CENTERS FOR MEDICARE & MEDICAID SERVICES
Special Open Door Forum:
Inpatient Rehabilitation Facility Tier Comorbidity Updates:
Soliciting Stakeholder Input
Moderator: Jill Darling
June 16, 2016
2:00 p.m. ET

Operator: Good afternoon. My name is Shannon and I will be your conference operator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum, Inpatient Rehabilitation Facility Tier Comorbidity Update Soliciting Stakeholder Input.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question at this time, you may press star followed by the number one on your telephone keypad. To withdraw your question, you may press the pound key.

It is now my pleasure to turn today's call over to Ms. Jill Darling. Ms. Darling, you may begin your conference.

Jill Darling: Thank you Shannon. Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communications. We appreciate your patience as always on all these open door forum calls and special open door forum calls as we do tend, you know, try to get as many people in as we can prior to the start of the call. So we appreciate your patience, again.

One brief announcement is this special open door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have inquiries, please contact us at press@cms.hhs.gov.

Now, I hand the call over to Gwen Johnson.

Gwen Johnson: Thank you, Jill. Once again, my name is Gwen Johnson. I work at CMS in the – with the IRF team and I would be leading the tier comorbidity updates project and welcome you all to this special open door forum.

I would like to thank everyone for joining us today to provide comments and suggestions on the tier comorbidities portion of the IRF PPS. I would also like to thank those providers who have submitted feedback through our IRF coverage mailbox. Incidentally, the e-mail address for the IRF coverage mailbox is listed on slide six of this today's presentation slide if you should not have the slide before you at this moment.

Before beginning with the brief introduction and then getting your feedback, I like first – I first like to introduce my colleagues who are in the room with me. If we could, could I have my colleagues to introduce themselves? Let's start with Todd.

Todd Smith: Hello, everyone. My name is Todd Smith. I'm the Acting Director of the Division of Institutional Post Acute Care.

Susanne Seagrave: And I'm Susanne Seagrave. I'm the Acting Deputy Director of Division of Institutional Post Acute Care.

Female: This is Catie Kraemer. I'm on the IRF team as well.

Gwen Johnson: OK, thank you very much. Because we will – we want to hear from you, I have just a short presentation before we open up the line. The slides that I will be using are located on the data files page on the IRF Web site, should you not have them before you now.

Let's start with slide two. The purpose of today's conference call is to allow IRFs and other stakeholders a chance to provide input and suggestions to CMS regarding the areas of most concern or interest for updating the tier comorbidity portion of the IRF PPS.

Next, slide three provides a short background on the tier comorbidities. Under the IRF PPS, Medicare patient cases are grouped into Rehabilitation Impairment Group Categories – Impairment Categories, pardon me, that's Rehabilitation Impairment Categories or RICs. RIC's represent the primary reason a patient would receive intensive inpatient rehabilitation care.

Cases are further grouped into case-mix groups or CMGs, which group similar cases according to age, motor, and cognitive scores.

Within each CMG, cases are grouped into one of four tiers based on the presence of certain comorbidities that have been found to increase the cost of care. As you can see, comorbidities are defined as conditions that are secondary to the principal diagnosis or reason for intensive rehabilitation care.

Each comorbidity tier adds a successively higher payment to the case where the lowest tier would be no additional payment through Tier 1, which would be the highest payment. Moving on to slide four.

We are working with Acumen on this project, who is assisting us with research and analysis of the tier comorbidities. Last time, this list was updated was roughly 10 years ago in 2006 and then again in 2007. Because we want to take into accounts stakeholders concerns we are seeking your feedback on this call and through the IRF coverage mailbox.

At this time, I would like to mention that we would continue to take comments through the IRF coverage mailbox regarding the tier comorbidity update until September 30th, 2016. That's September 30th of this year. Moving on to slide five.

