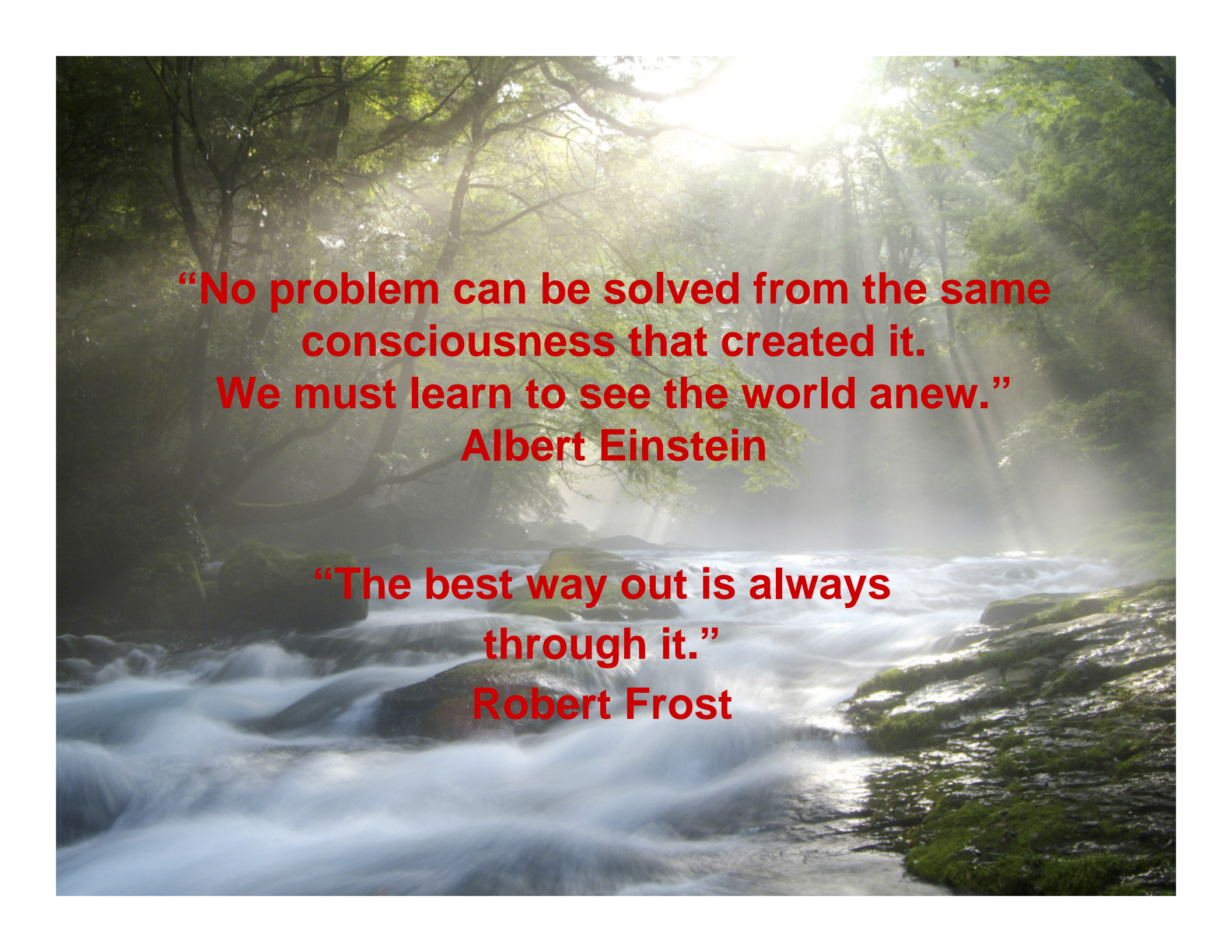




Assessing the Impact of the Inpatient Rehabilitation Final Rule and Medical Necessity Evidence Prior to IRH/U Admission

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**“No problem can be solved from the same
consciousness that created it.
We must learn to see the world anew.”
Albert Einstein**

**“The best way out is always
through it.”
Robert Frost**



Participant Learning Objectives

1. Describe the overall program evaluation and outcomes' evidence from the facility's experience
2. Outline the management systems that were instituted in response to the analysis and knowledge gains
3. Discuss the facility's success with application and dissemination of key outcomes that strengthen organizational commitment to overall quality of services to patients
4. Summarize the communication instituted to strengthen external referral hospital processes for safely and appropriately transitioning patients



Presentation Outline

- Review CMS Guidelines for Determining Medical Necessity
- Overview of Preadmission Screening Documentation
- Identify Differences in Admissions, Onset of Illness, and Emergency Discharges Since New Rule
- Highlight Lessons Learned from Implementation



CMS Guidelines for Medical Necessity



The Rule...

Access to the CMS Website for Chapter 1, Section 110 of the Medicare Benefit Policy Manual Effective 1-1-2010

<http://www.cms.hhs.gov/transmittals/downloads/R112BP.pdf>

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 112	Date: October 23, 2009
	Change Request 6699

Subject: Coverage of Inpatient Rehabilitation Services

I. SUMMARY OF CHANGES: This Change Request replaces the existing instructions in chapter 1, section 110 that describes coverage for inpatient rehabilitation services provided in inpatient rehabilitation facilities. These new instructions are supported by recent regulatory changes that can be found in 42 C.F.R. Section 412.622 (FR 74, 39762 (August 7, 2009)).

