American Hospital Association

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August 10, 2006

Ellen Evans, M.D.
Vice President and Medical Director
Mutual of Omaha Medicare
P.O. Box 1602
Omaha, NE 68101

Re: Draft Local Coverage Determination on Inpatient Rehabilitation Medical Necessity – Identification Number DL19890.

Dear Dr. Evans:

On behalf of our 4,800 member hospitals and health care systems, and our 35,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on Mutual of Omaha's June 28 draft Local Coverage Determination (LCD) concerning inpatient rehabilitation medical necessity.

The AHA is pleased that Mutual of Omaha met with numerous inpatient rehabilitation facilities (IRFs) to discuss the IRFs' concerns regarding enforcement of the current LCD, which took effect May 14, 2005. We are encouraged that you have re-evaluated the current LCD and, in an effort to improve the policy, have developed a new draft. In particular, the new section describing documentation requirements will help providers by clarifying expectations that go beyond current documentation practice. We applaud this effort and offer the following recommendations to further improve the LCD.

RECOGNIZE IRFS' SCOPE OF CARE AND THE PHYSICIAN'S ROLE

When considering medical necessity for IRF patients, it is important to note that inpatient rehabilitation patients receive coordinated, multidisciplinary care for both their medical condition *and* rehabilitation needs. This unique package of services is not generally found in any other health setting. In the "Abstract," "Regulatory Basis," "Indications" and "Criteria for Coverage" sections of the draft LCD, Mutual of Omaha should modify the language to recognize that an appropriate IRF admission is substantiated by a patient's need for medical oversight *in combination with* rehabilitation treatment, and that the physician has a supervisory role for both.

Further, the AHA supports strict adherence to the requirement that medical necessity determinations be based on individual case assessment, rather than on "diagnostic screens" or "rules of thumb." Therefore, we recommend that Mutual of Omaha state in the final LCD "Regulatory Basis" section that any denied claim must first be reviewed by a physician with experience in medical rehabilitation.

IMPROVEMENTS TO THE "CRITERIA FOR COVERAGE" SECTION

Because IRFs must comply with Medicare's conditions of participation for hospitals, the "Criteria for Coverage" section establishing that only licensed therapists may "provide therapy services covered by Medicare" should be made consistent with the existing Medicare guidelines on therapy practitioners.[1] The LCD should defer to the national criteria and existing state laws and regulations on qualified therapy personnel. In addition, before finalizing the LCD language in this section, we urge Mutual of Omaha to seek input from IRFs on how best to record therapy services in the medical chart. The final LCD should ensure accurate recording of therapy services provided and allow flexibility for providers. Today, Medicare Part B accepts therapy billed in 15-minute units while skilled nursing facilities bill actual minutes.

Under Item No. 1 in the "Criteria for Coverage" section, the draft LCD requires that the IRF base its admission decision on a negative standard – that the patient *cannot* be treated in a less-intensive setting. However, the logical and more-appropriate approach is for the decision to be based on the patient's clinical needs, the capacity of the IRF and the criteria in Section 110. If Mutual of Omaha proceeds with the negative standard, it must provide substantial clarification on how IRFs are to demonstrate in the chart that a patient cannot be treated in a less-intensive setting.

Item No. 5D in the "Criteria for Coverage" section regarding diagnoses that are "typically not covered" is an inappropriate "rule of thumb." It would encourage claims reviewers to adopt a bias against patients with the noted diagnoses, rather than considering each case on its individual merits. We urge Mutual of Omaha to strike this statement from the LCD and instead to guide claims reviewers to focus on determining medical necessity based on a case-by-case review, regardless of the diagnosis.

OTHER RECOMMENDATIONS

We encourage Mutual of Omaha to continue to promote dialogue with the inpatient rehabilitation field, as required in Chapter 13 of the Medicare Program Integrity Manual. We suggest you formally create a representative group of IRFs to provide Mutual of Omaha input on policy making and administrative processes. This type of dialogue has been very constructive with other fiscal intermediaries.

Chapter 13 also requires fiscal intermediaries to base LCDs "on the strongest evidence available." The AHA recommends that Mutual of Omaha incorporate the most recent medical literature into new drafts of the LCD.

[1] Title 42, Chapter IV, Part 482, Subpart D, Section 482.56: Condition of Participation for Hospitals – Rehabilitation Services.

Thank you for considering our comments and recommendations on the draft LCD. If you have any questions, please contact me or Rochelle Archuleta, senior associate director for policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

Rick Pollack
Executive Vice President