For those unfamiliar with the list – so this is tier comorbidities contains the ICD-10 diagnosis codes, code labels, the appropriate tier in any RIC's for which the codes are excluded from the tiers. The location of the list on the Web site is indicated here on the slide and it is indicated at what this URL.

On the last slide, we have listed the e-mail address for IRF coverage mailbox and the URL for the IRF PPS Web site. As I mentioned earlier, stakeholder

feedback may be send to the mailbox, the IRF coverage mailbox until September 30th. Thank you.

And at this time we are ready for calls.

Jill Darling: (Shannon) will open our Q&A, please.

Operator: At this time, I would like to remind everyone in order to ask a question please press star, one in your telephone. We'll pause to compile the Q&A roster.

At this time, I would like to remind everyone in order to ask a question please press star, one in your telephone. We'll pause to compile the Q&A roster.

Your first question comes from the line of (Carolyn Zollar). Your line is open.

(Carolyn Zollar): Hi, Gwen. Hello to the rehab team and thank you for undertaking this examination of the tier comorbidities.

We know that I believe in the slide (like since) that Acumen LLC will be your contractor working with you on doing this examination. And I was wondering if you could describe to us how you intend to undertake this analysis in terms of looking at the tier comorbidities and what financial data you'll be using to do that as well.

Susanne Seagrave: Hi, (Carolyn). This is Susanne. I'm not sure what you mean by what financial data we'll be using. We're going to be looking at all of the administrative data that we have available on the Medicare program, the IRF claims data, the IRF cost report data, the IRF–PAI data, that is the patient assessment instrument, IRF-PAI patient assessment instrument data as well as, you know, we also tend to typically use other administrative data we have available like other claims data, i.e. possibly, you know, prior hospital data and that kind of thing.

So, that – and, you know, we're going to do sort of – I mean, if you look back to the 2006 analysis that we've done by RAND to update the tier comorbidity

back in 2006. So I think that gives a good starting point for looking at the type of analysis we're going to do now.

(Carolyn Zollar): OK. So that was part of my inquiries if you are going to replicate the prior analysis. I felt that you clearly had to be able to get into the claims data or charge data. And the – following up on that would be my question of what I assume you're looking at the ICD-10 coding, I think there was a reference to having, you know, six months of data available at this point, but perhaps more. And then if you're matching that to claims data that matches the same time period.

Susanne Seagrave: We are going to be looking at ICD-10 data exclusively. I mean, it doesn't make sense to go back and look at ICD-9 data because that's not use anymore.

(Carolyn Zollar): Yes, right.

Susanne Seagrave: So we'll be looking at ICD-10 data exclusively and we will, you know, we'll be looking at it as it comes in.

Operator: Your next question comes from the line (Mary Hubert) from Ohio State University. Your line is open, please go ahead.

(Mary Hubert): This is in regards to adding hemipelvectomy and hip disarticulation for possibility of a tier item. We suggest adding hemipelvectomy and hip disarticulation codes as tier comorbidities for all RIC's including amputation.

Currently, those patients are coded as an above the knee amputation, which is not adequately describe the resources and time required to address the additional challenges these patients have with balance, mobility, skin and wound issues, drains, skin flaps, seeding and positing, unique emotional needs and higher than average pain experiences.

Furthermore, many of these patients are oncology patients who require an increase level of medical and nursing monitoring in palliative care as compare to a patient with an above knee amputation that is related to vascular disease. For these reasons, we suggest adding hemipelvectomy and hip disarticulation

codes as tier comorbidities for all RICs including the amputation RIC. Thank you.

Gwen Johnson: Thank you.

Operator: Your next question comes from the line of (Renee Dorsal) from Ohio State University. Your line is open, please go ahead.

(Renee Dorsal): Hi, there. We continue to suggest the needs at any active cancer diagnosis such as malignant neoplasm or neoplasm of uncertain or unspecified behaviors to the tier comorbidity list.