New / Revised Material

Effective Date: For IRF discharges occurring on or after January 1, 2010

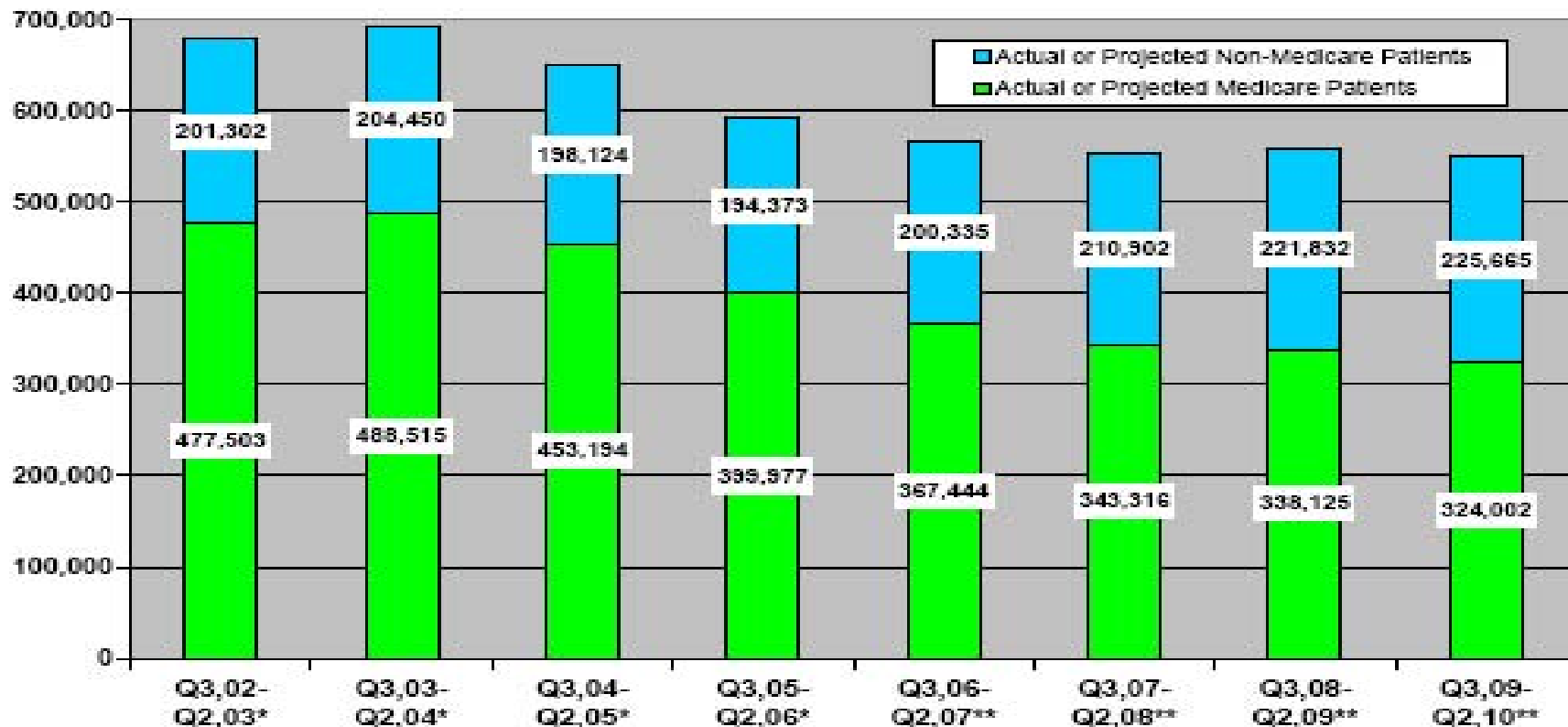
Implementation Date: January 4, 2010



National Trends in IRH/U Admissions

eRehabData.com

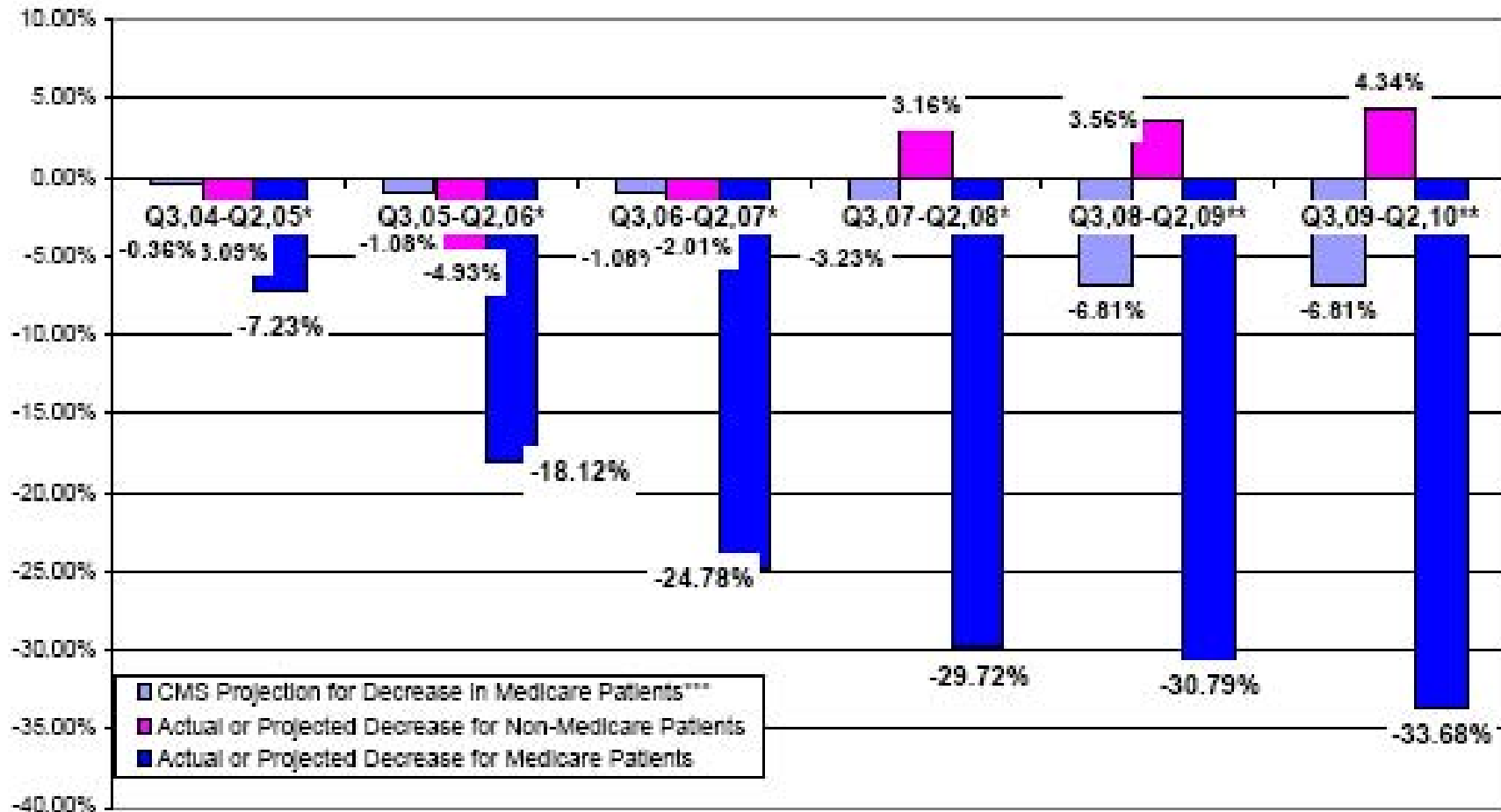
Inpatient Acute Medical Rehabilitation Discharges Per 12 Month Periods
Updated July 27, 2010



*Actual patient volume calculated from data supplied by UDSmr and eRehabData for 70% of patients.

**Projection of patients (both Medicare and Non-Medicare) accessing IRFs based on actual patient volume for 131 IRFs (20% of discharges nationally) in eRehabData for Q4 2009

Patient Reductions in Inpatient Rehabilitation Facilities Required to Meet May 7th 2004 65% Rule Compared to July 1, 2003 - June 30, 2004 as Percentage of Discharges by Payer
 Updated July 27, 2010



*Actual patient volume calculated from data supplied by UDSmr and eRehabData for 70% of patients.

**Projection of patients (both Medicare and Non-Medicare) accessing IRFs based on actual patient volume for 131 IRFs (20% of discharges nationally) in eRehabData for Q4 2009

***CMS projections based on May 7th, 2004 Federal Register page 25772 by dividing total estimated savings by the projected per discharge savings of \$5,710



Overview of New Policies

- Developed by CMS Workgroup
 - General physicians, physiatrists, therapists, and RNs
- Enlist input from
 - CMS/HHS Medical Directors
 - NIH
 - Stakeholders/industry partners



Purpose of New Policies

To provide clear, up-to-date instructions for determining and documenting the medical necessity of IRF admissions

- Stated Goals:
 - Identify characteristics of patients who require complex rehabilitation in a hospital environment and can most reasonably be expected to benefit from IRF services
 - Focus on patient characteristics on admission and all services provided during the IRF stay
- Focus of new policies
 - Admission decision that IRF can control as opposed to patient's projected rehabilitation trajectory
 - Rehabilitation physician's decision-making process in the decision to admit the patient



New Policies Outline Requirements For...

- Documentation
- Preadmission screening
- Post-admission physician evaluation
- Individualized overall plan of care
- Admission orders
- IRF-PAI
- IRF medical necessity criteria
- Multiple therapy disciplines
- Intensive level of rehabilitation services
- Ability to actively participate in intensive program
- Physician supervision
- Interdisciplinary team approach to delivery of care
- Definitions of measurable improvement



New Medical Necessity Documentation Process



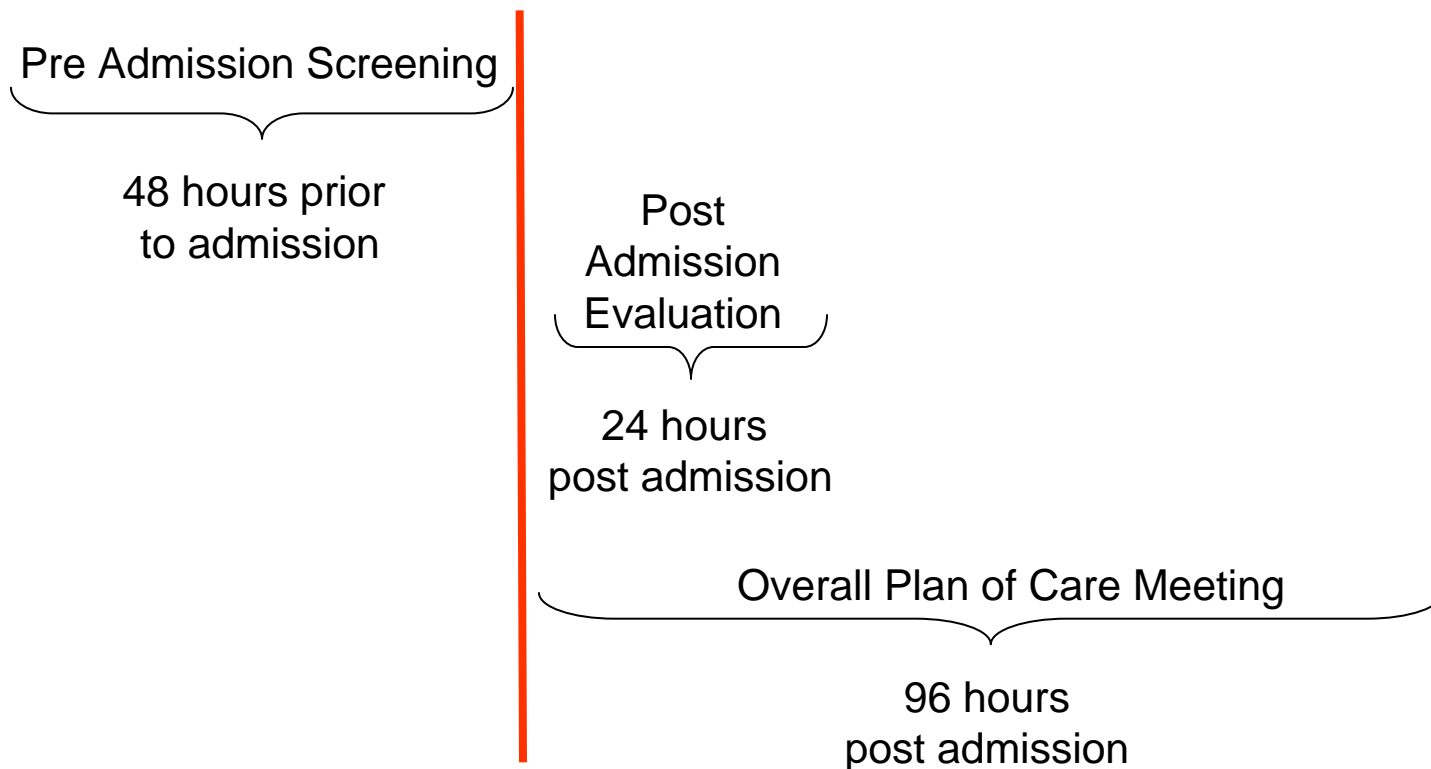
- **Criteria**

- Multiple Therapy Disciplines
- Intensive Level of Rehabilitation Services
- Ability and Wiling to Participate in Intensive Therapy Program
- Physician Supervision
- Interdisciplinary Team Approach to Care



CMS Has Established Time Thresholds for New Documentation

IRF Admission





Severe Consequences Have Been Defined for Non-Compliance

- Technical denial of Medicare claim
 - Loss of payment for entire course of patient's IRF stay, as well as MD component

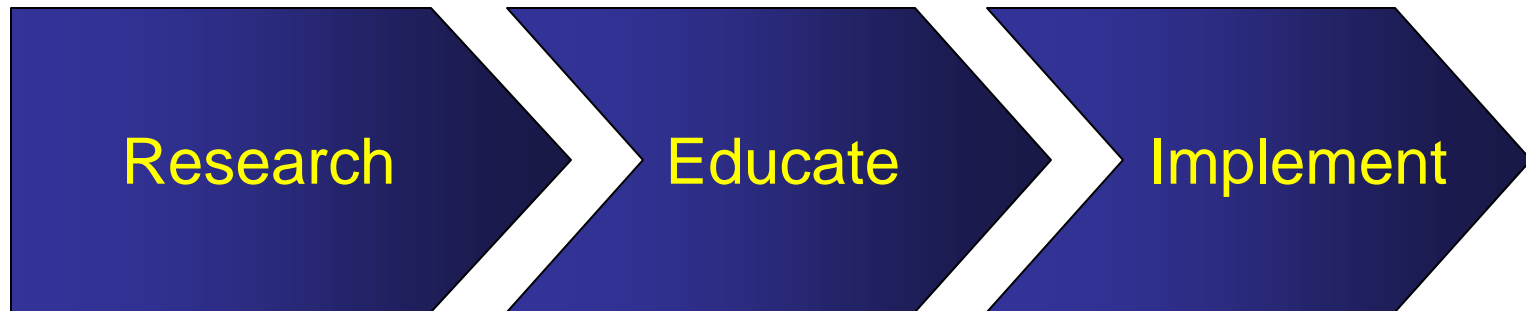




Pre-Admission Screening Documentation



Marianjoy Strategic Approach to Address CMS Mandates



- Understand guidance
- Assess operational impact across disciplines and functional areas
- Discuss with colleagues and other providers

