Via electronic mail to J10LCDComment@cahabagba.com

September 10, 2012

Cahaba Government Benefit Administrators, LLC
Comment for Draft LCDs
ATTN: Dr. Greg McKinney
P.O. Box 13384
Birmingham, AL 35202-3384

Re: **Draft LCD for Surgery: IRF Admission after Single Joint Replacement with CMGs A0801-A0806 (DL32816)**

Dear Dr. McKinney:

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 Medicare beneficiaries in inpatient rehabilitation facilities (IRFs). We appreciate the opportunity to comment on the Draft Local Coverage Determination for Surgery: IRF Admission after Single Joint Replacement with CMGs A0801-A0806 (Draft LCD). AOTA is concerned that the Draft LCD will deny patients admission to IRFs based on their diagnosis alone, rather than on an individualized assessment of their condition by a physician and an interdisciplinary team of rehabilitation professionals. We believe that the Draft LCD conflicts with established Medicare policy and could restrict access for patients who need an IRF level of care.

I. Denial Based on Diagnosis Alone Conflicts with Established CMS Policy

The Centers for Medicare and Medicaid Services (CMS) has established a comprehensive framework of coverage criteria to be used in determining whether IRF services are "reasonable and necessary" for individual patients. The Medicare Benefit Policy Manual (MBPM) requires that the IRF admission and coverage criteria be applied on a case-by-case basis, stating that, "Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs." MBPM, Chap. 1, Sec. 110. This policy statement reflects CMS's opinion in the Final Rule for the Fiscal Year 2010 IRF PPS in which CMS said it "believe[s] that each patient in an IRF requires an individualized standard of care." 74 Fed. Reg. 39,762, 39,796 (August 7, 2009). CMS regulations also focus on evaluation and assessment of each patient in determining admission and coverage. *See generally*, 42 C.F.R. Section 412.622. CMS has never indicated that a patient's

medical diagnosis alone should serve as the sole factor in determining whether her/his case is to be covered under the IRF PPS.

CMS has made it clear that it expects contractors to make coverage and medical necessity determinations for IRF services on a case-by-case basis. For example, in the Final Rule for the FY 2009 IRF PPS, CMS stated that it had "specifically instructed its contractors to make medical review determinations based on reviews of individual medical records by qualified clinicians, ***not on the basis of diagnosis alone***." 73 Fed. Reg. 46,370, 46,388 (August 8, 2008). (Emphasis added). CMS also expressed this view when it adopted the "75% Rule," now known as the "60% Rule." In that rulemaking, CMS made clear that a "diagnosis describes only some aspects of a patient's clinical status, but the diagnosis alone does not determine the medical necessity of treating a patient in an IRF as opposed to another type of treatment setting." 69 Fed. Reg. 25,753, 25,755 (May 7, 2004). The Draft LCD would deny IRF coverage for all non-comorbid joint replacement cases based on diagnosis alone, without any regard to other factors affecting patients' medical and rehabilitative conditions and needs.

II. Physicians & Interdisciplinary Team Play Key Role in IRFs

CMS has highlighted the role of rehabilitation physicians in IRFs. CMS stated in the Proposed Rule for the FY 2010 IRF PPS, it "recognize[s] the importance of the professional judgment of a rehabilitation physician in the review of the preadmission screen at the time an admission decision is made." 74 Fed. Reg. 21,052, 21,070 (May 6, 2009).

The Draft LCD appears to circumvent the expertise and judgment of rehabilitation physicians and the interdisciplinary team, which includes occupational therapists, by denying IRF coverage for patients based on diagnosis alone. There must be allowances for unique characteristics or situations so that each patient's determination is individualized.

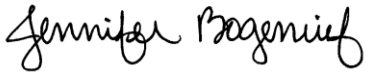
III. The Draft LCD Constitutes A Prohibited "Rule of Thumb"

It is a well-known that Medicare coverage policy prohibits the use of "rules of thumb" when determining coverage for given cases. As CMS noted in the Final Rule for the FY 2010 IRF PPS, "rules of thumb cannot serve as the basis of a coverage denial." 74 Fed. Reg. at 39,794. However, the Draft LCD is a "rule of thumb" because it would deny coverage for all non-comorbid joint replacement cases seeking to be admitted in IRFs, without regard to any other factors, such as an individual patient's medical or rehabilitative needs or the rehabilitation physician's professional judgment. This blanket policy would end IRF referrals and admissions for all non-comorbid joint replacement cases. Intensive medical rehabilitation provided by an IRF would no longer be an option for an entire class of Medicare beneficiaries based solely on their diagnosis.

The Draft LCD should be rescinded and withdrawn for the above reasons.

Thank you for the opportunity to comment on the Draft LCD. If you have any questions or wish to discuss our comments, please contact me at 301-652-6611 or jbogenrief@aota.org.

Sincerely,



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