Advances in care of oncology patients has created our new non-traumatic group of rehab patients for the IRF to care for and many of our referring sources understand the great benefit that we can provide these patients. So these people are being admitted to rehab facilities in growing numbers.

The oncology patients have functional impairments resulting from their disease or the treatments of their disease and they represent a unique subset of patients who are obscured across the number of different impairment categories.

However, they all share much higher acuity due to their medically complex conditions that are secondary to, you know, let say their brain injuries, stroke, amputation. They could have, you know, non-traumatic spinal cord injury, neuro-condition stability, et cetera.

And we believe that there is a higher cost of care in many special considerations associated with things like hematological monitoring, blood and blood product transfusions, additional testing, patient specific factor, such as cancer fatigue and pain.

Patients receiving chemo and radiation during rehab require more resources due to the types of drugs, procedures, factors; associated with their nausea, vomiting, fatigue. Certain chemo drugs required administration by specialty staff and medication exposure precautions.

So we would like you to please consider recognizing active cancer patients in rehab as a higher acuity patient through the tier comorbidity list. Thank you.

Gwen Johnson: Thank you, (Renee).

Operator: Your next question comes from the line of (Michael N. Parks) from HCA. Your line is open, please go ahead.

(Kris Webb): Hello, this is (Kris Webb). I'm here with the group with (Michael N.). And my question is in reference to your tuberculosis patients not just for the tier comorbidity listing, but also for the presumptive compliance list.

For many years I've wondered why the tuberculosis diagnoses were so, you know, were represented in such a large way with – in my now almost 32 years of clinical practice I've rarely seen a TB patient in a rehab environment and wonders what your case reviews have shown as far as continuing to carry all of the TB codes.

Susanne Seagrave: Hi, this is Susanne. Just respond to that, quickly. We don't have that data in front of us right now. We're really looking for stakeholder input on this call, but we will definitely take your concerns or suggestions into advisement, under advisement when we do this research, so thank you for your input.

Operator: Your next question comes from the line of (Rebecca Hample) from Ohio State Western. Your line is open, please go ahead.

(Rebecca Hample): Hello. We agree with the inclusion of morbid obesity at the Tier 2 comorbidity but suggest that patients with the BMI of 50 or higher to be classified in a Tier 1 category. These patients are often good rehab candidates, but a Tier 2 designation underestimates their resource use.

They should be considered for Tier 1 classification due to acquisition of specialized equipment, greater challenges with skin integrity and everyday difficulties with basic ADLs and toileting that require multiple staff members.

The needs for additional staff members to provide nursing care and therapy treatment due to patient size could be better accounted for if these patients were classified within a Tier 1 comorbidity level. Thank you.

Operator: Your next question or comment comes from the line of (Joan Dicmer) from Helen Hayes Hospital. Your line is open, please go ahead.

(Joan Dicmer): Hi. We were hoping that CMS would consider a increase reimbursement for patients who present with a combination of tier comorbidity codes. Currently, the way the tier comorbidities work is that the highest comorbid conditions trumps all the other conditions.

So you could actually have a patient who is straight and then have some other two or three comorbid conditions that are still impacting the care of the patient that require additional resources and you're only being reimbursed for one tier – comorbid condition.

So we were hoping that CMS would do some consideration to a combination tier comorbidity code or something to that effect, perhaps similar to the DRG Decision Tree that currently exists in acute care. Thank you.

Operator: You next question or comment comes from the line of (Albert Escuancy) from (Moss Rehabilitation Time). Your line is open, please go ahead.

(Albert Escuancy): Thank you. Good afternoon. This relates to three small areas, small in the number of patients. One is that those patients that have ventricular assist devices and require rehabilitation.

One is patients with transplantation who require additional medications and finally a new challenge those patients that have viral related transverse myelitis secondary to things like Zika virus if those should be consider in a special category. Thank you.

Operator: Your next question or comment comes from the line of (Mary Hubert) from Ohio State University. Your line is open, please go ahead.