- Physicians
 - Focus on required behavioral changes
- Staff
 - Focus on process revisions and improvements
- Referral sites of care
 - Focus on resetting expectations for consultation services

- Develop short and long-term plans for medical necessity compliance
 - Physician coverage and sign-off
 - Admissions policies
 - External liaison processes (eg, Net books and eRehab tool)
- Convene working groups to prepare for RACs



Pre-Admission Assessment

- Key Factor in initial identification of patients appropriate for IRF care
- Evaluation of patient's
 - Condition
 - Need for rehabilitation therapy and medical treatment
- Must be detailed and comprehensive
- Should demonstrate that patient:
 - Has expectations for measurable improvements
 - Is Able and Willing to participate as well



Pre-Admission Screening (PAS) Identify Appropriate IRF Patients

- **MD offers evaluation of the patient's:**
 - Condition
 - Need for rehabilitation therapy and medical treatment
- **Documentation must be detailed and comprehensive**
 - Specific forms have been created to help with the documentation process

JUSTIFICATION	
Date Patient Screened	
Evaluator	
Screening Method	
Screening Recommendations	
1. Rehabilitation Admission	unspecified
2. Patient able to tolerate therapy	unspecified
3. Rehabilitation Prognosis	unspecified
4. Patient is willing to participate in an intensive rehabilitation program	unspecified
Estimated Length of Stay	
95% Likely	unspecified
68% Likely	unspecified
+/-	unspecified
Anticipated Discharge Setting	
Anticipated Post-Discharge Treatments	
Rehabilitation Disposition	
Notes	
Physician Admission Justification	
Medically Stable : Patient's condition is sufficiently stable at the time of admission to allow the patient to actively participate in an intensive rehabilitation program.	unspecified
Close Medical Supervision : A rehabilitation physician, or other licensed treating physician with specialized training and experience in inpatient rehabilitation, will conduct face-to-face visits with the patient a minimum of at least 3 days per week throughout the patient's stay.	unspecified
This patient requires close medical supervision for the active management of the ongoing conditions and potential complications stated here:	
Intensive Rehabilitation Nursing : The patient demonstrates the need for 24-hour rehabilitation nursing care for active management of the following medical and functional deficits:	
Appropriate Therapy Needs : The patient requires the active and ongoing therapeutic intervention of at least two therapy disciplines, one of which must be physical or occupational therapy.	
Intensive Therapy : Patient requires and is reasonably expected to actively participate in at least 3 hours of therapy per day at least 5 days per week, and be expected to make measurable improvement that will be of practical value to improve the patient's functional capacity or adaptation to impairments. In addition, therapy treatments will begin within 36 hours after the patient's admission to the IRF.	unspecified
Expected duration and frequency of therapy	[unspecified] minutes/day,[unspecified] days/week
Interdisciplinary Team : Patient demonstrated the need for an interdisciplinary team for active management of the following medical and functional deficits:	
Additional Notes / Discussion	
Physician Signature	
I have reviewed this pre-admission screening document and concur with the findings. I believe the patient meets criteria, is sufficiently stable to allow participation in the program, requires an intensive level of therapy, close medical supervision, and an interdisciplinary team approach provided through an individualized plan of care. I approve admitting this patient for an intensive, inpatient rehabilitation hospital program.	Not Reviewed



Pre-Admission Assessment

Necessary Components

- Patient's prior level of function
 - Prior to the event that led to the patient's need for intensive rehab therapy
- Expected level of improvement
- Expected length of time needed to reach level of improvement
- Evaluation of patient's risk for clinical complications
- Conditions that caused need for rehabilitation
- Combination of treatments needed
 - One of which must be OT or PT
- Expected frequency and duration of treatment in the IRF
- Anticipated discharge destination
- Any anticipated post-discharge treatments
- Other information relevant to the care needs of patient



Marianjoy Initiatives

Pre-Admission Assessment

- **A comprehensive preadmission screening**
 - Meeting all of the essential requirements
 - Conducted by a licensed or certified clinician(s) designated by a rehabilitation physician
 - Completed in the 48 hours preceding the IRF admission
- **Informs rehabilitation physician who reviews and documents concurrence with findings and results of the preadmission screening**
 - Requires more than just a “check off” – must be a written note with signature
- **All pre-admission forms retained in IRF medical record**
- **Responsible parties include VP, Medical Affairs and Director of Admissions**

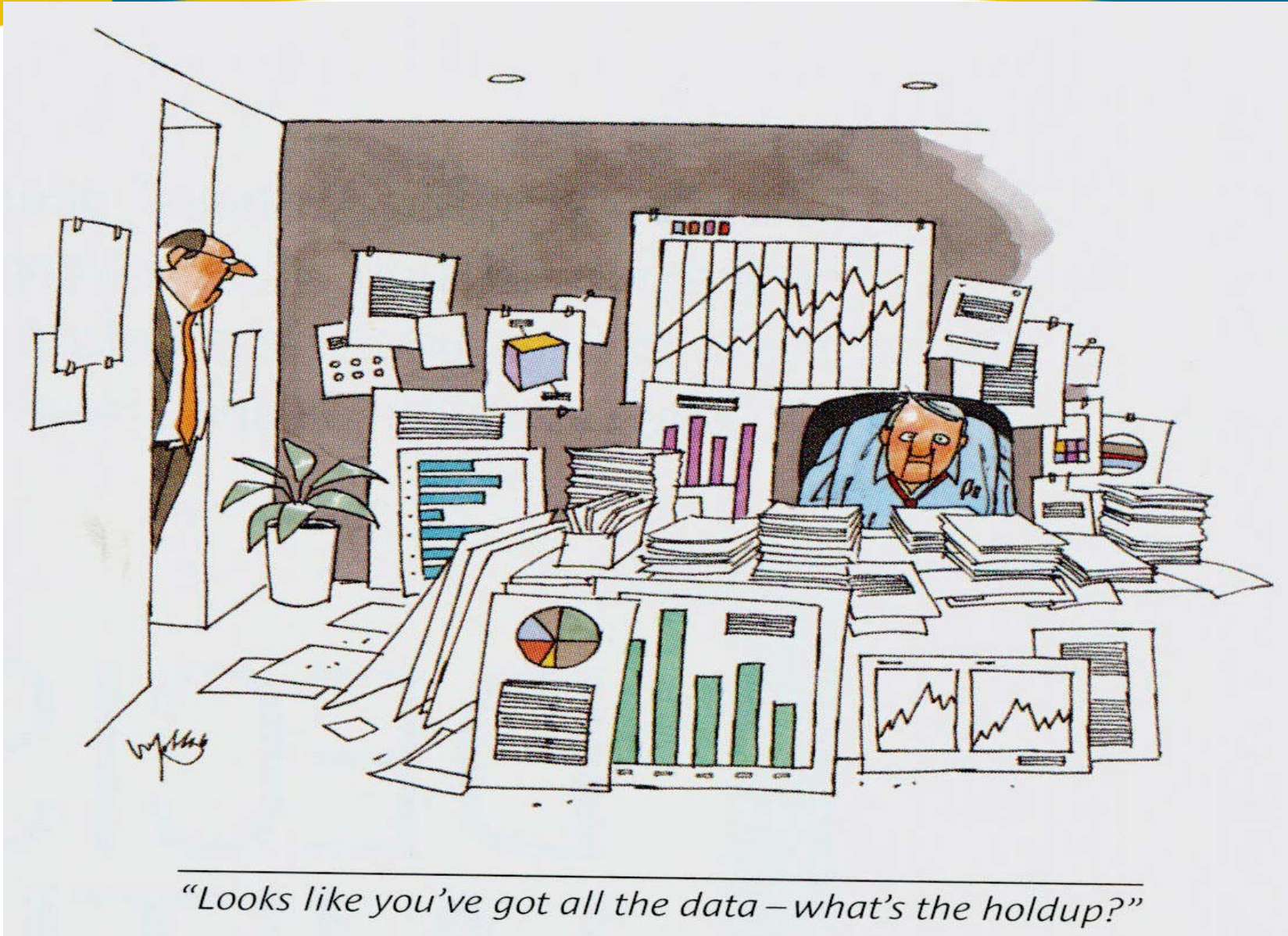


What Impact Have the New
Rules Had?





I Reject Reality and Substitute My Own





Methodology

- **Primary Objective:**
 - Identify any potential differences in the characteristics of patients admitted to an inpatient rehabilitation hospital/unit (IRH/U) that may have resulted from the CMS regulations for pre-admission documentation justification of medical necessity, effective January 1, 2010
- **Study Design:**
 - Retrospective analysis of admission patient demographic and outcome measures
 - Comparisons made from prior year (Jan-Jul 2009) to same time period of current year (Jan-July 2010) following the implementation of the new CMS regulations for medical necessity documentation
 - Analyses include comparisons using frequency distributions and descriptive statistics with external benchmarks where relevant.



Source for Data Collection

eRehabData.com - Windows Internet Explorer provided by Wheaton Franciscan Healthcare

https://web2.erehabdata.com/erehabdata/IRFPAI/AdvPreAdmit.jsp

File Edit View Favorites Tools Help

Star Home RSS Print Page Tools ? ? ?

erehabdata.com® Sep 20, 2010 | Welcome Alison!

[USER MANUAL](#) [AMRPA](#) [CONTACT](#) [LOG OUT](#)

HOME | **Pre-Admit Screening Tool** | Pre-Admission Assessment

Mgmt
Pre Adm
Custom
eRD
Notes
Metrics

[PRINT PDF](#) [HELP](#)

Demographics | Referral / Payer | Status | ROS | Labs | Function | Justification

Demographics

Patient Identification:

4. First Name:
5a. Last Name:
6. BirthDate: 8. Gender: Male Female unspecified
7. SSN: 5b. Patient ID Number:
2. Medicare #: 3. Medicaid #:
Address:
City: State: 11. ZIP:

10. Marital Status:
--select one--

16. Pre-Hospital Living Setting:
--select one--
Comments:

Done Local intranet 100%

Start | Inbox - ... | AMRPA ... | Ruroed... | AMRPA ... | Yosko P... | Slides fo... | DRAFT... | eRehab... | 2:06 PM



Marianjoy Study Findings

- No meaningful clinical outcome differences across the two time periods for the majority of discharged patients
 - The exception being a subset of patients emergently discharged back to an acute care facility
- The analysis to follow is limited to acute care discharges with literature evidence to support the importance of acute care discharge analysis.



