September 16, 2004

Mr. Robert C. Kuhl
Director
Division of Institutional Post Acute Care
Chronic Care Policy Group
Center for Medicare Management
Mail Stop C5-06-27
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 20041

Dear Bob:

I am writing this letter on behalf of the organizations identified above in regard to Transmittal 221 issued by the Centers for Medicare & Medicaid Services (CMS) on June 25, which pertains to implementation of the final rule on the classification of inpatient rehabilitation facilities (IRFs), popularly known as the 75% Rule. We have numerous questions about the rule that need clarification. While we appreciate the productive dialogue we have had with Pete Diaz and James Bowman, M.D. of CMS' staff, we request that these questions be clarified by CMS in writing and that such clarification be disseminated to inpatient rehabilitation facilities and the Medicare fiscal intermediaries.

The undersigned organizations would like CMS to address the following technical questions. These questions are in addition to the implementation concerns communicated in our July 29 letter sent to CMS Administrator, Mark McClellan, M.D.

A. Rehabilitation Impairment Group Codes and Etiologic and Comorbidity Columns

We understand that patients will be considered presumptively eligible if they fall within one of the IGC codes listed. We understand further that if patients do not fall within one of the IGCs codes listed, that they may be considered presumptively eligible to be within the threshold (for the first three years) if they have an Etiologic Diagnosis or comorbidity that meets the codes listed in the column titled "ICD-9-CM Codes." Further compliance would be dependent on meetingany of the other caveats or conditions mentioned for the various conditions in the final rule. Please confirm this understanding.

B. Rehabilitation Impairment Group Codes (IGCs)

We have reviewed the IGCs listed by condition. There is quite a bit of confusion and concern that they do not, in all instances, match with the IGC codes listed in the IRF Patient

Assessment Instrument (PAI) Manual. Specifically, we would like CMS to address the following questions:

1. Why were certain IGCs excluded?
2. Why were etiologic diagnoses (ED), that are usually associated with those IGCs excluded?

1. Excluded IGC Codes

We believe the following IGCs were mistakenly excluded. We feel the following IGCs should be included in the list of Rehabilitation Impairment Codes in Transmittal 221. They are:

02.9 Other Brain (brain injury)

03.3 Polyneuropathy (neurologic conditions). We are disturbed that polyneuropathy and Guillian-Barré are missing from the neurologic conditions since the text of the 75% Rule makes specific mention of polyneuropathy. It is a frequent problem for many rehabilitation patients, such as those with diabetic polyneuropathy (357.2). Does the statement under neurological disorders "for others, use diagnoses" include them?

03.4 Guillian-Barré Syndrome (neurologic conditions)

05.5 Bilateral lower limb above the knee (AK/AK) (amputation). This omission seems particularly puzzling since these patients would need considerable rehabilitation for their stumps and for working with prostheses and amputation.

05.9 Other Amputation (amputation)

08.02 Fracture of the femur shaft (hip fracture). We are particularly concerned that fracture of femur shaft is omitted since the text of the 75% Rule says fracture of femur.

08.3 Status post pelvic fracture (hip fracture)

08.4 Post major multiple fractures

08.9 Other Orthopedic

Additionally the condition regarding severe or advanced osteoarthritis does not have an IGC code related to it. Without regard to the number of joints required, it would seem to make sense to list IGC code 06.2. What was the rationale for excluding it?

Finally, the joint replacement Rehabilitation Impairment Group Codes, 08.51, 08.61, 08.71, should be added to joint replacements and tied to the Body Mass Index equaling or exceeding 50 just as they are tied to the age of equal to or greater than 85 in the Transmittal.

2. Excluded Etiologic Diagnoses

We note also that some etiologic diagnoses usually included with the specific EDs from the IRF PAI for the specific IGCs were not included. We believe these EDs should be added. From our review they are:

IGC	ED
02.1: Brain Injury	Alzheimer's Disease (331.0), senile degeneration of the brain (331.2) and Other benign neoplasm of connective

	and other soft tumor of the head, face and neck (215.0)
04.110-04-130, 04.210-04.230: Spinal Cord Injury	723.0, 724.00, 724.01, 724.02, 724.09 - Why are spinal stenosis (cervical and not) (723.0-724.00-724.09), as well as injury to nerve roots and the spinal plexus (953.0-953.8) excluded when they are included in the IRF-PAI?
05.4: Amputation Below the Knee	896.0-3 – Traumatic amputation of the foot
06.9: Other Arthritis	710.1 – Diffuse diseases of connective tissue, Systemic, sclerosis 711.0x – Arthropathy associated with infection, Pyogenic arthritis 716.xx-716.99 – Other and unspecified arthropathies