(Mary Hubert): We feel that any diagnosis of neglect such neurological neglect, hemispatial, sensory or visual neglect should be included as tier comorbidity for any impairment category. These diagnoses heavily impact a patient's recovery by causing additional challenges due to a patient's inability to be aware of one side of his or her body.

These causes difficulties with balance, transfers ADLs and safety considerations. These patients can be impulsive and often lack insight into their deficits. They have difficulty comprehending the cues that are provided and require additional therapy sessions and nursing carry over to learn to attend to their neglected side.

The evidence based review of strict rehab literature describes the presence of unilateral spatial neglect to be associated with longer lengths of stay and slower rate of improvement.

Clinically, this patient show significant safety deficits affecting their independence with ADLs, transfers, gait, stair climbing, wheelchair mobility, et cetera, requiring longer length of stay to advance their progress towards manageable levels of care at discharge. Thank you.

Operator: Your next question comes from the line of (Renee Dorsal) from Ohio State University. Your line is open, please go ahead.

(Renee Dorsal): Hi there. We would like you to please include diagnosis in the list that describes chronic neurological or neuromuscular diseases as tier comorbidities outside of (RIC6), the neurological conditions.

For example, a patient with multiple sclerosis could have an accident, injury or illness that's not related to their M.S. nor causing an M.S. exacerbation with their pre-existing conditions of fatigue~~s~~, spasticity, balance, cognition, et cetera are going to create additional challenges during the rehab program.

Patients with the neurological disease that admit to rehab for injuries or illness is not related to their existing neurological disease will require a longer and more extensive rehab program to address those additional problem. Thank you.

Operator: Your next question or comment comes from the line of Richard Kathrins from Bacharach Rehab. Your line is open, please go ahead.

Richard Kathrins: Thank you. During an early RAND study, I guess way back in 2002-2003 there was a discussion on the possibility outcomes including preventable conditions such as UTI, chronic, skin ulcers, osteomyelitis and others. And during the top that was reported in the RAND study that these conditions cause from 10 percent to 15 percent more than otherwise similar case without these conditions. I'm hoping that you might consider looking at this grouping again for inclusion as comorbidities. Thank you very much.

Gwen Johnson: OK, thank you.

Operator: Your next question or comment comes from the line of (John Veralou) from Rehab Coding Service. Your line is open, please go ahead.

(John Veralou): Hello, thank you. My question is about morbid obesity. Of course, morbid obesity is on the tier comorbidity list. However, the patient is morbidly obese and there's also diagnosed with (inaudible) (hyperstimulation) as a combination code in ICD-10 that is not included on a tier comorbidity list and we're like that to be considered.

Operator: Your next question or comment comes from the line of (Carolyn Zollar) from AMRPA. Your line is open, please go ahead.

(Carolyn Zollar): Yes. So I notice that comorbidities are now collected from item 24, but then there's complications that are collected from item 47. We are wondering if there's anyway to look at the second grouping, the items that come in from item 47 because, again, if these conditions occur during the rehab stay or may have occurred outside of what's consider the scope of one admission as define. They add cost to the treatment of the cases and I didn't know if you're going to look at those as well.

Gwen Johnson: Certainly, thank you for pointing that out.

Operator: Your next comment comes from the line of (Rebecca Hample) from Ohio State Western. Your line is open, please go ahead.

(Rebecca Hample): Hello. We agree with the inclusion of (P.E.s) as a tier comorbidity and request that DVTs of extremities are also included. These patients require close medication management and titration based upon blood draws for anticoagulation levels. They have activity restrictions and procedures for filter placement to prevent a DVT transitioning to a life threatening (feed).

We believe the addition of DVTs extremities as adhered comorbidity will account for the time and resources required to care for these patients in rehab to facilitate keeping the patient in the most appropriate setting. Thank you.