Acute Care Discharges 2009 and 2010 January – June

Medicare patients most vulnerable to acute care emergent discharge
(example of table structure)

Primary Pay Source

Time Period		Frequency	Valid Percent
2009	Medicare		
	HMO/PPO		
	Medicaid		
	Private Pay		
	Worker's Comp		
	Commercial		
	Total		
2010	Medicare		
	HMO/PPO		
	Commercial		
	Medicaid		
	Private Pay		
	Total		

Lower rate of acute care emergency discharges after the Medicare criteria changes on 1-1-2010
(example of table structure)

Program

	Time Period			
	2009		2010	
	Frequency (n)	Valid Percent	Frequency (n)	Valid Percent
Stroke				
Brain Injury				
Spinal Cord Injury				
Musculoskeletal				
Neuromuscular				
Total				



Acute Care Discharges 2009 and 2010 January – June

IRF patients emergently discharged were primarily at the higher Case Mix Group levels and had higher Case Mix Indices.

Patients emergently discharged back into acute care hospitalization had significantly lower Onset of illness and Admission FIM score means than external benchmarks

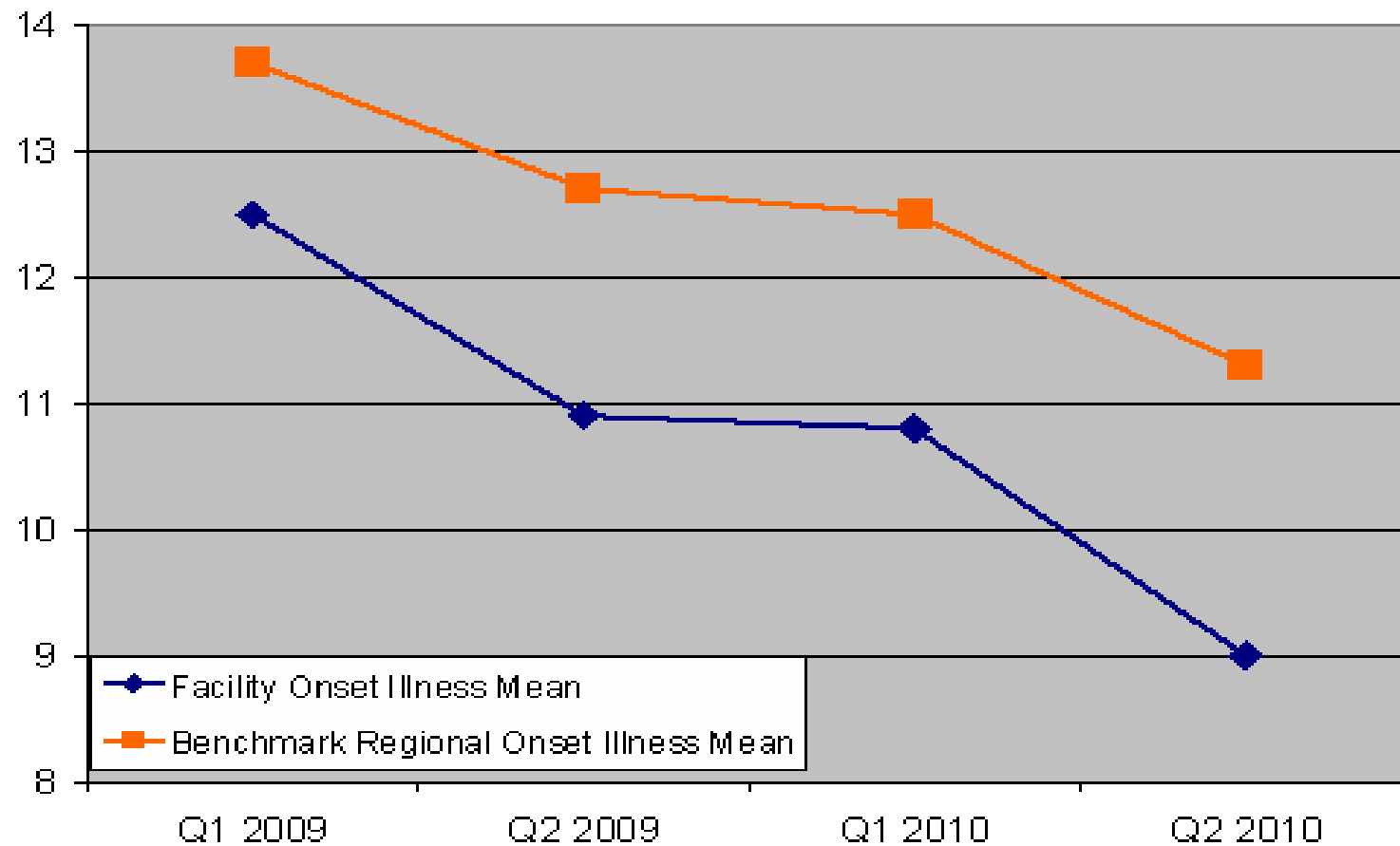
(examples of table structure)

	Time Period			
	2009 (n)		2010 (n)	
	Mean	Std. Deviation	Mean	Std. Deviation
Age at Admission				
Onset of Illness				
Total Admission FIM				
CMI				

CMG		
Time Period	Frequency (n)	Percent
2009 List CMGs		
2010 List CMGs		



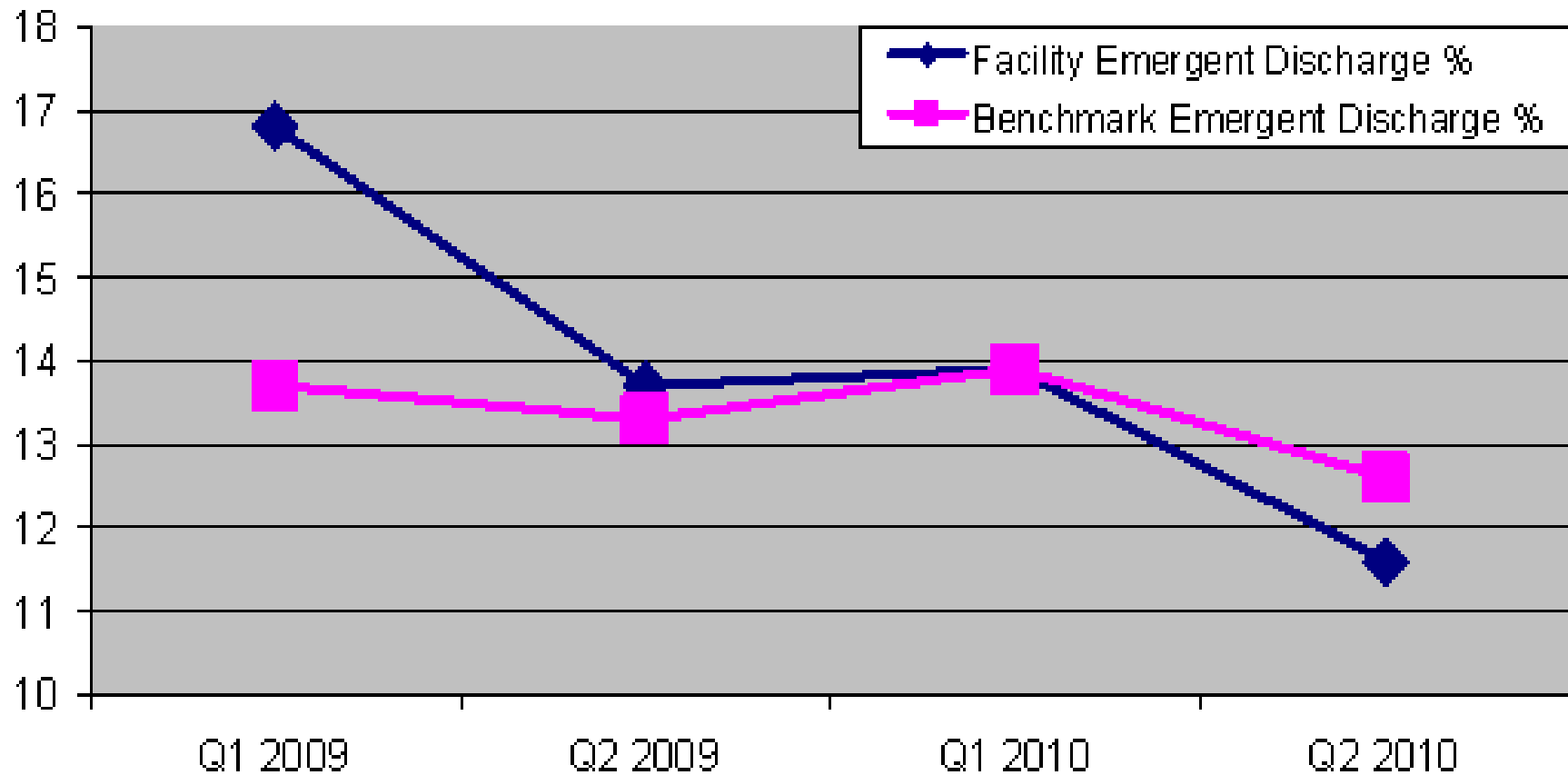
Onset of Illness Mean by Quarters 2009 and 2010



Time	Q1 2009	Q2 2009	Q1 2010	Q2 2010
Facility	12.5	10.9	10.8	9.0
Benchmark	13.7	12.7	12.5	11.3