With respect to other codes, we have the following comments:

a. 14.9 - Other Multiple Trauma
Under multiple major trauma (MMT), other multiple trauma does not include fractures of the pelvis. We think it would make sense to include this condition when coupled with other trauma codes. These would include: 808.2 – Fracture of Pelvis Pubis, Closed; 808.3 – Fracture of Pelvis Pubis, Open; 808.59 – Fracture of pelvis, Other specified part, open, Other; 808.8 – Fracture of pelvis, unspecified, closed; 808.9 – Fracture of pelvis, unspecified, open.

b. Kaschin-Beck
We understand that the various codes for Kaschin Beck disease may be inappropriate because the disease is usually found in children, and usually outside the U.S.

c. Other Exclusions
We are concerned about exclusion of the following conditions and codes:
   i. Under Rheumatoid Arthritis – Why is systemic sclerosis excluded as well as pyogenic arthritis and a series of other and unspecified arthropathies?
   ii. With respect to systemic vasculidities we raise the same question regarding systemic sclerosis (710.0). Since the exclusions for rheumatoid arthritis and systemic vasculidities are similar, how will the fiscal intermediary (FI) determine into which conditions the case falls?

d. ICD-9-CM List
In several instances a typical code is not included in the IGC (Guillian-Barré) or it is specifically excluded (foot amputations) but appears under the ICD-9-CM column. What is the rationale here?

3. Additional Comments on New Conditions

a. Seronegative Arthropathies
Seronegative arthropathies is too broad a category to assign one specific code. Specific conditions within the category of seronegative arthritis include ankylosing

spondylitis (720.0), Reiter's syndrome (099.3 and 711.1x), psoriatic arthritis (696.0), and gout (274.0). We suggest a list of these codes be added to the IGC column as EDs to establish the specific types of seronegative arthropathies to be counted under the 75% Rule.

b. Systemic Vasculidities with Joint Inflammation
Systemic vasculidities is also too broad a category for one code. Specific systemic vasculidities that should be articulated in Transmittal 221 are: systemic vasculidities (447.6), systemic lupus erthythematosus (710.0). Wegener's Granulomatosis (446.4), polyangitis (466.0), Churg-Strauss disease (446.4). We suggest that this list of codes be added to the conditions that count towards the 75% Rule or that CMS explain why they do not.

C. General Coding Comments

We also ask CMS to address the following issues:

1. Invalid Codes
Codes 715.02, 715.05 and 715.06 listed under Osteoarthritis are invalid. Other codes such as 715.91, 715.92, 715.95, 715.96 and 716.91, 716.92, 716.95 and 716.96 should be added in their place.

2. Fifth Digit
Some codes are missing the required fifth digit, such as codes 337.8, 358.0, and 359.8 under Neurological Disorders, as well as other codes (714.3, 214, 806.0, 438.4, etc). Does this mean that every code assigned in the code category listed (i.e. 714.3: 714.30-714.33) is included in the list? Example: Does Code 952.IX include 951.10 - 952.19? Will CMS be correcting this? If so, until then should providers assume that all fifth digits for a particular code are valid?

3. Header Codes
In addition, there are numerous header codes listed in the ICD-9-CM column. Does this mean all codes under headers are included? If not, only the included codes should be listed. These include, for example:

IGC	Code
Hip Fracture	820.1 – Fracture of pelvis Acetabulum, closed
MMT	828 – Multiple fractures involving both lower limbs, lower with upper limp, & lower limp(s) with rib(s) & sternum Closed
Neurological	357 – Inflammatory & toxic neuropathy
Rheumatoid	714.3 – Rheumatoid arthritis & other inflammatory
	714.8 – Rheumatoid arthritis & other inflammatory polyarthropathies Other specified inflammatory polyarthropathies
Spinal Cord	344.6 – Other paralytic syndromes Quadriplegia & quadriparesis, Cauda equina syndrome

	721.4 – Spondylosis & allied disorders, Thoracic or lumbar spondylosis with myelopathy
	806.0 – Fracture of vertebral column with spinal cord injury Cervical, closed
	839.3 – Other, multiple, & ill-defined dislocations Thoracic & lumber vertebra, open
	806.1 – Fracture of vertebral column with spinal cord injury Cervical, open
	806.2 – Fracture of vertebral column with spinal cord injury Dorsal [thoracic], closed
	806.3 – Fracture of vertebral column with spinal cord injury Dorsal [thoracic], open
	806.6 – Fracture of vertebral column with spinal cord Injury Sacrum & coccyx, closed
	806.7 – Fracture of vertebral column with spinal cord Injury Sacrum & coccyx, open
	839.0 – Other, multiple, & ill-defined dislocations, Cervical vertebra, close, Cervical vertebra, unspecified
	839.1 – Other, multiple, & ill-defined dislocations, Cervical vertebra, open
	839.2 – Other, multiple, & ill-defined dislocations, Thoracic & lumbar vertebra, closed
Stroke	438.2 – Late effects of cerebrovascular disease Hemiplegia/ hemiparesis
	438.3 – Late effects of cerebrovascular disease Monoplegia of upper limb
	438.4 – Late effects of cerebrovascular disease Monoplegia of lower limb
	438.5 – Late effects of cerebrovascular disease, Other paralytic syndrome

