May 11, 2023

SUBMITTED ELECTRONICALLY

Michael Chernew, Ph.D. Chairman Medicare Payment Advisory Commission

Jim Mathews, Ph.D. Executive Director

Re: MedPAC Commentary re: Activity Not Attempted Codes in March 2023 Report to Congress

Dear MedPAC Commissioners and Staff:

On behalf of the members of the American Medical Rehabilitation Providers Association (AMRPA), we write to you today regarding information presented in Chapter 9 of the March 2023 MedPAC Report to the Congress on Medicare Payment Policy. AMRPA is the national trade association representing more than 700 inpatient rehabilitation hospitals and units (referred to by the Centers for Medicare and Medicaid Services as Inpatient Rehabilitation Facilities, or IRFs). The overwhelming majority of our members are Medicare-participating providers. Our member hospitals have actively engaged in the development and refinement of the Standardized Patient Assessment Data Elements (SPADEs) and measures included in Quality Reporting Program (QRP), and AMRPA supports CMS' efforts to represent the value of inpatient rehabilitation through QRP modernization.

As the Medicare Payment Advisory Commission (MedPAC) enhances its focus on the IRF QRP and trends in IRF-Patient Assessment Instrument (IRF-PAI) reporting, we believe it is imperative that MedPAC and all policymakers have a clear understanding of the significant changes that have been implemented in recent years and some of the inconsistencies in guidance and training that have been provided to the field. We are concerned about the insinuations in recent sessions that certain trends – particularly with the utilization of activity not attempted codes (ANAs) - may be attributed to "gaming" practices. As illustrated by our extensive overview below, the changes in ANA utilization are instead directly attributable to the evolving guidance provided directly from regulating agencies. Any suggestion that coding practices and financial incentives are tied to ANA utilization trends fails to recognize a multitude of issues related to the implementation of the SPADEs in Section GG of the IRF-PAI and their utilization in the IRF PPS. By providing a historical context to these issues, we are hopeful that MedPAC will offer alternative recommendations as it assesses payment and reporting-related recommendations, and potentially engage with the Centers for Medicare and Medicaid Services (CMS) and stakeholders to determine how to best capture patient severity moving forward. We appreciate your consideration of our technical response to the most recent Report to Congress,

and our objective is that that AMRPA can work with MedPAC in an accurate and meaningful assessment of reporting challenges and the implications for the field.

I. Evolution of Activity Not Attempted Codes Before & After the Implementation of the IRF PPS

Prior to the implementation of the IRF PPS, the FIM Instrument was utilized for functional assessment. The original FIM Instrument did not have a response code or option for ANA, and instead relied upon clinical guidance that instructed clinicans to utilize the lowest score over the first three days following admission in order to capture the burden of care. The assumption was that even if the patient could not perform an activity on the first day, the activity would be performed on the second or third day, therefore providing an opportunity to produce an assessment value representing the patient's need for assistance. All the analysis performed by the RAND Corporation in consideration for the IRF PPS utilized this version of the FIM Instrument.

Only in consideration for the implementation of the IRF PPS was an ANA code introduced. When the IRF PPS began in January 2002, code 0 - Activity Does Not Occur was added to the FIM Instrument. As part of the implementation and ongoing training and education of the FIM Instrument, clinical guidance was provided in Section 3 the IRF-PAI Training Manual-effective-2004, and suggested the following related to the use of this new code:

"A code of 0 may be used for some FIM items and some Function Modifiers to indicate the activity does not occur at any time during the assessment period…A code of 0 means that the patient does not perform the activity and a helper does not perform the activity for the patient, at any time during the assessment period. Use of this code should be rare for most items, and justification for the use of 0 should be documented in the medical record. Possible reasons as to why the patient does not perform the activity may include the following:

- *The patient does not attempt the activity because the clinician determines that it is unsafe for the patient to perform the activity (e.g., going up and down stairs for patient with lower extremity paralysis).*
- *The patient cannot perform the activity because of a medical condition or medical treatment (e.g., walking for the patient who is unable to bear weight on lower extremities).*
- *The patient refuses to perform an activity (e.g., the patient refuses to dress in clothing other than a hospital gown or the patient refuses to be dressed by a helper)."*

In Section 3 of the IRF-PAI Training Manual-effective-2004, it further noted:

"Prior to recording a code of 0, the clinician completing the assessment must consult with other clinicians, the patient's medical record, the patient, and the patient's family to determine whether the patient did perform or was observed performing the activity. Do not use code "0" to indicate that the clinician did not observe the patient performing the activity; use the code only when the activity did not occur."

This clinical guidance related to the use of zero remained in place for the FIM Instrument throughout its use on the IRF-PAI and as part of the IRF PPS, and facilitated a reporting system where ANA code utilization was limited.