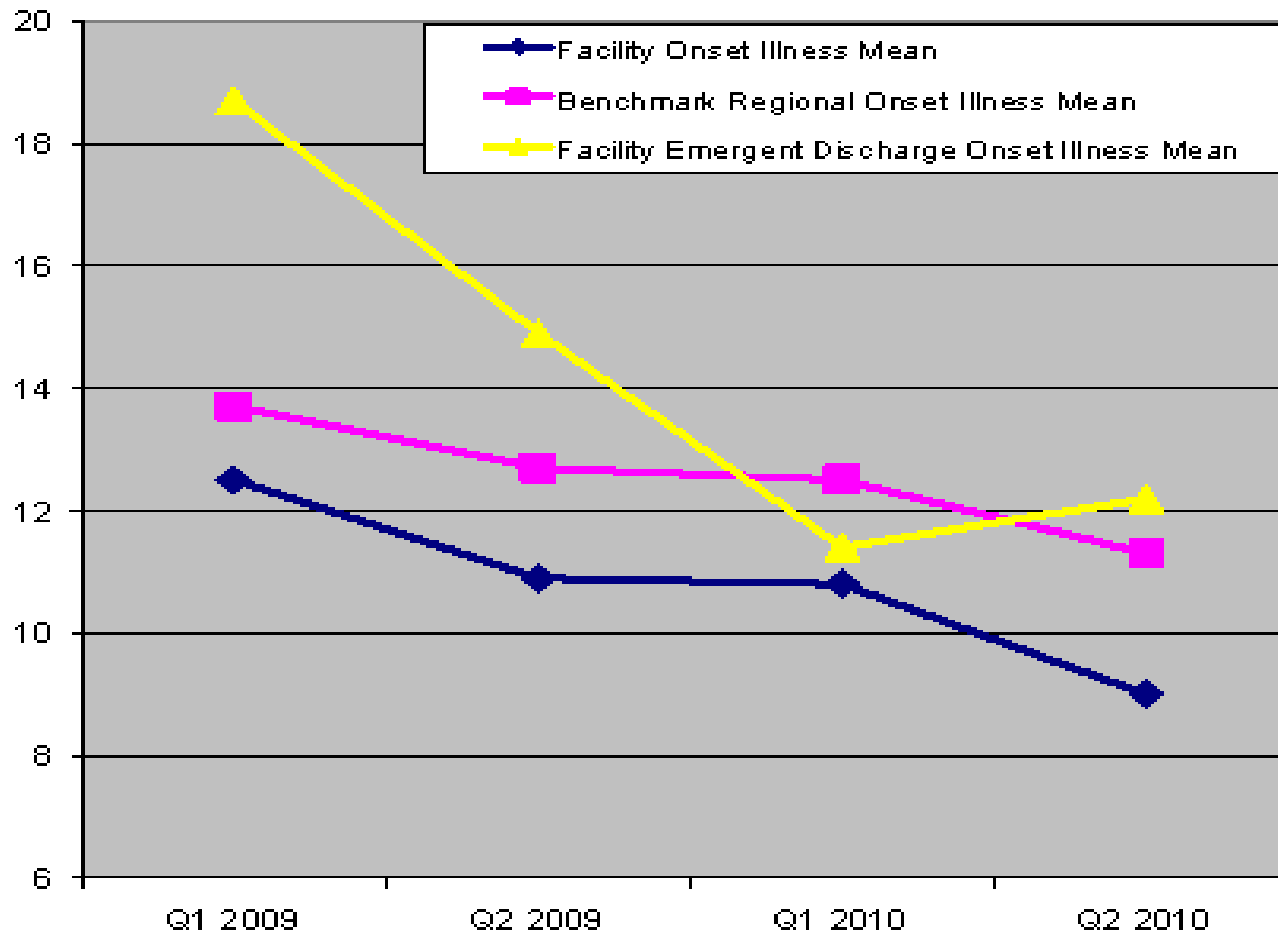
Emergent Discharge Percentage by Quarters 2009 and 2010



Time	Q1 2009	Q2 2009	Q1 2010	Q2 2010
Facility	16.8%	13.7%	13.9%	11.6%
Benchmark	13.7%	13.3%	13.9%	12.6%



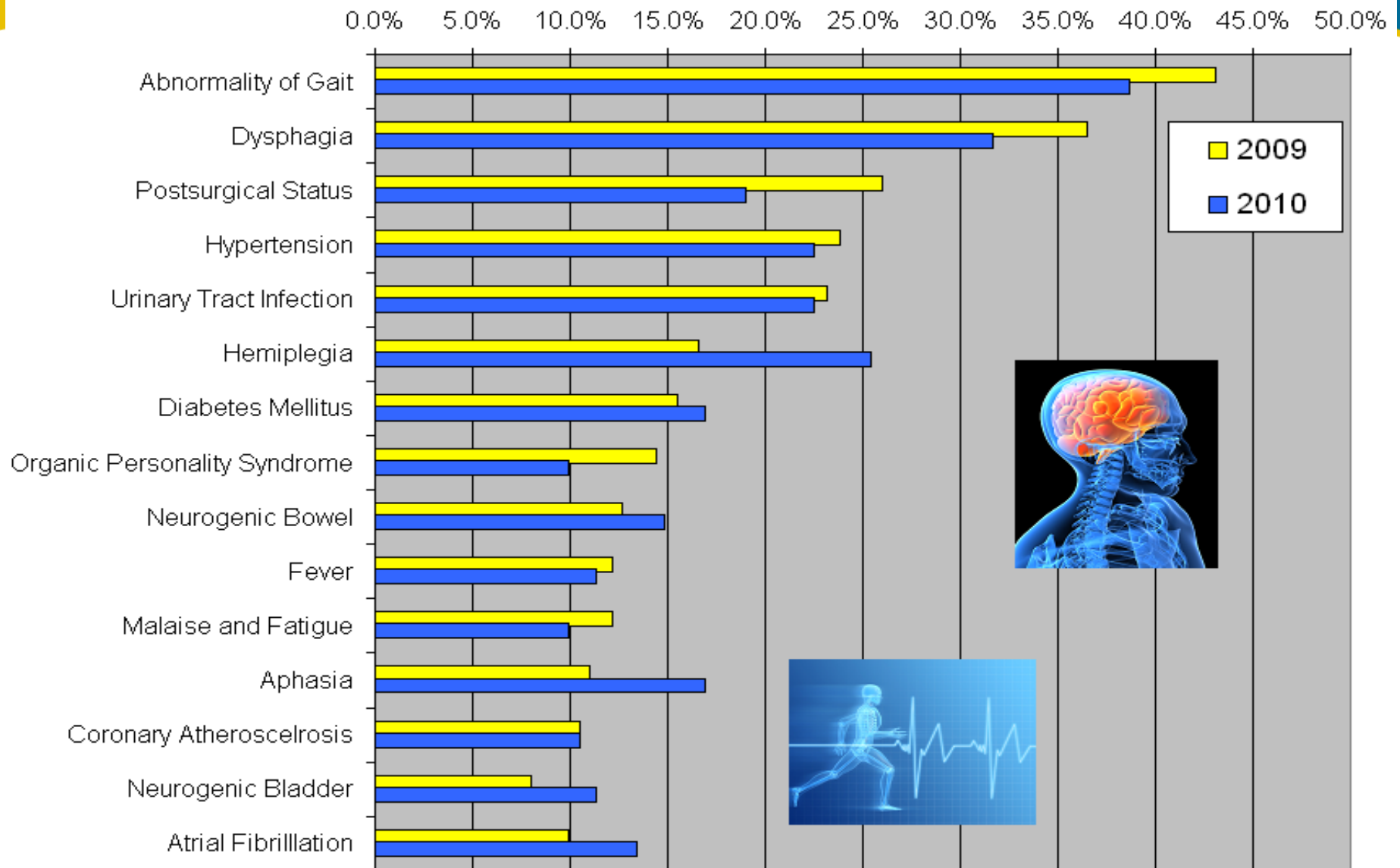
Onset of Illness Mean by Quarters 2009 and 2010



Time	Q1 2009	Q2 2009	Q1 2010	Q2 2010
Facility	12.5%	10.9%	10.8%	9.0%
Benchmark	13.7%	12.7%	12.5%	11.3%



Comorbidities for Emergent Discharges





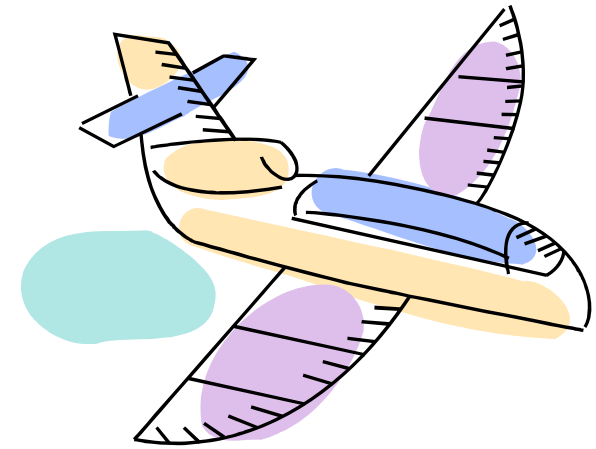
Discussion of Findings





The Commonwealth Fund – The Transition Care Journey

JOURNEY
(White Space)



(Transition Space)

TAKE OFF

HOSPITAL

LANDING

- Home/ Home Health
- Nursing Home
- Primary Care Physician Office
- Rehabilitation
- Integrated Delivery System
- Community Health Center
- Etc...

State Ranking on Potentially Avoidable Use of Hospitals and Costs of Care Dimension