4. The ICD-9 codes listed in the Osteoarthritis section are codes that specify osteoarthritis of individual sites only (i.e., hip, shoulder, etc.). The multiple site codes for osteoarthritis and other and unspecified arthritis codes, with a fifth digit of 9 for multiple sites, are not listed in this section. Therefore, when coding a patient that has osteoarthritis/arthritis of multiple sites, would it be appropriate to assign a code for osteoarthritis/arthritis for each individual site or assign one osteoarthritis/arthritis code with a fifth digit of 9 for multiple sites? Example: For a patient with osteoarthritis of the hip and knee, should he or she be assigned a code for osteoarthritis, multiple sites or would codes 715.95 (hip) and 715.96 (knee) be assigned for the hip and knee separately?

5. Should the comorbidities coded on the IRF-PAI form be listed in any certain order/sequence? Should the comorbidity that caused the most significant decline be listed first in the comorbidity section?

6. Code 713.0 through 713.8 are listed in the Rheumatoid Arthritis section. These codes are secondary codes. The code for the underlying disease is always coded first according to the ICD-9 code book. Are these codes listed correctly in this section?

D. Etiologic and Comorbidity Codes

We have also reviewed this column in some depth and have several questions.

1. If there are no changes by year four under the final rule, will patients who have comorbidity codes in Item 24 of the IRF-PAI continue to be able to be considered to be presumptively in compliance? Will patients who have an etiologic diagnosis in Item # 22 continue to be able to be considered to be presumptively in compliance?

2. Will the FIs only scan the etiologic diagnosis (IRF PAI item number 22) or will they also scan IRF PAI item 24, the comorbid conditions in reviewing cases for presumptive compliance?

3. We recommend that the following codes be added:
    a. 348.3 Nontraumatic Brain Injury (NTBI)/Encephalopathy NOS: the ICD-9 code of 348.3.
    b. 357.2 Polyneuropathy/Polyneuropathy in Diabetes.
    c. 355.8 Other Neuro/Mononeuritis of lower limb.

4. Codes 430, 432.0, 432.1 and 432.9 related to brain hemorrhages are usually found under the stroke IGCs. What was the rationale for listing them under Brain Injury as well?

5. The 850.x codes include eight codes but only three are listed? We believe all eight should be listed.

6. With respect to burns, we recommend adding those more severe than third degree burns as well as second-degree burns.

7. The cerebral palsy codes are listed under congenital deformities and are usually considered neurological conditions (although in reality it can occur at birth). Please clarify the intent of including them here as well. Perhaps these codes should be listed under both categories.

8. The multiple fracture codes listed are inconsistent with the ICD-9-CM *Official Guidelines for Coding and Reporting* which are part of the Health Insurance and Portability and Accountability Act (HIPAA) electronic transaction standards. According to these guidelines: "Fractures of specified sites are coded individually by site in accordance with both the provisions with categories 800-829 and the level of detail furnished by medical record content. Combination categories for multiple fractures are provided for use when there is insufficient detail in the medical record (such as trauma cases transferred from another hospital), when the reporting form limits the number of codes that can be used in reporting pertinent clinical data, or when there is insufficient specificity at the fourth-digit or fifth-digit level." In addition, the same coding guidelines

clarify "Multiple fracture categories 819 and 828 classify bilateral fractures of both upper limbs (819) and both lower limbs (828), but without any detail at the fourth digit level other than open and closed type of fractures."

9. With respect to spinal cord injuries, we recommend adding the following missing codes in the 806.xx list:

    - 806.04 -- C1-C4 level fracture of vertebral column with other specified spinal cord injury since all of the other 806.0x codes are included.
    - 806.8 -- Closed Fracture of vertebral column with spinal cord injury, unspecified site; and
    - 806.9 Open Fracture of vertebral column with spinal cord injury, unspecified site since all 806 categories by specific site are included.

If you have any questions about this letter, please contact Carolyn Zollar at AMRPA (888-346-4624 or czollar@13x.com) or Nelly Leon-Chisen at AHA (312-422-3396 or nleon@aha.org).

Sincerely,

Carolyn C. Zollar, J.D.
Vice President for Government Relations and Policy Development
American Medical Rehabilitation Providers Association on behalf of the

American Academy of Physical Medicine and Rehabilitation
American Hospital Association
American Medical Rehabilitation Providers Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Federation of American Hospitals

Cc: Pete Diaz, CMS
Laurence Wilson, CMS