In contrast, with the introduction of the Section GG functional items in October 2016, CMS both implemented new additional ANA code options *and* changed its clinical guidance as to how and when to use ANA codes. The initial clinical guidelines, as stated in the Section GG IRF-PAI v1 4.pdf document included in the Updated IRF-PAI Training Manual - IRF QRP Measures Information - Effective October 1, 2016 (ZIP), specifically provided:

> ***Steps for Assessment***
> *1. Assess the patient's self-care status based on direct observation, the patient's self-report, family reports, and direct care staff reports documented in the patient's medical record during the 3-day assessment period.*
> *2. Patients should be allowed to perform activities as independently as possible, as long as they are safe.*
> *3. If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.*
> *4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.*
> *5. If the patient's self-care performance varies during the assessment period, report the patient's usual status, not the patient's most independent performance and not the patient's most dependent episode.*
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> ***Coding Tips***
> *• When reviewing the medical record, interviewing staff, and observing the patient, be familiar with the definition for each activity. For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food to the mouth and swallow food once the meal is presented on a table/tray.*
> *• On the admission assessment, code the patient's usual performance using the 6-point scale, or one of the 3 "activity was not attempted" codes to specify the reason why an activity was not attempted, as well as the patient's discharge goal(s) using the same 6-point scale and "activity was not attempted" codes. Instructions about coding discharge goals are provided below under Discharge Goal: Coding Tips.*
> *• On discharge, use the same 6-point scale or "activity was not attempted" codes that were used on the admission assessment to identify the patient's usual performance on the discharge assessment.*
> *• Record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance during the assessment period.*
> *• Do not record the staff's assessment of the patient's potential capability to perform the activity.*
> *• If two or more helpers are required to assist the patient to complete the activity, code as 01, Dependent.*
> *• If the patient does not attempt the activity and a helper does not complete the activity for the patient, code the reason the activity was not attempted. For example, code 07 if*

the patient refused to attempt the activity, code 09 if the activity is not applicable for the patient, or code 88 if the patient was not able to attempt the activity due to medical condition or safety concerns.
• To clarify your own understanding of the patient's performance of an activity, ask probing questions to staff about the patient, beginning with the general and proceeding to the more specific. See examples of using probes when talking to staff, at the end of this section.
• A dash ("-") sign indicates "No information." CMS expects dash use for quality indicator items to be a rare occurrence. Use of dashes for quality items may result in a payment reduction. Do not use a dash ("-") if the reason that the item was not assessed because the patient refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88).

II. Challenges with Accurate ANA Utilization in the FIM to Section GG-Based Functional Reporting

As it relates to ANA codes, the initial guidance offered in the context of the GG functional items produced more questions than answers, especially with clinicians having to collect both the FIM Instrument and Section GG functional items simultaneously. The FIM clinical guidance indicated that the ANA code should only be used if the activity was not attempted at any time during the assessment period, whereas the Section GG clinical guidance provided that the use of ANA codes was appropriate if that was the usual performance during the assessment period. For an example of this difference in clinical guidance, if during the 3-day assessment period a patient performed an activity once and it was unsafe for the patient multiple times prior to that, the FIM Instrument would record the performance on the activity while Section GG would record the most usual performance (which would be an ANA code of 88 - Not attempted due to medical condition or safety concerns).

Not only did the clinical guidance for Section GG create an increased utilization of ANA codes but also the instructions for certain functional items. For example, Eating for Section GG requires an ANA code if the patient utilizes a gastrostomy tube and does not eat by mouth, while for the FIM Instrument the use of a gastrostomy tube would not require an ANA code and at a minimum would have been a level 1 – Total Assistance with consideration up to level 6 – Modified Independence if the patient self-administers the parenteral or gastrostomy feedings. Similarly, the Walking 150 Feet item on Section GG requires an ANA code if the patient is unable to complete the full 150 feet. Comparatively on the FIM Instrument, if the patient walked a shorter distance an actual performance value could be utilized with a household ambulation exception for level 5 if the patient walks only short distances (a minimum of 50 feet or 15 meters) *independently* with or without a device.