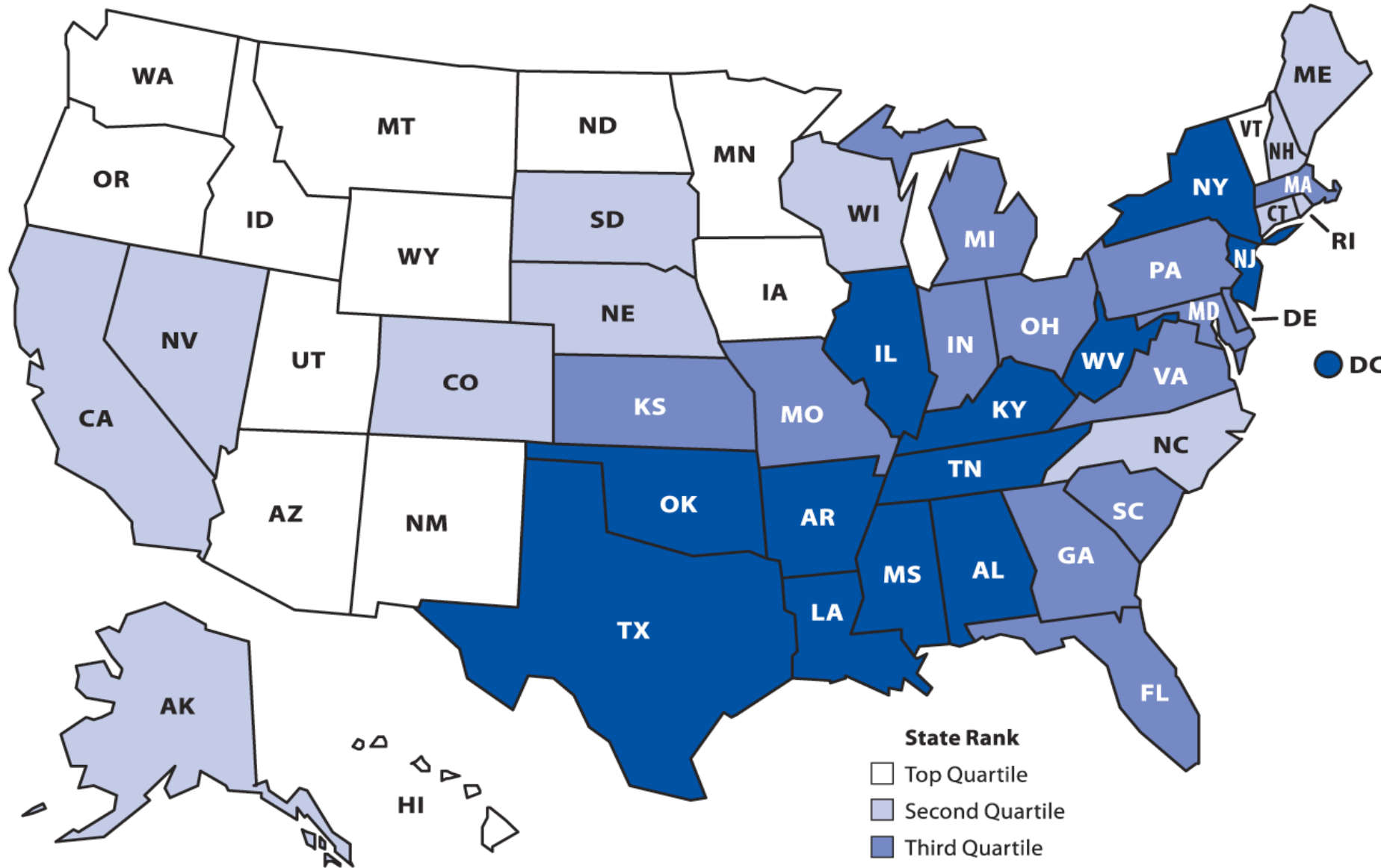
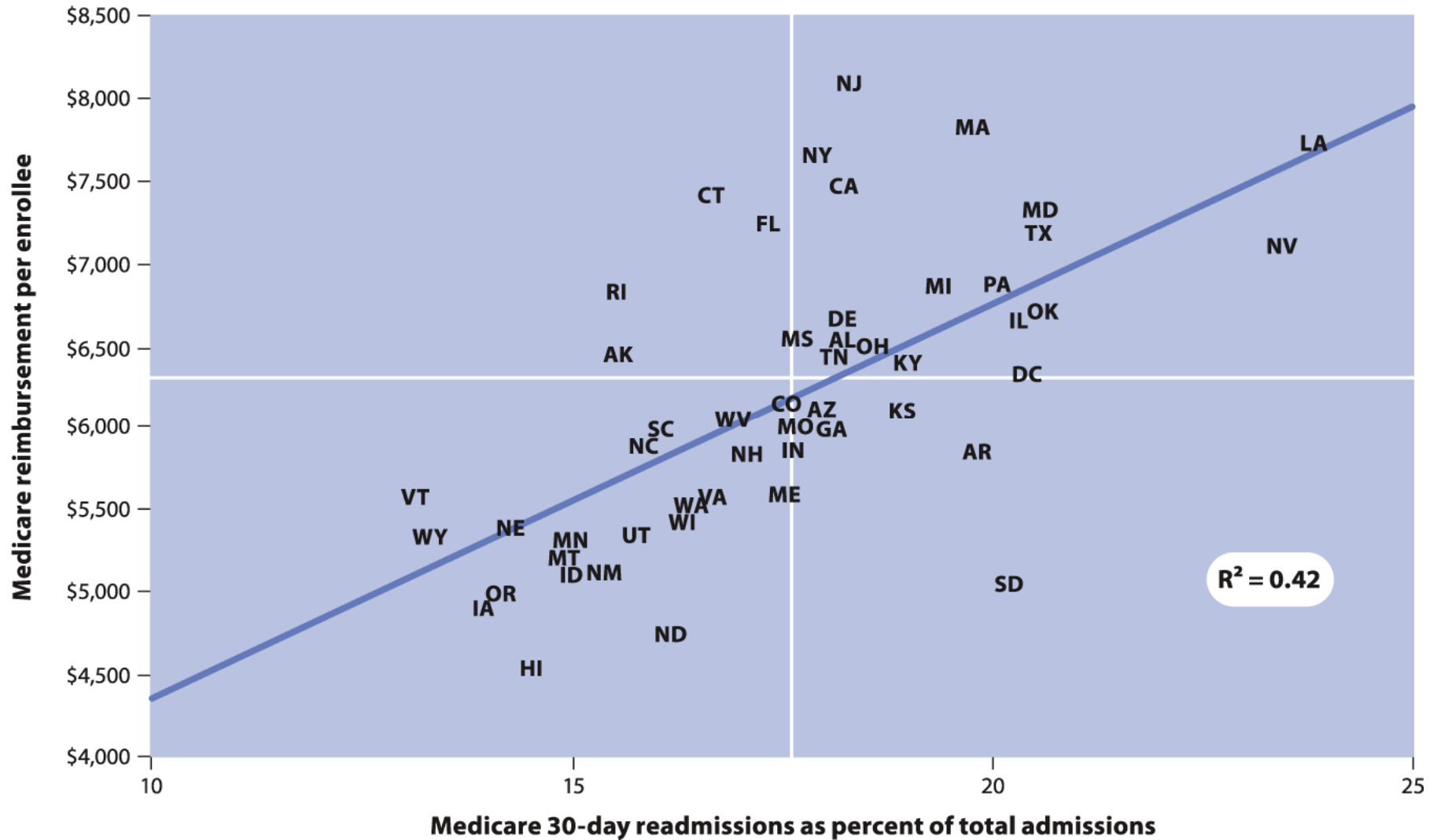


Exhibit 3. Medicare Reimbursement and 30-Day Readmissions by State

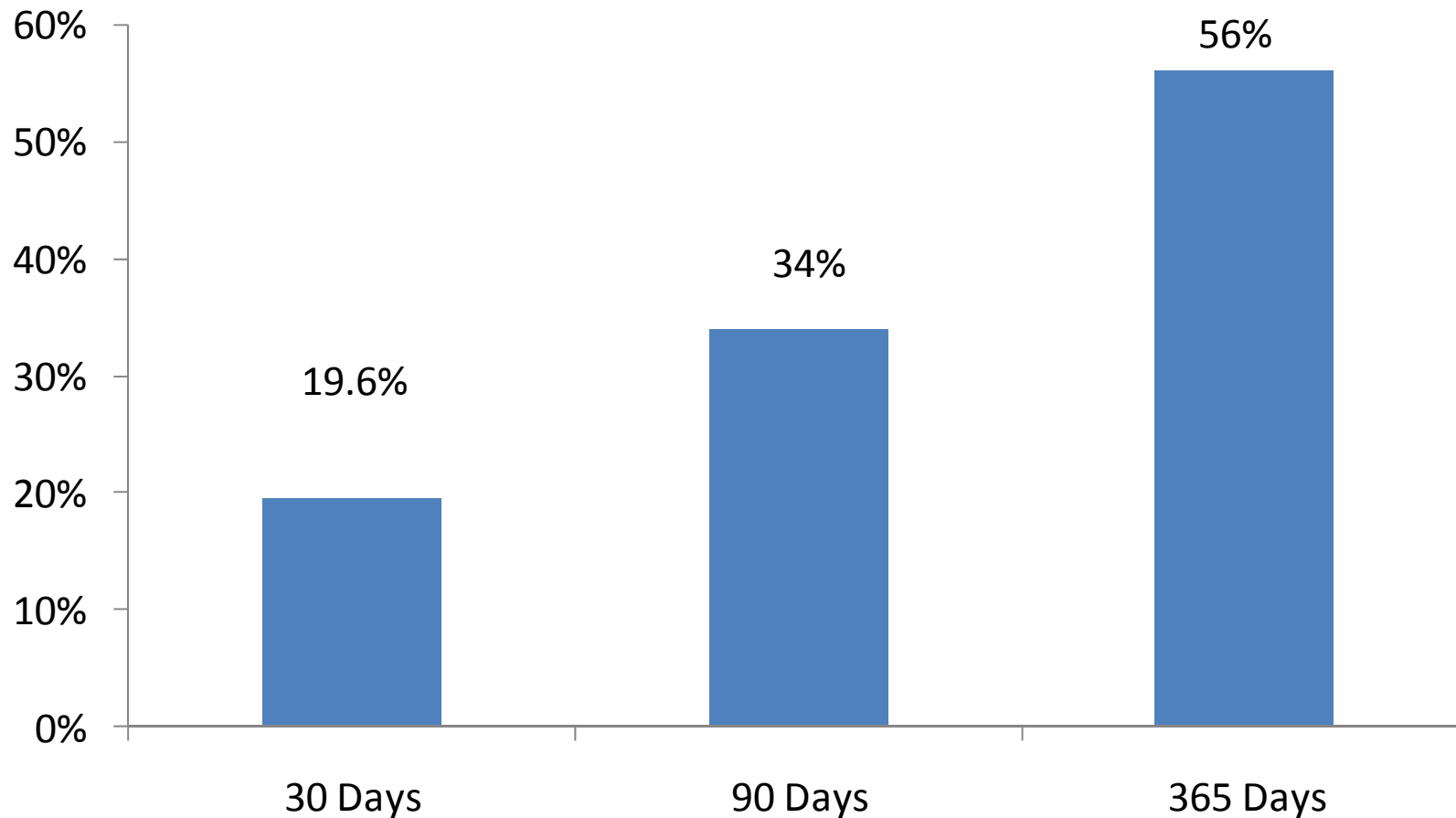


Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.



