



**American Hospital  
Association**

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September 7, 2012

Greg McKinney, M.D.  
Medical Director  
Cahaba Government Benefit Administrators, LLC  
P.O. Box 13384  
Birmingham, AL 35202-3384

**Re: *Draft Local Coverage Determination DL32816. Surgery: IRF Admission after Single Joint Replacement with CMGs A0801-A0806.***

Dear Dr. McKinney:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on Cahaba's draft local coverage determination (LCD) DL32816; Surgery: IRF Admission after Single Joint Replacement with CMGs A0801-A0806.

This draft Cahaba LCD would narrow national Medicare coverage by categorically eliminating Medicare coverage for selected lower extremity joint replacement patients treated in inpatient rehabilitation facilities (IRF). Specifically, under this LCD, Cahaba would categorically deny Medicare payment for patients in IRF payment units A0801 through A0806.<sup>1</sup> This proposed restriction of coverage goes beyond the permissible limits of how Medicare administrative contractors (MACs) may use an LCD; therefore, **we urge Cahaba to rescind this draft LCD.**

National Coverage Standards for IRF Admission and Care. The national medical necessity law and guidelines for hospital, and specifically IRF care, are provided in statute, regulation and sub-regulatory guidance. Section 1862(a)(1)(A) of the *Social Security Act*, provides that Medicare Part A and Part B payment for hospital care is covered for items and services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Refined IRF coverage criteria were implemented in January 2010 in regulatory and companion manual provisions. Medicare regulations *42 CFR §§412.622(a)(3), (4), and (5)* establish patient admission, patient care and documentation standards that must be met for an IRF claim to be considered reasonable and necessary. And the companion provisions in Section 110 of the *Medicare Benefits Policy Manual* establish the following:



*The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.*

Section 110 lays out further clinical criteria that must be met for a patient to be admitted and treated in an IRF. In addition, Section 110 specifies that a patient's compliance with the IRF coverage provisions is to be based on a physician's assessment of each patient:

*Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs.*

Draft LCD Restricts National Coverage of IRF Services. The draft LCD would narrow national coverage policy for IRF services by prohibiting payment for a group of IRF patients based on the patient's diagnosis. Cahaba lacks the authority to unilaterally and proactively narrow national IRF coverage in this manner. The proposed categorical denial based on diagnosis prevents access to care for beneficiaries who otherwise meet Medicare medical necessity guidelines. Specifically, this proposed narrowing of IRF policy by Cahaba violates Chapter 13 of the *Medicare Program Integrity Manual*, which requires that all LCDs be consistent with national statutes, rulings, regulations, and coverage, payment and coding policies. In addition, LCDs are prohibited from restricting or conflicting with national coverage provisions – a standard that is clearly violated by the draft LCD.

Draft LCD Eliminates Physician Role in Determining Medical Necessity. The draft LCD's across-the-board denial of coverage based on diagnosis also ignores the requirement that IRF medical necessity solely be established by physicians who conduct an individualized medical evaluation. Specifically, Section 10 of the *Medicare Benefits Policy Manual* states that the physician is "responsible for deciding whether the patient should be admitted as an inpatient." It notes that "the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting."

By denying care based on a patient's diagnosis, Cahaba disregards the requirement that a physician's clinical assessment of medical need be the core element of deciding whether IRF care is medically necessary. The proposed LCD directly contradicts CMS's guidance in the fiscal year (FY) 2009 IRF prospective payment system final rule that established the refined IRF criteria. In that regulation, CMS unequivocally stated that it "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." Furthermore, the *Medicare Benefits Policy Manual* states 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."

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Retroactive Implementation of LCD is Unwarranted. Cahaba released this draft LCD for public comment on July 27, and is receiving comments through September 10. However, the proposed effective date for the LCD is July 12, 2012. While the AHA does not support the implementation of this draft LCD and recommends that it be rescinded, we question why Cahaba has chosen to establish an effective date for the LCD that precedes the conclusion of the comment period. The draft offers no rationale for this early effective date when the LCD remains subject to public comment and potential revision as a result of comments received, nor does it explain the urgency of implementing this proposed coverage restriction prior to conclusion of the comment process. The effective date appears both arbitrary and patently unfair to providers that are otherwise complying with existing national Medicare coverage guidelines for the patients targeted by the draft LCD.

Thank you again for the opportunity to comment. If you have any questions, please contact me or Rochelle Archuleta, senior associate director for policy, at (202) 626-2320 or [rarchuleta@aha.org](mailto:rarchuleta@aha.org).

Sincerely,

Linda Fishman  
Senior Vice President, Policy Analysis & Development

Cc: Marilyn Tavenner, CMS Acting Administrator

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<sup>i</sup> The draft LCD would prohibit payment for Case-Mix Groups A0801 through A0806. These are the subset of lower extremity joint replacement cases that lack any of the selected comorbidities that elevate IRF joint replacement claims to a higher payment level (Tiers B, C and D) under the IRF PPS.