III. Current ANA Utilization Trends Following the 2019 IRF PPS Payment Transitions

With clinicians communicating to CMS the inconsistencies between the FIM Instrument and Section GG following the October 2016 implementation, CMS proceeded to make multiple updates to guidance and provide Q&A documents that continually changed the manner of assessing the Section GG items and the use of ANA codes. By the time that the Section GG items were to be used for the motor score and payment as part of the IRF PPS for cases discharged on or after October 1, 2019, clinical guidance had changed significantly from what was first implemented in October 2016. The CMS IRF-PAI Manual Version 3.0 effective for October 1, 2019 now stated the following for assessment of the Section GG items in the IRF-PAI Manual Chapter 2 - Section GG v3.0-508C:

> *"Clinicians should code the patient's admission functional status based on a functional assessment that occurs soon after the patient's admission. The admission function scores are to reflect the patient's admission baseline status and are to be based on an assessment. The assessment should occur prior to the patient benefitting from treatment interventions to capture the patient's true admission baseline status. This is because therapy interventions can affect the patent's functional status; the score should reflect the patient's status prior to any benefit from therapy. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment."*

The instructions to obtain a true admission baseline status prior to the patient benefitting from treatment interventions was a significant change from guidance regarding consideration of "usual performance", even though language related to "usual performance" remained in the CMS IRF-PAI Manual. This change had major implications for the assessment of patient function and the use of ANA codes as now the assessment needed to occur prior to any treatment interventions. Of particular note, this typically meant the first time the activity would occur immediately following admission.

CMS reinforced this modification to the assessment guidelines and use of ANA codes in the IRF-PAI Quarterly Q&As that are posted on the IRF QRP Website. For example, in the September 2020 IRF-PAI Quarterly Q&As, the following guidance was provided:

> *"**Question 6**: We understand that if a patient initially refuses to attempt an activity during the assessment period, but later agrees to perform the activity, the code that represents the patient's actual performance supersedes the refusal code (07). What if on day 1 or day 2 a safety or medical issue prevents the patient from attempting an activity, but on day 3, after benefiting from therapeutic intervention, the patient can now perform the activity? Which code should be reported on the IRF-PAI: Code 88 - Not attempted due to medical condition or safety concerns, or one of the performance codes, 01-06?*

***Answer 6**: At Admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your facility staff. "Prior to the benefit of services" means prior to provision of any care by your facility staff that would result in more independent coding.*

Use of an "activity not attempted" code should occur only after determining that the activity is not completed prior to the benefit of services, and the performance code cannot be determined based on patient/caregiver report, collaboration with other facility staff, or assessment of similar activities.

If this is the case in your scenario, code 88 - Not attempted due to medical condition or safety concerns even if the patient's status changes and the patient is able to complete the activity on a later day during the assessment period. "

CMS reinforced this guidance and the use of ANA codes with another update to the IRF-PAI Quarterly Q&As for December 2021:

*"**Question 10**: When determining the appropriate performance code at admission for the GG self-care and mobility activities there are times when the score on day 1 differs from the scores on days 2 and 3. For example:*

- *On Day 1 when attempting to perform a sit to stand transfer, even with assist from the therapist the patient is unable to complete the transfer due to pain. The therapist scores GG0170D - Sit to stand as a Code 88 - Not attempted due to medical condition or safety concerns in day 1 notes. On day 2, per therapy notes the patient was able to complete the sit to stand transfer with assistance of two people. Which code would I use? Code 88 - Not attempted due to medical condition or safety concerns or Code 01 - Dependent?*
- *On Day 1 there is no mention of sit to stand noted in documentation. On day 2 documentation reports that the patient requires partial/moderate assistance of 1 (Code 03) and later that day the therapy note shows that the patient required the assistance of two people to stand. How would this scenario be coded? Does any source take priority? Do I look at all three days and select usual performance from all sources?*

***Answer 10**: At Admission, the self-care or mobility performance code is to be based on a functional assessment that occurs at or soon after the patient's admission, and reflects the patient's baseline ability to complete the activity prior to the benefit of services provided by your facility staff.*

"Prior to the benefit of services" means prior to provision of any care by your facility staff that would result in more independent coding.

When the baseline function code differs from the usual performance during the assessment period, report the baseline function code.

If in your first scenario, the patient being unable to complete the sit to stand activity due to medical conditions or safety concerns represents their baseline ability, then code 88 - Not attempted due to medical condition or safety concerns.

In your second scenario, as in all admission scenarios, select the code that represents the patient's baseline ability to complete the activity as independently as possible as long as they are safe, prior to the benefit of services provided by your facility staff."

As noted in the information above related to changes to clinical guidance and standards for functional assessment, we believe that the utilization of ANA codes is due primarily to IRFs following CMS guidance on how to capture a patient's baseline status prior to the benefit of therapeutic interventions or other services. We therefore urge MedPAC to take these payment and guidance changes into account in future commentary and related recommendations.

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We appreciate your time and consideration, and please let us know if we can provide any additional information related to this topic. If you have any questions on these matters, please reach out to AMRPA Director of Quality and Health Policy, Troy Hillman (THillman@AMRPA.org).

Sincerely,

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