Rehospitalizations After Discharge in Medicare Fee-for-Service Programs

Percent of patients rehospitalized (cumulative)



Source: Adapted from S.F. Jencks, M.V. Williams, and E.A. Coleman. Rehospitalization Among Patients in the Medicare Fee for Service Program, *New England Journal of Medicine*, Apr. 2, 2009 360(14):1418-28





Timing of the Patient Hand Off is Decreasing

- According to the AHRQ Healthcare Cost and Utilization Project,
 - National average acute care LOS = 4.6 days^{1, 2}.
 - The hand off of patients between levels of care is critical to avert unplanned readmission
 - Especially for clinically complex Medicare patients.
- Average onset of illness days (ie, LOS) for acute care patients admitted to an IRH/U during 2009 – 2010 was between 13.1 and 14.3 days
 - Per eRehabData® database



Impact of Emergency Readmissions

- Of the patients returning to acute care within 30 days
 - Between 20-40% do not go back to the original hospital¹,
 - This leads to under reported readmission rates by the index hospitals.
- Estimated costs from unplanned rehospitalizations
 - in 2004 was \$17B¹
 - in 2008 MedPAC estimated \$18B was spent on readmissions of Medicare patients within 30 days⁴.
- Medicare also calling for seamless transition of patients across the continuum with improved coordination
 - Desired result = decrease of readmissions⁴.



Lessons Learned From Implementation



Partnership With Acute Care Providers Is Mutually Beneficial

- The Medicare RPPS rules regulate the types admissions an IRH/U can accept as well as the criteria medical necessity criteria
- Acute care hospitals also have Medicare PPS regulations for admissions and the management of LOS efficiency
- Partnerships between IRH/Us and acute care hospitals are critical to appropriately transition patients between levels of care
- Improvement opportunities are essential for providers to reduce readmission rates of patients in transition.



Action Steps to Prepare IRH/U

- Initiate internal systems to institute clinical and administrative corrective action plans
- Establish a database to track future RAC audits, denied claims, and management of appeals
- Develop databases and processes to be used for statistical and financial analysis
- Be involved in CMS policy discussions, in professional associations or trade organizations
- Take responsibility for your own education as a professional and advocate with colleagues



Action Steps to Prepare IRH/U

Microsoft Excel - PAS & PAE Educational Review worksheet_blank form

File Edit View Insert Format Tools Data Window Help

Type a question for help

N229

	A	B	C	I	J	K	L	M	N	O	P	Q
1	Admission							PAS Signed				
2	Date	Time	Name	Evaluator Name	Re-Screen Date	Liaison	Liaison Sign Date	MD Name	Date	Time	hr priors to admit	within 48 hr? pr
215												
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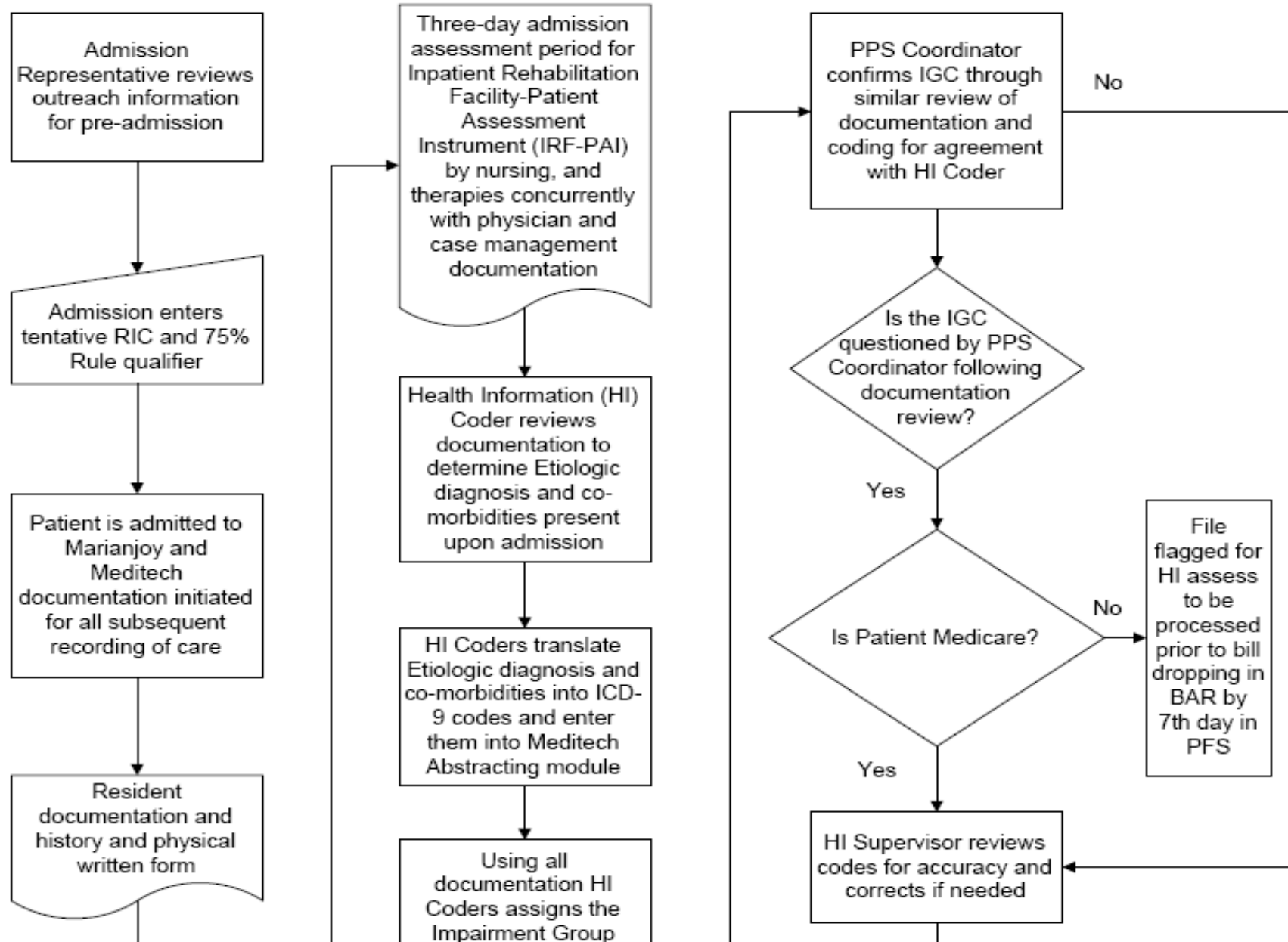
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Ready

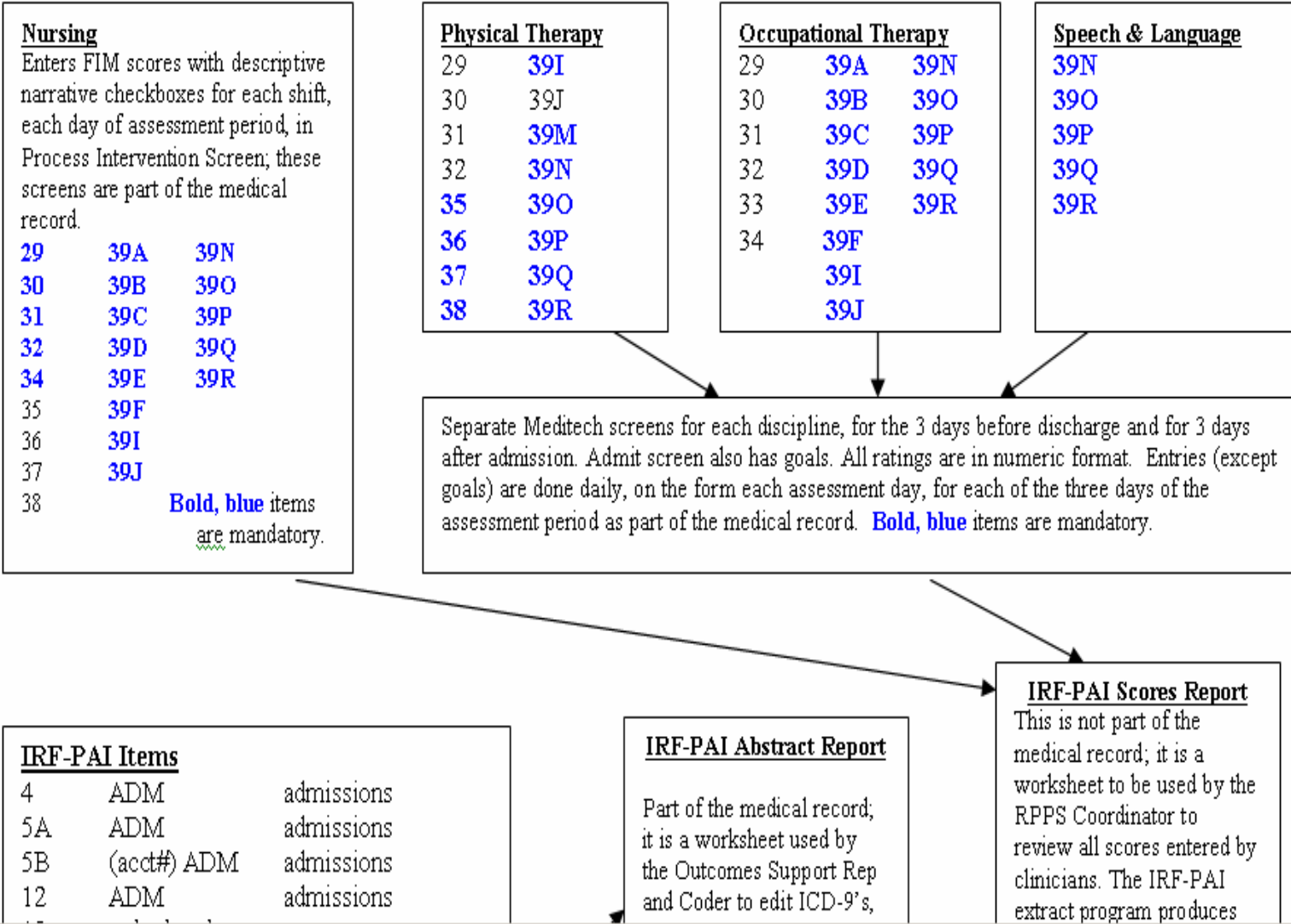
NUM

Establish a scorecard to track compliance of the documentation required

Prospective Payment System Documentation and Coding: Process Map for Patient Admission Process



Basic Structure of IRF-PAI Data Entry, Review, and Final Score Determination



Nursing

Enters FIM scores with descriptive narrative checkboxes for each shift, each day of assessment period, in Process Intervention Screen; these screens are part of the medical record.