Operator: Your next question comes from the line of (Martha Ramirez) from Del Sol Inpatient. Your line is open, please go ahead.

(Martha Ramirez): Yes. I just agree with the comment that we just hear about the including acute pulmonary embolism. We do have it. I see that in the list, in the current list of tier comorbidities. You have chronic pulmonary embolism, but I think it would be appropriate to include the acute pulmonary embolism because at times of patient requires consultation with hematology to followup on the anticoagulation.

Operator: Your next question comes from the line of (Rebecca Hample). Your line is open, please go ahead.

(Rebecca Hample): Hi. We recommend adding any diagnosis related to blindness or visual disturbances as a tier comorbidity. This will allow for the capture of the complexity related to rehabilitating a patient that cannot adequately see.

Vision is an adult primary balance system, therefore, patients with visual problems require more therapy services to develop and master compensatory balance systems to improve independence with all transfer gate and self-care. Thank you.

Operator: Your next comment comes from the line of (Renee Dorsal) from Ohio State University. Your line is open, please go ahead.

(Renee Dorsal): Hi there. I just wanted to support the comment that was made by the other individual who suggested somehow capturing cumulative comorbidities. You know, for example if somebody has a Tier 1 for a trach but they also have a Tier 2 or a Tier 3, those are not captured because it goes, you know, directly to that Tier 1.

But the example that we wanted to share was, you know, for example a patient could have diastolic heart failure, cellulitis and diabetic neuropathy but this person is only going to be classified within the Tier 3 comorbidity level. And we feel this designation underestimates the complexity that more than one tiered comorbidity produces.

So we would suggest the need for additional acuity capture of patients who have more than one tiered comorbidity within the same level or amongst the three levels. Thank you.

Jill Darling: Sure.

Operator: Your next question comes from the line of (Mary Hubert) from Ohio State University. Your line is open, please go ahead.

(Mary Hubert): Hello. Many people with MRDD or other intellectual disabilities are living with family or in a group home. It could present to rehab after accidents, injuries or chronic disease.

These people deserve to have access to in-patient rehab to improve their function enough to return to their family's home or their group home settings. These patients require more resources due to challenges with cognition, impulsivity, reduced insight into new impairments and safety concerns.

We suggest adding MRDD, developmental delays or any other intellectual disability as a tiered comorbidity. Thank you.

Operator: Your next question comes from the line of (Albert Escuancy) from (MossRehab Prime). Your line is open, please go ahead.

(Albert Escuancy): Thank you again good afternoon. We want to suggest for consideration deafness as a comorbid condition that needs to be consider in tiering. So it usually requires having the availability of translators to help with the care of these individuals who may have other disabilities. Thank you.

Operator: Your next comment comes from the line of (Michael N. Parks) from HCA. Your line is open, please go ahead.

(Kris Webb): Hello, this is (Kris) again and I have two questions. Number one is request for consideration of patients with polypharmacy. Patients who are – been attended to and administering 10, 12, 15 different medications requires not only nursing care and time but also the various modes of administration that this multiple meds are being administered to these patients especially our dysphasia patients.

The amount of interaction and monitoring for drug to drug interaction, renal clearance and other type of management on the part of the nursing and medical staff and then also with patients with polypharmacy, the patient education and review of financial impact to the patient prior to their discharge.

We've seen in the past that patients that have polypharmacy issues and concerns have contributed to high readmission rates and it would be helpful to be given some additional compensation or consideration for these types of patients that require that additional time.

And then my last question is in reference to your plan implementation for the exchanges should they occur.

Susanne Seagrave: Hi, this is Susanne. We were in the very, very early stages of this and we don't yet have a planned implementation time for this.

Operator: Your next question comes from the line of (Renee Dorsal) from Ohio State University. Your line is open, please go ahead.

