options under item 20B, Secondary Source. If the proposed secondary response is being limited to codes 02, 51, and 99, we suggest displaying the current comprehensive listing of payment sources under item 20A, Primary Source. This arrangement would allow facilities that track this information on all their patients (both Medicare and non-Medicare) to continue to use this data for program management.

We agree with the premise of adding a signature page to the IRF-PAI, but we do not believe that this page should be used by every clinician who has had input into a particular case. Instead, we suggest that the signature page be limited to clinicians who are attesting to the accuracy of the information that is contained on the IRF-PAI. We also recommend more specific instructions as to the completion of this document.

XIII. Proposed Revisions and Updates to the Quality Reporting Program for IRFs

2. New Quality Measures Proposed for Quality Data Reporting Affecting the FY 2016 IRF PPS Annual Increase Factor
   i. Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)

3. Quality Measures Proposed for Quality Data Reporting Affecting the FY 2017 IRF PPS Annual Increase Factor and Subsequent Years
   i. Proposed IRF QRP Measure #1: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities
   ii. Proposed IRF QRP Measure #2: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)
   iii. Proposed IRF QRP Measure #3: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678)—Proposal to Adopt the NQF Endorsed Version of This Measure

The FY 2017 proposed quality measures for the IRFs will pose an increased burden on clinicians. For example, information related to NQF measure #0680, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay), will have
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to be collected and documented for all admissions. This information may not be easily accessible in the medical history, or it may be information the patient is unable to recall.

We are concerned about the “All Cause Unplanned 30-Day Readmission” quality measure. The IRF is responsible for improving the function of a patient while at the same time managing the patient’s medical conditions. The IRF should not be penalized for readmission conditions that are unrelated to the IRF impairment diagnosis. We do not believe that sufficient documentation or guidance from CMS exists at this time to identify those conditions.

We understand CMS’s desire to initiate cross-cutting quality metrics across the post-acute care settings, but we are disappointed that the additional process measures do not truly reflect the achievement of quality in the IRF setting. The recommended measures do not allow facilities to quantify the quality of their rehabilitation program.

As we have stated previously in our comments to CMS, the emphasis on restoration or maintenance of function affected by the patient’s illness or injury is paramount in the episode of care, yet the proposed measures do not adequately capture function or functional improvement. We argue that the IRF patient would be better off if the quality measures established the burden of care, the functional improvement achieved, and the percentage of patients returned to a community setting.

Our most highly effective and respected instrument, the FIM® instrument, is used across the post-acute care continuum. The FIM® instrument has a high overall internal consistency, can capture significant functional gains during rehabilitation, has high discriminative capabilities for rehabilitation patients, and is an indicator of the burden of care. Measures of effectiveness, efficiency, timeliness, resource use, and safety are an integral part of the FIM® instrument. CMS already endorses the FIM® instrument as part of the IRF-PAI to capture functional health in patients seen at IRFs. Using the FIM® instrument as part of CMS’s quality indicator set would not create any additional costs to IRFs because IRFs are already transmitting the current IRF-PAI form to CMS.

Any quality indicators used in the IRF setting must account for the overriding goal of inpatient rehabilitation, which is decreasing the burden of care among individuals who require rehabilitation and, by doing so, allowing the patient to return to a community setting. The FIM® instrument is a highly researched tool with several hundred peer-reviewed journal publications, and it can calculate a definitive burden of care for each patient or the amount of time required by a helper for each patient in the home setting.

In particular, we suggest three specific quality indicators:

1. Length-of-stay efficiency (i.e., FIM® points gained per day—higher is better)
2. Discharge percentage to community settings (higher is better)
3. Discharge percentage to acute care hospitals (lower is better)

The first two indicators address the following objective put forth by CMS: “The measures should address the needs of the individual including improved functional status and achievement of successful return to the community post-discharge.” The acute hospital discharge percentage may be used as a proxy for a readmission measure. UDSmr has the ability to risk-adjust the expectation of this indicator by using an indirect standardization method to adjust the CMG. We would be happy to share additional details on this procedure with CMS.
We recognize that CMS is trying to find indicators that are “harmonized” from the acute and across post-acute care settings. Our indicators are not only available in the IRF-PAI but also available via the AcuteFIM™ instrument and the SigmaFIM™ instrument for all post-acute venues of care.

We would welcome the opportunity to discuss with CMS these post-acute care instruments and their utility in achieving cross-setting quality metrics.

We appreciate this opportunity to provide our comments on the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2014 Proposed Rule. We would welcome further discussion with CMS about any of the provided comments.

Sincerely,

Carl V. Granger, MD Fran Hagerty
Executive Director Associate Director