29 39A 39N
30 39B 39O
31 39C 39P
32 39D 39Q
34 39E 39R
35 39F
36 39I
37 39J
38

Bold, blue items are mandatory.

Physical Therapy

29 39I
30 39J
31 39M
32 39N
35 39O
36 39P
37 39Q
38 39R

Occupational Therapy

29 39A 39N
30 39B 39O
31 39C 39P
32 39D 39Q
33 39E 39R
34 39F
39I
39J

Speech & Language

39N
39O
39P
39Q
39R

Separate Meditech screens for each discipline, for the 3 days before discharge and for 3 days after admission. Admit screen also has goals. All ratings are in numeric format. Entries (except goals) are done daily, on the form each assessment day, for each of the three days of the assessment period as part of the medical record. **Bold, blue items are mandatory.**

IRF-PAI Items

4 ADM admissions
5A ADM admissions
5B (acct#) ADM admissions
12 ADM admissions

IRF-PAI Abstract Report

Part of the medical record, it is a worksheet used by the Outcomes Support Rep and Coder to edit ICD-9's,

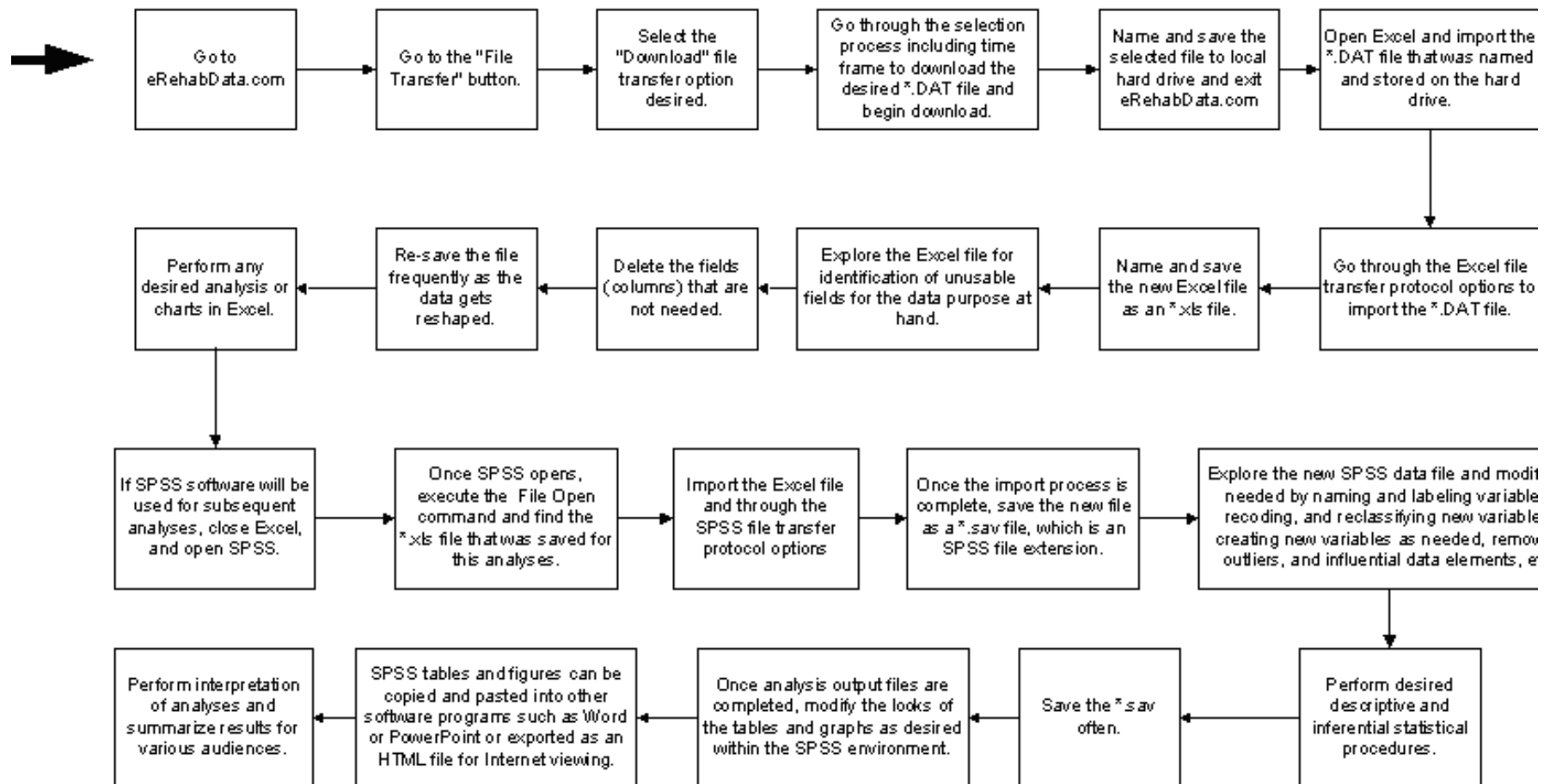
IRF-PAI Scores Report

This is not part of the medical record; it is a worksheet to be used by the RPPS Coordinator to review all scores entered by clinicians. The IRF-PAI extract program produces



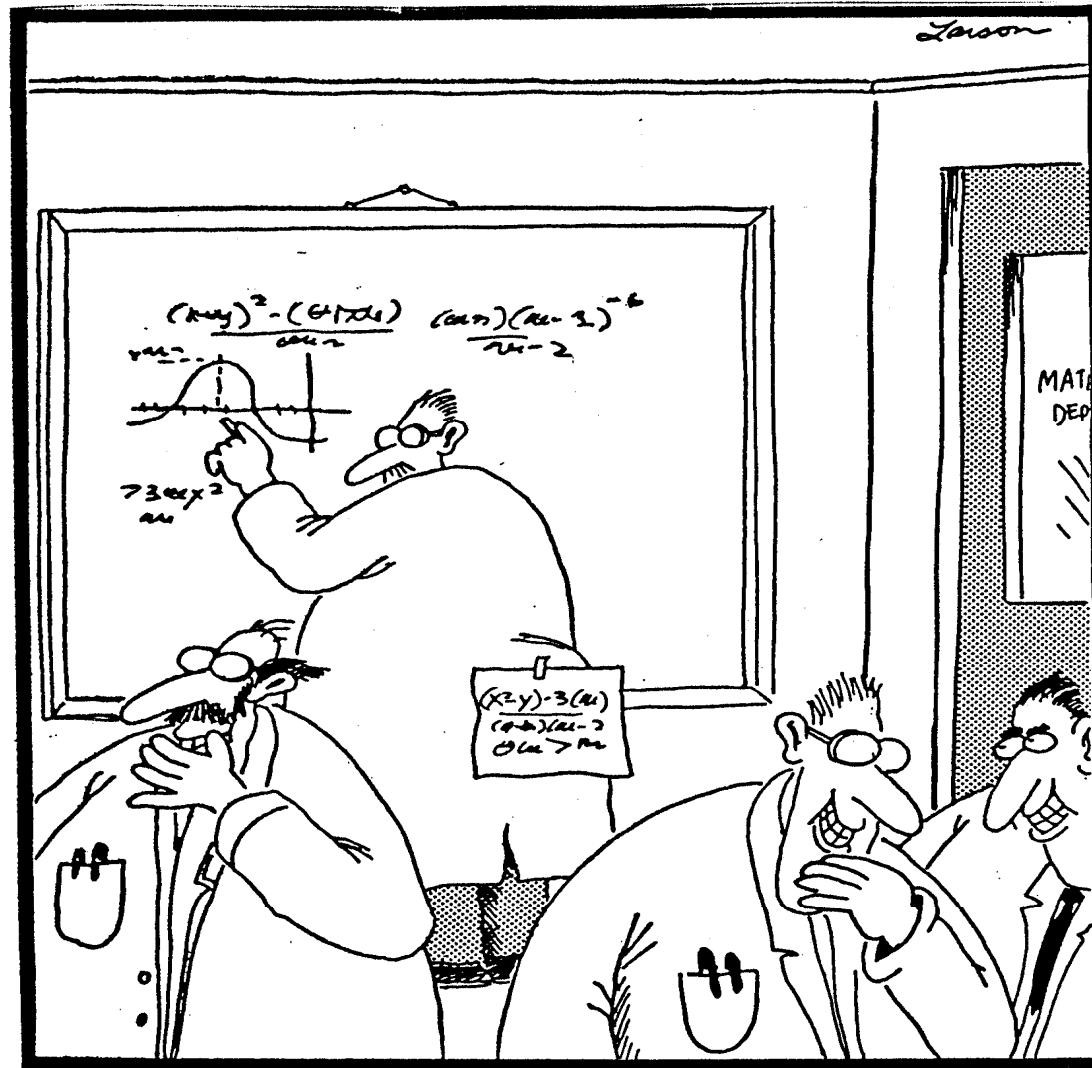
A Simple 22-Step Process

How to Download Data from eRehabdata.com Data Warehouse





Where Would We Be Without Data Geeks?





Action Steps to Prepare IRH/U

- Have effective Pre-Admission Screening process
- Cultivate close working relationships between Pre-Admission, Admission, Health Information, RPPS, and Finance functions
- Create critical checks and balance systems between departments and functions
- Conduct peer-review audits by physicians and other clinicians – practice will be needed for RACs
- Use outcomes data and benchmarks to demonstrate system effectiveness
- Network with other facilities across the continuum
- Consider collaborative research and education with referral providers



Questions and Discussion





References

1. Jencks, S.F., Williams, M.V., & Coleman, E.A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *The New England Journal of Medicine*, 360, 1418-1428.
2. Hospital average length of stay, changes, and costs by patient type, *Hospital Review Magazine*. Available: <http://www.hospitalreviewmagazine.com/news-and-analysis/current-statistics-and-lists/hospital-average-length-of-stay-charges-and-costs-by-patient-type.html> [September 28, 2009].
3. *HCUP Facts and Figures: Statistics on Hospital-based Care in the United States, 2007*. Rockville, MD: Agency for Healthcare Research and Quality, 2009 (<http://www.hcup-us.ahrq.gov/reports.jsp>).
4. Minott, J. Reducing Hospital Readmissions. 2008. Academy Health. Accessed online at: http://www.academyhealth.org/files/publications/Reducing_Hospital_Readmissions.pdf on March 15 2010).

Thank You

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