(Renee Dorsal): Hi there. We support the previous commenter in her concerns with the polypharmacy patients and the resources required to care for them. And to kind of piggyback onto that, we suggest adding to the tiered comorbidity list

patients who have had solid organ transplant, stem cell transplant or bone marrow transplants because they require more resources for care related to their conditions of immunosuppression, viral loads, anti rejection medications and medical fragility.

Please consider adding any transplant status as a tiered comorbidity. Thank you.

Operator: Your next comment comes from the line of (Mary Hubert) from Ohio State University. Your line is open, please go ahead.

(Mary Hubert): Hello. We believe that patient with an implantable heart assist device for example an LVAD have special needs that represent a higher acuity in rehab.

A patient with this device requires machine-related testing, close lab monitoring and are at an increased risk for bleeding. They are often on heparin drips with a bridge to Coumadin requiring close nursing and medical supervision.

These patients have special activity considerations due to endurance issues and require additional education for device management and dressing changes. Thank you.

Operator: Your next question or comment comes from the line of (Lisa Mossier) from Virginia Baptist. Your line is open, please go ahead. (Lisa Mossier), your line is open, please go ahead.

(Lisa Mossier): Yes, yes, I'm sorry. Yes we'd like a consideration of patients use for sitters to be a tiered item. Since (falls) are basically now a quality measure required, they're not desired or actually penalized.

Yes, we can't require families to keep supervision on patients who require this impulsivity and it's obviously very growing in patient rehab with patients who are trying to get more mobile.

So we'd like that consideration be done at four tier. Thank you.

Operator: Your next question or comment comes from the line of (Rebecca Hudson) from Ohio State Western. Your line is open, please go ahead.

(Rebecca Hudson): Hello. An anoxic brain injury in addition to a traumatic brain injury represents two distinct injuries creating a more complex set of rehab problems than just a traumatic brain injury or anoxic injury alone.

We believe it's a combination of these injuries results in more complicated behaviors and emotional regulation that requires additional services. There are extra considerations of medication trial, multiple staff for safety and behavior management, extensive memory issues, visual problems and spasticity that usually results in longer lengths of stay and extensive family training.

These all increases the cost of care and complicates discharge planning factors. Please revise the comorbidity list to not exclude G93.1 from the RIC to the traumatic brain injury. Thank you.

Operator: Your next question or comment comes from the line of (Albert Escuancy) from (MossRehab Prime). Your line is open, please go ahead.

Female: Yes, good afternoon. We would like a consideration for individuals who exhibit significant behavior issues that require additional pharmacological intervention and also require extensive nursing and team management to identify areas of least restrictive measures where we're not able to use restraints or in the unfortunate case where we need to use some type of restraint, where we are required to intervene and de-escalate individuals every two hours, and to attempt to remove that device and keep them off the device.

We would like those issues to be considered. Thank you.

Operator: I would take this moment to remind our participants that if they have a question or comment you may press star followed by the number one on their telephone keypad.

Your next question or comment comes from the line of (Carrie Morella) from Alexian Brothers. Your line is open, please go ahead.

(Carrie Morella): Hi, thank you very much. We just wanted to express support, I think it was mentioned earlier something briefly about chronic skin ulcers. We would like to support as well, looking at the skin ulcer issue, wound care is a significant cause often at facilities that take these patients and we would like to have them considered to be added to the tiering list. Thank you.

Operator: Your next question or comment comes from the line of (Mary Hubert) from Ohio State University. Your line is open, please go ahead.

(Mary Hubert): Hello. We would the consideration of addition of BPPV or vertigo related symptoms. Normally this interferes with the ability to rehab a patient due to nausea, sometimes even (MSS) and affects all of their movement within their rehab stay. Thank you.

Operator: There are no additional questions on the phone lines at this time. I would return the call to the presenters.

Male: If there are no other questions we really did appreciate hearing from you. It's really a big help. And we'll certainly take this information into consideration during our analysis. And have a wonderful afternoon.

Operator: This concludes today's conference call you may now disconnect.

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